Common Mental Health Problems and Early Interventions in the Workplace
'How early is early'

Dawn M Bailey

A thesis submitted in partial fulfilment of the requirements of Nottingham Trent University for the degree of Doctor of Philosophy

2022

Acknowledgements

There were times throughout this research when I did not think that I would complete it. Throughout this time many curveballs were thrown at me ranging from personal bereavements and other life challenges to workplace restructures and job role changes. However, there have been several people that have been there and supported me all the way. Acknowledgement in the first instance goes to my supervisors Professor Diane Bailey and Dr Maria Karanika-Murray. Acknowledgement also goes to my workplace and close colleagues who have been on this journey with me, as without their continued support and engagement this study would not have succeeded.

There is one person who deserves an accolade for his dedicated and unwavering support and that is my long-suffering husband Graham, who has supported me through thick and thin, highs and lows, tantrums and tears. Never once did he complain about the hours and hours, I was sat at the computer reviewing literature, analysing data, writing, or putting our social life on hold so that I could keep focused. Our daughter Karenza was also a great support who would often give me the inspirational kick that I needed. I also wish to thank my close friends for their continued support.

Finally, I dedicate this study to my mum, and my stepdaughter Emma who sadly did not get to see me complete this very long intense journey.

Abstract

Previous studies have established that within the workplace, targeting both individual and organisational level factors are the most effective ways to prevent, protect or improve the impact of common mental health problems (CMHPs) (LaMontagne et al., 2007b, Memish et al., 2017, Cvenkel, 2020). However, current evidence has remained inconclusive in terms of timings for early interventions and there is little understanding of '*how early is early'* when instigating early workplace interventions for CMHPs.

Situated in a United Kingdom public sector workplace, this study through a qualitative participatory action research (PAR) design aims to answer two key questions. Firstly, when instigating early interventions for CMHPs in the workplace – *"how early is early?"* and secondly, does *"early"* differ in terms of what employees would find beneficial and what management currently provide? The study takes a social constructionist position and where a focus group data collection method is employed. Focus groups allows for social interaction and discourse within both employee and manager participant groups to explore the research questions in depth and provides opportunities for contributing to organisational change. Data analysis employs a grounded theory data method and draws upon social constructionist ideas whereby subjective reality, experiences, challenges, and meanings are made sense of in a social context. In turn the generated theory from the collective data of individuals contributes to organisational learning (Charmaz, 2008).

The findings identified three overarching themes, 'the mis-understanding of CMHPs in the workplace, management skills, and behaviours and 'the invisible employee'. The evidence confirms that to be '*early*', interventions need to be instigated at the '*earliest'* opportunity such as immediately following a diagnosis or when an individual is beginning to experience a decline in mental health. However, for such interventions to be effective, a multidisciplinary approach is needed and situated within a wider management framework to ensure that the workplace is a psychologically safe place.

Table of Contents

List of Tables

List of Figures

Chapter 1

1.1 Introduction

It is well known, and generally agreed that being in, and staying in work, is a major contributing factor to supporting an individual's mental health and wellbeing (Waddell, 2006, Black, 2008, Nielsen, et al., 2010, Farmer & Stevenson, 2017). However, there is a growing body of literature that has continued to focus on the negative impact that work may have on an individual's health such as excessive workloads and work pressures, thus failing to recognise that employers can benefit by taking proactive early intervention approaches that maximise the positive benefits that work can offer to individuals (Hill et al., 2007, Joyce, 2016, Farmer & Stevenson, 2017).

As several studies suggest, a continuing problem is that interventions have tended to be made once an individual is off work sick, thus purely focusing on return-to-work targets and rehabilitation measures (Seymour and Grove, 2005, Hill, 2007, Waddell, 2008). It is therefore questionable whether this type of approach constitutes an early intervention in the true sense and suggests that there is an undisputed understanding of what an early intervention is. Amongst the existing literature there are a number of inconsistencies in understanding and approaches within professional disciplines such as medicine, public health and psychology and where workplace interventions are underpinned by legislation (Seymour and Grove, 2005, Hill et al., 2007, Waddell, 2008, LaMontagne, 2014, Vargus-Prada, 2017). However, over the last two decades there has been much debate in terms of the proactive and preventative implementation of early workplace intervention methods for those with common mental health problems (CMHPs) (Sorensen et al., 2021, Health and Safety Executive (HSE) 2020).

Over many years there has been much debate regarding the implementation of early workplace interventions for those with CMHPs. Research studies have grown at a rapid rate with early workplace interventions continuing to be identified as high priority. In addition, much of the debate has pointed towards a need for qualitative explorations of such interventions in order to provide a deeper understanding of what factors facilitate or hinder intervening early

(Memish, et al 2017 & LaMontagne, 2014). Despite many arguing that a proactive approach to CMHPs in the workplace could benefit employers as well as employees (Fenton, 2014, La Montagne, 2014, Joyce, 2016), many researchers (Golembiewski et al., (1987) Munn-Giddings et al., (2005) NICE, (2009), Stevenson & Farmer, (2017) Quirk, et al., (2018) had undertaken qualitative studies with a range of 'experts' included senior management, human resources, and academics. However, although professionals are experts in their field, to understand the context of the problem 'through the lived experiences' of those affected, the instigation of an exploratory and participatory review through a social constructionist lens has largely been neglected.

For the purpose of this study, CMHPs will mean anxiety and depression as medically diagnosed conditions (Hill et al., 2007, The British Psychological Society & The Royal College of Psychiatrists, 2011). For the purposes of this research, stress is not being included as a CMHP per se. Although stress is recognised by mental health services (psychiatrists and psychologists) it is not clinically considered an illness although general practitioners (GPs) will often cite 'stress' as an umbrella term as a reason for an employee being off work sick (Hultén, et al., 2020). Typically, stress is understood as an adverse reaction that people may experience when excessive pressures or other types of demands are placed on them (Health and Safety Executive, (HSE) 2017). Stress can therefore be incurred by the work environment when work becomes overwhelming, stress can have a negative impact on individuals' who have existing CMHPs or can lead to the development of a diagnosable CMHP. The challenges surrounding the identification of anxiety and depression as CMHPs affecting the workforce as distinct from stress will be discussed later in the literature review.

1.2 Research questions and Objectives

This study is situated within a large unitary local government organisation in the United Kingdom (UK) and aims to explore through social discourse with employees and managers, what factors either enhance or hinder proactive early workplace intervention approaches in order to prevent sickness absence and/or support those with a CMHP. Current evidence remains inconclusive in terms of understanding the timing of interventions and the inconsistencies in the

definitions of what '*very early'* and '*early*' interventions mean (Vargas-Prada, 2017) - the question remains '*how early is early*?'.

Two key questions are therefore explored within this study to yield an original contribution to knowledge as follows:

- "*When instigating early interventions for common mental health problems in the workplace - how early is early?"* and
- Does *"early"* differ in terms of what employees would find beneficial and what management currently provide.

The key objectives are to understand:

- whether barriers to intervening early exist and if so, what these are from the perspective of different stakeholders for example: lack of management awareness, training, or support for employees.
- what types of targeted early intervention strategies could be implemented to benefit the manager, employee and the organisation in the proactive management of those with common mental health problems and
- what aspects of organisational change might be needed to allow improved interventions to happen.

A point to note is that this study was undertaken prior to COVID-19 so therefore does not discuss the issues that may have arisen from its impact on CMHPs in the workplace during/post pandemic. The full consequences of the pandemic on individuals with CMHPs are currently unknown, with research being in its infancy. However, it is fully acknowledged that the unprecedented disruption to the daily lives of through home or remote working is likely to be wide ranging with the consequences and impacts unlikely to be uniform in nature (Jia, et al., 2020). For example, social isolation whilst simultaneously being in work or on furlough may lead to a subjective experience of loneliness with associated detrimental effects, such as symptoms of CMHPs.

Therefore, exploring and understanding the '*how early is early'* question when instigating early interventions for those with common mental health problems remains relevant in the post COVID era as further studies emerge.

1.3 Background of the Research Problem

It is widely recognised that CMHP's are the leading causes of workplace sickness absence and disability across Europe and most other developed countries worldwide (Hill et al., 2007, The World Health Organisation (WHO), 2008, Joyce, 2016, Public Health England (PHE) 2019, Chartered Institute of Personnel Development (CIPD) 2021). Due to the economic burden on both employers and society in general, these conditions continue to be a major concern for policy makers and public health alike (Joyce, 2016, WHO, 2008). For example, in 2020 it was estimated that poor mental health resulted in absenteeism costing employers up to £45bn with further concerns being attributed to the continuing rise in 'presenteeism' (working whilst unwell) and a more recent concern of 'leavism' where employees are unable to disconnect from work thus impacting on those with CMHPs (MIND, 2020). Across the UK alone, the Labour Force Survey (2020) estimated that CMHPs accounted for 17.9 million working days lost and where 1 in 6.8 employees experience mental health problems with some of the highest rates of self-reported stress, anxiety and depression being attributed to those working in medium/large public sector organisations (Labour Force Survey & HSE, 2020).

It is well known that the public sector workforce, for many reasons are more likely than the private sector workforce to be exposed to organisational problems that are likely to impact on employees' mental health. For example, the past decade has seen public sector organisations, particularly Local Government being subject to continual austerity measures, restructuring processes, workforce cutbacks and increasing job demands. Because of this it is more likely that there has been a significant impact on sickness absence, productivity, and presenteeism (sub-optimally productive at work) in addition to impacting the individual's socioeconomic position (Getzel, Long & Ozminkowski, 2004, Sanderson & Andrews, 2006, Cocker, Martin & Scott, 2011, Reavely, 2014). Furthermore, these issues have led to much discussion in relation to the extent of negative attitudes towards CMHPs in particular stigmatisation of these conditions, which can lead to non-disclosure and ultimately sickness absence (Bergstromm, 2009, Hussey, 2012, Thisted, 2018).

A noteworthy point is that, although there is clear agreement that a poor psychosocial work environment can increase the risk of CMHPs (Stansfeld & Candy, 2006, Bonde, 2008, Cox et al., 2009, HSE, 2015) the fact that not all CMHPs are caused by the work environment, but often stem from life adversities (McManus, 2012) has not been given much attention, and little is known about how to tailor early interventions in a variety of occupational settings across the working population (Guthrie, 2017). Although policy and practice in the workplace intervention arena continues to develop, much discussion has taken place with theoretical frameworks being implemented in order to encourage a healthy workplace (WHO, 2010, WHO, 2019). However, these have principally concentrated on 'blanket' organisational level CMHP interventions, that lean heavily towards tackling workplace environmental causes that instigate work-related stress (Karanika-Murray, Biron & Saksvik, 2016,). Therefore, the opportunity to socially construct knowledge from 'the lived experiences' of those affected by CMHPs has been missed and where a vital piece of the jigsaw is to understand the cultures and behaviours within the organisational environment that can negatively impact on, or positively alleviate CMHPs.

Moreover, given the scale of the problem, literature in terms of early interventions and supporting those with CMHPs not specifically caused by work is relatively rare (Spurgeon, 2007). Despite the increasing recognition that the workplace is an important setting for health promotion (Hill, et al., 2007, Reavley, 2014, WHO, 2019), there is an identified need to address early interventions for CMHPs, not necessarily caused by work but that become visible or exacerbated within the working environment, and thus assisting individuals to remain in work (Sanders & Crowe, 1996, Martin, Sanderson, & Cocker, 2009, LaMontagne, Noblet, & Landsbergis, 2012). More recently it has become more evident that whilst it is acknowledged that CMHPs exist in the workplace, stigma and social exclusion of those with CMHPs have led to an 'under-recognition' of CMHPs. Because of this it has been suggested that subsequent proactive 'early' interventions are not being made (Mental Health Foundation, 2018, WHO, 2019, Paterson et al., 2021).

It has been suggested that whilst some improvements have been made in the effectiveness of interventions, researchers often struggle to effectively

communicate workplace health research findings to organisational policy and practice decision makers (Reavley, 2014, Christensen et al., 2020). This suggests there may be value in implementing collaborative, participatory and qualitative research methods involving stakeholders and decision makers in order to further shape the knowledge and understanding of workplace interventions for CMHPs. Additionally, participatory methods have increasingly been recognised as an effective means of enabling and implementing research recommendations based on practice-based-evidence as opposed to evidence-based-practice (Greenhalgh et al., 2004).

Despite the increasing recognition of the need to address CMHPs in the workplace through a range of initiatives, there is a distinct lack of qualitative studies undertaken from a social constructionist position that explores and understands from those with lived experiences of CMHPs what early interventions are needed in the workplace to support them. Intervening early for those with CMHPs in the workplace also needs to be framed within the UK policy context, which recognises the economic impacts on the employer of absenteeism through poor mental health (McDaid, 2013). Therefore, by instigating early interventions these are more likely to reduce troubling symptoms associated with CMHPs, rather than wait to intervene until an individual is off work sick (Goetzel, Long, & Ozminkowski, 2004, Cocker, Martin & Scott, 2011, Sanderson and Andrews, 2006, McDaid, 2007, Ivandic et al., 2017, Attridge, 2019).

In summary, there has been an acknowledgement that little is known about how to tailor early interventions in a variety of occupational settings across the working population (LaMontagne et al., 2007, McManus et al., 2012, Brunton et al., 2016, Joyce et al., 2016, Guthrie et al., 2017, Harvey et al., 2017, Black Dog Institute, 2021). Therefore, such interventions need to be clearly understood and defined to ensure that there is a balance in respect of employer vs employee contributions for example duty of care and individual responsibility. This research therefore aims to close the gap by exploring '*how early is early*' when instigating early workplace interventions for CHMPs and to identify what types of targeted early intervention strategies could be implemented to benefit the manager, employee and the organisation in the proactive management of those with CMHPs.

The following chapters (2&3) presents a discussion of the literature that exists in terms of CMHPs, early workplace interventions and moving into discussion of UK policy, occupational health and workplace health and wellbeing.

Chapter 2

Review of the literature

2.1 Introduction

In order to support the research questions and objectives of this study the literature review has been framed by themes and split across two chapters. This chapter reviews and discusses the published academic literature that exists around CMHPs, early workplace interventions, how these are defined within the literature and how does it relate to this study. Directly linked with the key research question "*When instigating early interventions for common mental health problems in the workplace - how early is early?"* this chapter considers and discusses linked topics and themes from the body of literature in order to identify key concepts, terminology, theories and definitions. Furthermore, the review considers whether there are multiple viewpoints or positions in terms of work and mental health, and at what level '*early*' interventions are targeted, for example organisational or individual level or both.

Being that the study is situated in a local government setting the following chapter (3) discusses the literature that surrounds the development of UK policy, the development of occupational mental health, workplace health & wellbeing, organisational participatory action research and organisational impact and change. There has been a growing agreement that poor mental health attributed to CMHPs often leads to significant impacts on individuals and the workplace (Hassan et al., 2009, Stevenson & Farmer, 2017, Chartered Institute of Personnel and Development (CIPD), 2021). Because of this there has been a renewed focus for government and public health bodies as to the adverse effects of poor mental health and the potential economic and societal consequences due to sickness absence (McDaid, 2017, Stevenson & Farmer, 2017, Health and Safety Executive (HSE) 2017, Hesketh et al., 2020). In turn, this has led to a range of national policy, strategies and initiatives being developed consequently impacting on public body organisations in particular, as they are often seen as leaders and beacons of change (NICE, 2009, Proper et al., 2019, Hesketh et al., 2020). It is therefore important to understand the organisational workplace response to national and international policy development and implementation

for CMHPs, in addition to considering the similarities and differences between public and private sector organisations.

I firstly make clear that for this study, the focus is on mild/moderate common mental health problems (CMHPs) such as anxiety and depression which may be either clinically diagnosed or undiagnosed and not necessarily caused by work-related factors. Whilst not included in a diagnostic category, work-related stress is often discussed in the same context as anxiety and depression and often used as an umbrella term (Tennant, 2001, Leka & Jain, 2010). However, an extensive body of literature currently exists in terms of work-related stress and associated management interventions and are therefore not debated in detail within this study (Department of Health (DoH), HSE, Department for Work and Pension (DWP), 2007, Kerr et al., 2009, Harvey, et al 2017, Cvenkel, 2020). Although it is accepted that organisational pressures and the associated impacts that stress can have on those with existing diagnoses of anxiety and depression cannot be totally ignored. (Funk, World Health Organisation (WHO), 2000, Tan et al., 2014, Public Health England (PHE) 2016).

There is a substantial body of literature in existence that focuses on early interventions and organisational effectiveness which aims to prevent, protect and improve employee mental health (Martin, et al., 2009, LaMontagne et al., 2014, Joyce et al., 2016, Martin et al., 2017, PHR, 2016, Lomas et al., 2019, Pieper et al., 2019). However, occupational health psychology has tended to lean towards the individual and treatment which consequently means that interventions are implemented at a singular level and often being reactive as opposed to proactive (Martin, et al., 2014). More recently, a study by von Thiele Schwarz et al (2020) suggested that for maximum impact organisational interventions that involve change cannot be researched without substantial collaboration from within the organisation and the researcher (Kristensen, 2005, von Thiele Schwarz et al, 2020). The authors went on to propose the Stigtuna Principles providing ten principles of how to design, implement and evaluate organisational interventions based on expertise from multiple disciplines (von Thiele Schwarz et al., 2020 pg:415-427). This view was supported by Ipsen & Bergmann (2021) who found that despite many tools and methods being available to ensure employee wellbeing, organisations continued to struggle to

deal with the increasing problem of CMHPs. Although the study had focused on work stress it aimed to co-create and produce a framework that focused on preventative strategies by combining a systems perspective on prevention. It could therefore be suggested that the same could be applied for workplace interventions for CMHPs in general (Ipsen & Bergmann, 2021).

For this study, I therefore define early interventions as being multi-level or multi-faceted, that regardless of cause prevent psychological ill-health whilst reducing work-related risk factors, promoting good psychological health and well-being. In addition, this includes promoting the positive aspects of work through the development of organisational competence and resilience, for example: what to do, when and how and by whom (Martin, et al., 2014, LaMontagne et al., 2014, McDaid, et al., 2017, von Thiele Schwarz et al., 2020).

The review of the available literature has taken the path of identifying evidence, theory and research gaps, in an attempt to address the research question and the aims and objectives of this study. The review begins with a discussion of the literature in terms of how CMHPs and early workplace interventions are defined in a social and workplace context, looking at the differences and similarities in relation to early intervention mechanisms for prevention of CMHPs and support whilst still in work. The discussions and debate then turn to the literature that surrounds the role of managers in the workplace, manager awareness, emotional intelligence and attitudes, and approaches to CMHPs, whilst the final section reviews and considers the literature on whether barriers to disclosure exist with a particular focus on stigma.

2.1.1 Literature Review Strategy

The literature review strategy implemented for this study begun with a preliminary search of the broad range topics that were linked to the research question and provided the background and context of the study. A strategic and selective literature review process was then implemented to support the underpinning arguments that formed the basis of my research and verified the gap in the knowledge.

The literature review had gathered pace during the cycles of PAR and the ongoing data analysis. During the cycles the emergent themes and sub-themes had identified key concepts, terminology, theories and definitions that were then compared and contrasted to the available literature specific to the research question.

- **Primary sources** included peer reviewed studies, journals and articles from a variety of academics and scholars with searches made in databases such as Elsevier, Google Scholar, Jstor, MEDLINE, PsycINFO, PubMed, Science Direct, Web of Science Core Collection, SAGE.
- **Secondary Sources**: Articles cited by others, abstracts, non-peer review papers & articles (meta-analysis and systematic review), papers and books .
- **Tertiary/Grey Literature:** Reports, working documents, Government reports and white papers, guidelines, theses, reports produced by government departments, regulatory bodies, business and industry.

- **Inclusion criteria:**
  Participatory action research studies, grounded theory reviews, systematic reviews, pilot studies, interventions delivered at an organisational level, organisational multi-level interventions, organisational and manager training studies. Public sector workforce studies, local government workplace/workforce common mental interventions, Workplace intervention studies that promote and or support common mental health problems. Literature relating to the themes, sub-themes and concepts that emerged from the data analysis.
- **Exclusion criteria:** Studies not in English Language, Clinical treatment studies, patient studies, severe mental health problems and treatments, statistical/theoretical models for mental health improvements, early interventions delivered outside of the workplace, interventions that address workplace issues such as bullying or harassment. Studies focused on the work environment factors and stress.

Keywords:

Boolean search included AND, OR, NOT to limit, broaden and define the search results: Anxiety, depression, intervention, mental disorder, mental health, work, UK Workplace, early interventions, common mental health problems,

manager training, manager competencies, occupational psychology, public sector, local government, mental health literacy, mental health first aid, confidence, stigma, disclosure.

2.2. Background

Research into workplace CMHPs and workplace interventions has a long history (Waddell & Burton, 2004, Corbière, 2009, WHO, 2017, Farmer & Stevenson, 2017, Hesketh et al., 2020). Although, in terms of instigating interventions when an individual within the workplace presents or discloses a CMHP, Wagner et al., (2016) found that the current body of literature tends to be dominated by intervention studies, and mainly focused on interventions that relate to improvement in mental health functioning. Wagner (2016) went on to suggest that workplace stakeholders tended to be only concerned with reducing absenteeism, presenteeism and reducing costs and where factors such as improved workplace outcomes have not been directly addressed in workplace intervention literature (Wagner, 2016). However, this stance could be open to challenge where it could be suggested that improved mental health functioning and positive workplace outcomes would go hand in hand (LaMontagne, 2014).

Over several years, the term 'early workplace interventions' for CMHPs has tended to encompass a broad range of interpretations and implementations, ranging from basic awareness and information leaflets through to complex interventions such as multi component physical and psychosocial support (Wagner et al., 2016). More recently, Hesketh's (2020) review of workplace CMHP intervention literature, suggested that opportunities exist for researchers to work with employers to strengthen the body of evidence on what interventions could work to improve workplace mental health and providing benefits for the organisation (Hesketh et al., 2020). However, the question that remains unanswered, is what constitutes early and what does this mean for those that either implement, or are the receiver of, an early intervention for a CMHP?

According to Bryan et al (2018) intervening early is more likely to determine the potential outcomes for those individuals that become unwell with a CMHP. In addition, it has been suggested that within organisations managers have a

pivotal role to play and are well positioned to the enabling of primary early workplace interventions (Seymour, 2010, Farmer & Stevenson, 2017, Greden, 2017, Dimoff & Kelloway, 2018, Karanika-Murray et al., 2018), although good relationships with managers need to exist and are key to enabling success (Buck, et al. 2001). These assumptions have been supported by a vast body of evidence-based guidelines that confirms the workplace as being an essential commodity in supporting CMHP interventions (UK Health and Safety Executive (HSE), 2006, NICE, 2009, WHO, 2005, Nexø et al., 2018). Current guidelines suggest that workplaces are best placed to intervene and support those with CMHPs by way of primary, secondary and tertiary interventions, however, it is important to draw attention to how these are defined and implemented (Nexø et al., 2018, Tsutsumi et al., 2019, Mental Health Foundation, 2021, HSE, 2021).

As the name suggests, primary interventions are important in that they aim to be proactive and preventative and look to reduce or eliminate occupational risk and promoting positive factors of work such as wellbeing, cohesion, supporting whilst building individual and team resilience. Secondary interventions can target individuals at risk providing support whilst they are in work in a bid to prevent sickness absence. Tertiary interventions, on the other hand, are reactive that aim to rehabilitate once an individual is off work sick or is returning to work following a period of sickness absence (HSE, 2006, Sidle, 2008, LaMontagne et al., 2014, Wagner et al., 2016, Joyce et al., 2016, Memish et al., 2017, Nexø et al., 2018). However, findings from Corbière's, (2009) review suggested that despite the positive evidence highlighting the value of interventions for those with CMHPs, the bulk of workplace interventions focused on secondary and tertiary instead of primary interventions. These views were supported by a range of published studies and discussed further within the sections of this chapter (Seymour & Grove, 2005, Hill, 2007, Waddell, 2008, LaMontagne, 2014, Vargus-Prada, 2017, Nexø et al., 2018).

It is widely agreed that mechanisms designed to prevent sickness absence and support individuals with CMHPs through early interventions require managers' understanding and support (Munir, 2009, Pomaki, 2010, Simpson, 2015, Wagner et al., 2016, Nicholson, 2018, Hesketh, 2020). However, participating managers in Wagner's (2016) study reported that they felt unsure about how, when, why,

and what types of mental health interventions are necessary to support those individuals presenting with CMHPs (Wagner et al., 2016). According to Bandura (1997) those with CMHPs often have low self-efficacy to manage their problem.

More recent studies appear to support the previous findings (Gayed et al., 2019, Dimoff et al., 2019, Christensen et al., 2020), Although, Bandura (1997) went on to suggest that supportive attitudes and relationships with managers can enhance self-efficacy to self-management of a CMHP (Bandura, 1997). The findings of Buck's (2011) study concluded that within the workplace the role of line managers is key. The authors suggested that further studies were required, not only in terms of CMHP early intervention approaches and frameworks, but also to explore and identify barriers that may or may not exist between manager and employees (Buck, 2011). Since this time, a range of studies have been undertaken to review the evidence and have focused on subjects such as managers responses to CMHPs amongst their employees and the effectiveness of manager mental health training. Whilst these studies reveal that there is some evidence that manager training programmes can improve knowledge, it has been suggested that more focus should be on manager competence, behaviour changes and altering attitudes thus potentially improving manager confidence (Black, 2011, Milligan-Saville et al., 2017, Bryan et al., 2018, Gayed et al., 2018, Tetui et al., 2018, Christensen et al., 2020). In addition, Nielsen (2017) suggested that leaders and managers have the power to make or break an intervention. Further to this Christensen et al., (2020) posited that the creation of a psychologically healthy workplace outcome is closely linked to managers actions Nielsen, 2017, Christensen et al., 2020). Manager understanding and support is therefore key when seeking to address the '*how early is early'* conundrum when instigating interventions. Therefore, it is as equally important to understand, in addition to employees, what barriers, if any, exist that may contribute to the stalling of 'early' interventions.

Furthermore, this then indicates a need to explore whether managers would be more confident with implementing interventions and adjustments at an early stage if they were equipped with appropriate skills and tools. Therefore, when coupled with the obtaining of a deeper understanding of CMHPs this would further enable managers to interact and engage more proactively and at an

early stage with employees who are diagnosed or present with a CMHP. But '*how early is early?*'

Common Mental Health Problems and the Workplace

It has been recognised that multiple factors can contribute to mental illness, which may include work and job stress, an ineffective work-life balance, family and/or relationship problems or unhealthy habits (Drawert, 2013, Wang et al., 2007, Saju, et al., 2019). In addition, CMHPs represent a large and complex phenomenon in the workplace (WHO, 2006, LaMontagne, 2014, Peterson et al., 2021), therefore it is important to review existing literature to understand how CMHPs and early workplace interventions have been defined. This section then turns to discussion of whether there are clear understandings or misunderstandings of CMHPs.

2.4 How are Common Mental Health Problems Defined in the Literature?

Over time, research has shown that there has been a shift in defining mental health, accepting that there is a presence of social psychological and emotional wellbeing and not focused on the absence of a problem or an illness (Loisel et al., 2013, Drawert, 2013, Galderisi et al., 2015, 2017, WHO, 2018). The WHO in 2004 described mental health as "*a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*" (WHO, 2004, p.12). Furthermore, theory-based definitions of common mental health problems often differ between a theoretical based view and that of the lay person, taking into account lived experiences (Milburn, 1996, Marchant, 2013). In support, Barnes, et al (2008) suggested that within the social context of a work setting that there has been little understanding of how CMHPs are defined from a lay persons perspective. However, what is clear is that mental health and illness has been conceptualised and understood as a spectrum which is holistic and interconnected by three themes – there is no health without mental health, mental health should not be viewed as purely an absence of ill health but a state of positive physical, mental and social wellbeing (Hassard, Cox & Murawski, 2011 pg:5, LaMontagne et al., 2014).

Attention is therefore drawn to a similar mental health continuum model, where Keyes (2002) coined the phrases '*flourishing*' meaning experiencing optimal mental wellbeing and '*languishing*' representing low mental wellbeing arguing that mental health and mental illness are not opposite ends of a single continuum. The approach means that an individual may be diagnosed with a CMHP but copes and functions positively, whilst others may not have a diagnosed CMHP but has poor mental health and experiences problems coping or functioning from time to time. In short, everyone is on the continuum somewhere and dependent on life experiences will move up and down the continuum throughout life. This means that the absence of complete subjective wellbeing (fully flourishing) does not necessarily mean they are mentally ill (Languishing) (Keyes, 2007). The de facto position tends to be that mental health is a complete state and individuals are presumed to be mentally healthy where there is an absence of mental illness (Keyes, 2005, Hassard, Cox & Murawski, 2011) however, the continuum acknowledges those who are neither flourishing or languishing are described as having moderate mental wellbeing.

Building on the mental resilience theory of Ryff (1989), who advocated that to assess an individual's resilience, indicators needed to encompass more than absence of illness, Keyes (2002) was instrumental in presenting a mental health classification (dual continua) model integrating the Diagnostic and Statistical Manual of Mental Disorders (DSM). The main assumption being the absence of a mental illness did not imply the presence of mental wellbeing but viewed as two interrelated, yet separable dimensions. Summing up and as outlined by Keyes, (2005) multi-dimensional psychological functions such as emotional, and social wellbeing contribute to 'flourishing' mental wellbeing. What is noteworthy is that the workplace is important in a social context for promoting positive mental health and wellbeing (Hassard, Cox & Murawski, 2011). Moreover, the workplace has been recognised as an important setting for the instigation of early interventions and initiatives for CMHPs (Leka & Cox, 2008; Cox, Leka, Ivanov & Kortum, 2004, Hassard, Cox & Murawski, 2011). However, for this to be successful the organisation and the workforce need to be engaged in an environment that understands the factors that contribute to the instigation and effectiveness of early interventions for CMHPs (Hassard, Cox & Murawski, 2011,

Hesketh et al., 2020). This now leads me to the discussion of early workplace interventions for CMHPs and how these are defined.

2.5 Early workplace Interventions for CMHPs: how are these defined within the literature?

Several studies confirm that 'early' interventions for CMHPs have tended to be reactive in nature, largely based on return-to-work targets and rehabilitation measures, and only made once an individual is off work sick (Seymour and Grove, 2005, Hill, 2007, Waddell, 2008) therefore by definition, do not constitute early interventions in the true sense. Moreover, the literature has continued to show that there are ongoing inconsistencies in the definitions of what 'very early' and 'early' interventions mean, and current evidence remains inconclusive in terms of the timing of the interventions (Vargus-Prada, 2017) thus adding to the '*how early is early debate'*.

Traditionally, early workplace interventions for CMHPs have developed relatively independently from one another across the medical, public health and psychology disciplines (LaMontagne, 2014). Evidence has shown that the determinants that are embedded in the psychosocial and physical work environment are likely to have an adverse impact on those that have an existing CMHP (Laka, 2008). However, psychosocial risk management in the workplace tends to be underpinned by legislation in many countries, with early interventions for CMHPs therefore being focused on workplace conditions and organisational pressures (European Agency for Safety and Health at Work (EU-OSHA), 2012, Sivris & Leka, 2015), with 'early' interventions only being implemented to remove or reduce the risk factors that can trigger an adverse reaction (Marmot, 2009).

In the UK, the regulating and enforcement body for health and safety in the workplace - the Health and Safety Executive (HSE, 2004, LaMontagne et al., 2014), introduced a framework which identified six areas of work that are deemed to be the main sources of workplace stress with interventions broadly focusing on the workplace environment and the impact on an individual's mental health. However, the interventions do not account for the non-work-related personal factors that may contribute to the adverse impact on those already

diagnosed or are presenting with a CMHP i.e. anxiety and depression (HSE, 2016) There is, therefore, a need for clear recognition that not all CMHPs are caused by the work environment, and can often stem from life adversities (McManus, 2012). In addition, the HSE (2016) identified and reported that statistically higher levels of mental ill health appeared to be across workplace sectors such as public administration and the health sectors, suggesting that these sectors should be areas of focus when undertaking further studies in terms of early workplace interventions for CMHPs (Vargas-Prada, 2017).

Additionally, the last decade has produced a range of systematic reviews in terms of early interventions for CMHP in the workplace, however, these have been focused on the effectiveness of the prevention of CMHPs and improved organisational outcomes (Richardson, 2008, Czabala, 2011, Reavley et al., 2014, Wagner et al., 2016). Other system-based reviews have found, like many others, that the main aim of CMHP interventions has been concerned with organisational impacts and outcomes per se, as opposed to early, focused and individually framed early interventions (Corbiere, et al., 2009, Pomanki, et al., 2012). A relatively small sample of workplace intervention studies have aimed to reduce symptoms of CMHPs (Martin, et al., 2009), although Reavely et al., 2014 highlighted that over half the 17 intervention studies that they reviewed purely focused on individual resilience interventions such as the provision of psychoeducation, cognitive behaviour therapy and coping skills and only showed a small positive effect on symptoms of depression and anxiety (Reavley, 2014).

More recently there has been a push for organisations to implement mental health first aid (MHFA) training in order to aid recognition of CMHP at an early stage thus having the potential to make an early intervention. Although still in its infancy in the UK, there is ongoing debate amongst academics as to its effectiveness (Bell et al., 2018, HSE, 2018, Narayanasamy et al., 2018). In addition, there is no current evidence to suggest that MHFA has improved organisational management of CMHPs, with limited evidence to confirm if the content is specifically designed with the workplace in mind (HSE, 2018). In addition, a collaborative feasibility study carried out by University of Nottingham and London South Bank University (2018) found that, although the provision of MHFA training is likely to demonstrate that an organisation is taking mental

health seriously, concerns were raised in terms of the lack of operationalisation of boundaries for the trained person and the lack of recording and measurement of the impact on the end user (Narayanasamy, 2018). Evidence has also shown that early interventions that aim to assist individuals to remain in the workplace are particularly important for those in work with a CMHP (Vikerstaff, et al., 2012).

Although the emergence of an increasing amount of literature surrounding early interventions, the interventions have often been designed to prevent, detect and manage CMHPs in the workplace. However, these have tended to emerge independently from a variety of professional disciplines such as public health, psychology, medicine, and occupational health and safety, thus negating the opportunity to develop a holistic and integrated approach that could be deemed as an 'early' intervention (Memish, 2017, LaMontagne, et al., 2014, Alexander & Campbell, 2011 and Martin et al., 2009a, 2009b). Over time there have been a variety of definitions and meanings for what is generally understood to be early interventions for CMHPs. However, the general consensus amongst the literature of '*early*' interventions have been broadly classified as primary, secondary or tertiary and where they aim to prevent, treat and rehabilitate those diagnosed with CMHPs (Seymour & Grove, 2005, LaMontagne et al., 2007, Martin et al., 2009, Joyce et al., 2010, Bhui et al. 2012, Joyce, et al., 2016). It is therefore suggested that '*early*' is defined as when an individual shows first signs of a decline in their mental health or of being symptomatic.

As an example, the meta-review undertaken by Joyce et al., 2016 identified a number of primary and secondary prevention approaches that demonstrated either moderate or strong efficacy in terms of reducing the severity of symptoms related to CMHPs. However, on the other hand it was identified that a gap in the literature existed in relation to understanding what types of early interventions would lead to meaningful outcomes in the workplace (Joyce, et al., 2016). The review also found that there was limited evidence as to how primary, secondary and tertiary interventions could be developed, combined and coordinated to ensure a balanced mix of early interventions for CMHPs (Joyce, et al., 2016). In essence, this would mean making early interventions at the earliest possible

time such as symptom(s) identification, which leads to an early intervention, but also enabling interventions from primary care.

However, an individual would firstly need to feel confident in themselves before disclosing a CMHP, whether it be at a stage of a job interview or following a diagnosis and secondly, they would need to have trust and confidence in their manager to provide a supportive environment. On the other hand, a manager will also need to be confident in either approaching an individual that may be showing signs of a CMHP and knowing how and what procedures to implement, whether it be having a difficult conversation or referring to an employee assistance and onward support, if indeed one exists.

Having discussed the definitions of CMHPs and early interventions in a workplace context, it is important to discuss the wider context to further understand if over time CMHP definition developments have provided the general population with a clear understanding or whether a misunderstanding exists (Seymour, 2010).

2.6 Common Mental Health Problems in the Workplace An 'understanding' or 'misunderstanding'?

The definitions of mental health and subjective meanings have continued to be presented in a variety of ways and is often the term used for mental health conditions. 'Mental health problems', 'mental illness' and 'mental ill health' are all common terms that are used to refer to the full spectrum of diagnosed clinical conditions such as depression, anxiety, psychosis, bipolar, or schizophrenia (Fingret, 2000). Conditions formerly referred to as 'neuroses' appear to be more frequently called 'common mental health problems', although 'neurotic' also covers those symptoms which can be regarded as extreme forms of 'normal' emotional experiences such as depression, anxiety, or panic (Goldman, 2006). However, what is clear from the body of literature, is that the experiences of CMHPs are not continuous or static in nature and where there is a likelihood for individuals to be mentally well for long periods of time. Although, it is noted that some individuals will explain an adverse reaction to a life event as a blip and may not necessarily consider themselves as having a CMHP thus taking steps to maintain their mental health, and in turn increasing resilience (Irvine, 2012).

The definitions noted appear to have originated from theory-based concepts and influenced by academic knowledge (Drawert, 2013). It is therefore not surprising that the representations of CMHPs are confusing with presumptions often being made by those who do not understand how each individual is affected by a mild or moderate CMHP (Kinman & Jones, 2005, Drawert, 2013). It is recognised that theory-based concepts of CMHPs provide a basis for evidence-based research and practice, however, these can detract from further exploration of the meanings and perspectives of those that have the lived experiences of CMHPs. Furthermore, it has been argued that subjective representations of CMHPs and illness have their value (Helman, 1985), with evidence suggesting that subjective constructs are important, particularly to explain causes and experiences of CMHPs that may be perceived differently from those with little or no understanding (Kinman & Jones. 2005). In addition, it could be suggested therefore, that laypersons views are likely to provide further insights and a deeper understanding of CMHPs that lead to positive mental health and wellbeing interventions (Keyes, 2005, Barry, 2009).

A range of studies have suggested that anxiety and depression are the most prevalent CMHP amongst workers (Meunier et al., 2019, Sanderson & Andrews, 2006, Theis et al., 2018), therefore there is no surprise they have been associated with diminished work functioning, absenteeism and increasing presenteeism (Sanderson & Andrews, 2006). As previously discussed, stress has tended to be included in the CMHP debate, despite theoretical models conceptualising stress as a reaction to adverse life events and stressful environments. In addition, over several decades there has been a continuing tendency to attribute CMHPs to stress and the work environment (Kiman & Jones, 2005, McCormick, 1997, Warr & Payne, 1983). The significant body of literature on work-related stress has appeared to put theoretical debates of CMHPs into a secondary position thus occupying a contested position between poor mental health, stress and a significant clinical disorder (Bhui, et al., 2016, Cooper et al., 2001, Cox, 1993, Kinman & Jones, 1993, Irvine, 2014). Furthermore, within the research literature, qualitative studies that explored lay person conceptualisations of 'life stress' and CMHPs have also suggested there are considerable variations in how the concepts of stress and CMHPs are

understood. (Helman, 1985, Hodgetts & Chamberlain, 2000, Pollock, 1988, Kinman & Jones, 2005).

Mental illness (or mental distress), on the other hand, appears to be an umbrella term that refers to a variety of psychiatric disorders although like physical illnesses they can vary significantly in severity and in the symptoms (Department of Health, (DOH) 1997). The World Health Organisation (WHO) defines health as: ... "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" although the report suggests that "*there is a wide and varied interpretation across cultures*" (WHO 2001a, p.1). The WHO (2004) report outlines key ideas that mental health is made up of three important components, stating that mental health is an integral part of the definition of health, mental health is the absence of mental illness and mental health is linked to physical health and behaviour. Although, the report concedes that there is no consensus in relation to the definition of mental health due to the wide range of international differences and cultures. This is supported by the International Labour Office (ILO, 2000) who suggests that the term 'mental health' is not easy to define.

Overall, there continues to be a contested position of CMHPs between the concepts of mental health and wellbeing, mental illness, stress, distress and a significant clinical disorder. As pointed out by Irvine (2012), CMHPs frequently originate from outside the workplace with factors and complexities existing that are outside an employer's control, although public health policy has moved to the positive stance of mental wellbeing, typically CMHPs will include anxiety and depression. However, it is acknowledged that mental health and mental ill health fluctuates along a continuum as a state of 'being' with an understanding that an individual may experience poor mental health without having a more significant clinical disorder (Irvine, 2012). In her study Irvine (2012) suggested that that some conceptualisations of CMHPs can have particular significance especially where an individual considers disclosure to a manager for help seeking and support, however, the author points out that evidence suggests that what managers perceive as 'personal problems' is outside their responsibility thus being unresponsive and hampering the opportunity to instigating an early intervention (Vikerstaff et al., 2012, Irvine, 2012).

Summary

From the literature presented it is difficult to determine what the studies and reports mean by the generalised term 'mental health', a variety of terms have been used interchangeably across a plethora of studies which then causes confusion. However, as a starting point the literature needs to be explored to understand how mental health is defined within the workplace and to identify any variations that may exist across occupational sectors. This approach will require the moving away from the 'medicalisation' of CMHPs. In addition, there is a need to differentiate between mental health problems and common mental health problems (Hill, et al., 2007).

Furthermore, the extent to which any of the suggested individual early interventions prevent or alleviate common mental health problems such as stress, anxiety or depression remains unclear, and studies are limited. Highlighting the need for a consensus amongst stakeholders and policy makers on what constitutes 'early' intervention as a key factor, and further research was needed to address the question (Hill, et al., 2007, Vargas-Prada, 2017). This therefore, further substantiates the need to explore and uncover 'how early is early' and needs to be implemented to assist individuals thus ensuring maximum gain for both the individual and the workplace itself.

In order to understand these discussions and unanswered questions in more depth, the following sections discusses the literature that surrounds early interventions for CMHPs and the role of the workplace. This section proceeds with discussion of the literature in terms of the workplace as an enabler of early interventions, moving on to what constitutes an early workplace intervention. This section concludes with discussion of the economic and policy drivers for the management of CMHPs and interventions within the workplace.

2.7 Early Interventions for Common Mental Health Problems and the Workplace

It has often been assumed that CMHPs develop outside of work and are not the responsibility of the workplace. However, it is now well established within the body of literature that instigating a primary prevention intervention within the workplace is likely to be more effective when the intervention targets the

individual and organisational factors (Giga et al., 2003, LaMontagne et al., 2007, Memish et al., 2017). Therefore, from a social constructionist perspective the aim had been to understand what drives early workplace interventions and why they are deemed important. Underpinning this, is the workplace itself and how it supports those with CMHPs thus leading me to the discussion of the literature that encompasses the workplace and how it can become an enabler of early interventions.

2.7.1 A landscape view of the workplace as an enabler of early interventions

It is well known that being in and staying in work is a major contributing factor to supporting mental health and wellbeing (Royal College of Psychiatrists, (RCPsyc) 2010). It is also recognised that CMHPs such as anxiety and depression are the leading causes of workplace sickness absence across Europe and other developed countries (WHO, 2012). However, instead of considering the determinants, promotion and prevention of CMHPs in a wider context, policy makers and public health bodies have tended to concern themselves with the economic costs of CMHPs such as lost productivity, sickness absence, and the impact on the welfare system (Joyce, 2016).

Describing their review as a 'best evidence synthesis' Waddell and Burton's (2006) evaluation of a variety of published literature, looked to make sense of the question 'Is work good for your health and wellbeing?'. The authors suggested that the relationship between work and CMHPs should be embedded in a broader social context, identifying that work is central to social identity, social roles and social status, therefore indicating that the 'problem' should be considered wider than the economic policy context (Waddell & Burton, 2006). However, despite reviewing over 40 studies that focused on mental health in the workplace, Waddell & Burton (2006) neglected to identify the potential of instigating early workplace-based support interventions particularly where they are more likely to reduce mental ill health and absenteeism (McDaid, 2011). Because of this, a gap continues to exist where there has been a lack of focus on the potential benefits of the social context of the workplace within the literature. Moreover, it opens the door for exploring 'how early is early' in terms of early workplace interventions for CMHPs, allowing for the voices of those who

experience CMHPs to be heard thus providing an opportunity to 'fill the gap' through social discourse and viewed through a social constructionist lens.

Even though CMHPs represent a complex phenomenon in the workplace which includes the fear of disclosure resulting in stigma, discrimination and social exclusion (WHO, 2010); traditionally interventions for CMHPs have developed relatively independently from one another across the public health, psychology and medical disciplines (LaMontagne, et al 2014). Primarily, public health concerns itself with occupational safety, and health and health promotion, while psychology seeks to understand and intervene in positive psychology and behaviours, whilst psychiatry and medicine seek to treat mental health illness (WHO, 2004). However, prevention interventions are often individually focused lacking practical tools for implementation (Nicholson, 2018). According to Memish, (2017), evidence indicates that interventions should be designed taking into account not only individual factors but factors such as the workplace culture and management and leadership styles (Joyce et al., 2016, LaMontagne, et al., 2007b, 2014).

Prominent academics in occupational health and wellbeing, LaMontagne et al., (2014) introduced an integrated approach to CMHPs in the workplace, suggesting that integrating the three threads of preventing, promoting and managing would provide a comprehensive approach to intervention and support for those with CMHPs (LaMontagne, 2014). The authors vision consisted of weaving together the prevention of mental health problems by reducing the work-related environmental risk factors, promoting the positive aspects of the workplace and ensuring effective management of CMHPs regardless of cause into an integrated model of intervention (LaMontagne, 2014). They argued that the approach would align to the existing systems approach to reducing job stress, in addition to concluding that the model also had the potential for preventing and managing CMHPs (LaMontagne, 2014).

Moreover, Nielsen et al., (2010) noted that many workplace interventions had been designed to modify the causes of mental illness and were primarily targeted at large organisational groups and in a uniform way (Mikkelsen, 2005). Nielsen (2010) questioned what process related factors affect intervention

outcomes, what factors are targeted and are these correct and whether current assumptions of research designs and paradigms help to understand interventions and their outcomes? It was also noted that similar issues such as sample sizes and sustainability had previously been raised in other studies (Kompier, 2004, Cox, Karanika, Griffiths & Houdmont, 2007, Semmer, 2011) However, LaMontagne et al., (2014) further identified a need for both individual level and organisation wide intervention approaches, recommending that future research enquiry should be based on sound principles and theory that acknowledges the views of relevant stakeholders. Although, this came with a caveat that both organisational and individual approaches would need to be fully supported by the organisation to ensure success (LaMontagne, 2014). This gap in the literature therefore lends itself to social constructionism epistemology and where social discourse of the management of CMHPs in the workplace can be socially constructed thus attempting to identify 'how early is early' in terms of interventions for CMHPs.

In summary, it is fully acknowledged and widely agreed that the workplace provides a convenient setting to instigate early interventions for those with CMHPs whether work is the causal factor or not (RCPsyc, 2010, WHO, 2010, LaMontagne, 2014, Joyce, 2016, Memish, 2017, Nicholson, 2018). However, the body of literature that exists in terms of early interventions and how these have been developed and depicted within the literature requires further review and discussion, which I now turn to.

2.7.2 The Development of Early (Workplace) Management Interventions for CMHPs

Attention is drawn to the research into CMHPs such as anxiety and depression in the workplace which dates back several decades and where there has been an increasing involvement of occupational health practitioners (Fingret, 2000). Despite occupational physicians demonstrating an interest in the psychological aspects of work as far back as the 1960's, Jenkins (1993) questioned why research in mental health and work was so under-developed particularly when anxiety and depression were a common phenomenon in the workplace. Since this time a range of studies have been published in terms of CMHPs such as anxiety and depression in the workplace (Jordan et al., 2003, Hill et al., 2007,

Montagne et al., 2007, Seymour, 2010, McVicar, 2013, Joyce, et al., 2016, Nicholson, 2018).

Nevertheless, studies were found to be limited in terms of exploring the understanding CMHPs and early workplace interventions and particularly through the utilisation of a participatory action research approach (Baum, 2006, Feltner et al., 2016). Furthermore, The WHO had suggested that the impact of poor mental health on productivity was greatly underestimated, recognising that CMHPs were likely to affect an estimated 15-30% of employees during their working lives and should be seen as a top priority for the workplace (Harnois and Gabriel, 2000). Although the report flagged workplace CMHPs as a 'top priority' it merely took a practical look at strategies from across the European Union (EU) to identify best practice in terms of promoting and sustaining good mental health in the workplace. The report placed very little emphasis on the development of social policy in order to provide informed, effective and responsive workplace interventions for CMHPs, despite acknowledging that employment and the workplace promotes social contact and social identity (Harnois and Gabriel, 2000).

Subsequently, emerging guidance confirmed that government and businesses alike had important roles to play in the development of workplace mental health policy and practice, outlining that policy should be based on a comprehensive understanding of the issues of CMHPs (WHO, 2005). Moreover, and directly linked to the assumptions of WHO (2005), was the growing recognition that the obstacles of managing CMHPs within the workplace and are often challenging, particularly in terms of managing the disclosure of illness which can result in stigma and discrimination (Corrigan, 2012). It has been well documented that whilst disclosing an CMHP and individual is often faced with the associated feelings of shame, fear and rejection that can in turn lead to social exclusion by way of public and self-stigmatisation, thus further impacting on an individual's psychological health (Liimatainen & Gabriel, 2000, Brohan et al., 2010, Corrigan & Rao, 2012, Hanisch et al., 2016, Elraz, 2018). It could therefore be suggested that opportunities were therefore missed by WHO (2005) to using alternative and innovative ways of intervening early in order to provide multi-faceted support mechanisms in the workplace whilst developing their guidance.

Notwithstanding that over time a plethora of studies (Waddell & Burton 2006, McDaid, 2011, WHO, 2012, LaMontagne, 2014, Joyce, 2016) have emerged that investigate early interventions in the workplace in relation to mental ill health and particularly in terms of primary and secondary organisational interventions. Bellón et al., (2019) found amongst their systematic review and meta-analysis of randomised controlled trials (RCT) that there was a gap in terms of the prevention of CMHPs. The authors argued in a hypothetical sense, that if all existing cases of CMHPs were adequately treated that new cases could only be avoided through primary prevention interventions (Bellón et al., 2019).

Similarly, Karanika-Murray (2015) noted that many inconsistencies and gaps in knowledge exist in terms of the success of workplace interventions for CMHPs, particularly as intervention research is known to be notoriously difficult within a complex and dynamic organisational setting (National Institute for Health Care Excellence, (NICE) 2016). Furthermore, Memish et al., (2017) found shortcomings in the quality of occupational intervention guidelines due to a lack of consultation with relevant professionals and population groups such as employers and the workforce itself (Cates et al., 2006, Memish et al., 2017). The authors went on to suggest that the lack of engagement with these groups could reasonably explain why there are consistent failures in implementing guideline recommendations (Memish et al., 2017). Similarly, Hesketh et al., (2020) suggested that the available evidence and range of interventions for CMHPs was so diverse that it was difficult to draw robust conclusions as to their implementation and effectiveness (Hesketh, 2020).

There appears to be ongoing confusion amongst the body of evidence particularly when linking the literature with the definitions and understanding of CMHPs and interventions, which could also indicate the reluctance to implement early interventions (Corbiere, et al., 2009). Reporting to the HSE, Cox, (1993) commented that researchers in workplace mental health should seek to address the design and implementation of interventions for CMHPs as numerous risk factors and groups have previously been identified with theories and causes being examined (Cox, 1993). Although the trend appears to have continued where Corbiere, (2009) identified 24 studies undertaken between 2001-2009,

with the primary focus being on preventative interventions for CMHPs within organisations. However, these studies were mainly limited to workplace 'stress' factor interventions to improve mental health issues by implementing the Karasek's (1990) model of job demands, control and support (Karasek, 1990, Corbiere, 2009) thus not recognising that work may not necessarily be the causal factor, or what and how effectiveness of interventions can be improved (Nielsen, Taris & Cox, 2010).

In further support, Cooper, (2010) noted that we know what causes individuals to become ill in the workplace, what we now need is solutions. Moreover, Karanika-Murray (2015) recommended for intervention research to move away from intervention evaluation, but instead focus on what works for whom, in what circumstances and why, quoting "*little real progress is being made in intervention research and we do not need more of the same*" (Nielsen, Taris & Cox, 2010, Karanika-Murray, 2015 pg:3, NICE, 2016). This approach builds on the thinking of Nielsen & Randall (2015) who argued that for interventions to be successful, consideration should be given to how the interventions will fit with individuals and the context in which they function (Nielsen & Randall, 2015).

A further review of work-based interventions for those with CMHPs revealed that most interventions focused on the individual, and targeting individual coping strategies (Pomaki *et al.*, 2012). The authors recommended the implementation of a systematic early intervention approach by making improvements to employer-employee communication channels in order to support individuals at risk of being absent due to a CMHP (Pomaki *et al.*, 2012). On the other hand, for the approach to be successful, a culture would need to exist within the workplace where managers feel confident with having a conversation with an individual who firstly discloses a CMHP, then knowing what steps to take and what support could be provided (The Mental Health Foundation, 2016). Fenton, (2014) suggested that only a limited amount of good quality evidence exists that underpins proven techniques that are primarily designed for early detection and prompt management, leading to the prevention of sickness absence and/or supporting individuals with CMHPs whilst they remain in work (Hill, et al., 2007, Fenton, 2014). However, to be successful, workplace interventions for CMHPs

will be reliant on the process and context of how they are implemented (Karanika-Murray, 2015, NICE, 2016).

Despite there being a plethora of studies that investigate early CMHP interventions in the workplace, evidence has continued to suggest that some interventions place more emphasis on the individual and less on an holistic and integrated approach (LaMontagne, 2014, Joyce et al., 2016, Memish et al., 2017). As previously noted, the body of evidence has tended to focus on tertiary reactive rehabilitation or treatment interventions that are instigated to support an individual back to work, thus cannot be deemed an early intervention (HSE, 2006, Sidle, 2008, LaMontagne et al., 2014, Wagner et al., 2016, Joyce et al., 2016, Memish et al., 2017, Nexø et al., 2018).

In addition, the body of literature is evidenced by a range of co-morbidity surveys and occupational health recording mechanisms, where 347,000 new cases of work-related stress, anxiety and depression were recorded in 2019/20 in the UK alone (HSE and the Labour Force Survey (LFS) L2020). However, most of the literature refers to CMHPs or mental illness per se as a burden on society with government mental health policies geared to integrate policy into public health and general social policy, with the main thrust being to increase the attention of the economic impacts of CMHPs across society (Black, 2008, Farmer & Stevenson, 2017). These include the direct costs on health care and other public services in the form of the welfare system with Black, (2008) suggesting that improved workplace health could generate cost savings to the UK government of over £60 billion (Black, 2008). It is not disputed that an economic burden exists and is likely to be more prevalent with the emergence of COVID-19 and the potential to impact further on the prevalence of CMHPs and the financial problems of business per se, although the true costs are likely to become clear in time (HSE, 2020).

In terms of the workplace, the economic lens has continued to shine, focusing on the costs from lost productivity and sickness absence (Curran, Knapp and Beecham, 2004, Farmer & Stevenson, 2017) with interventions tending to centre on treatment and reactive interventions instigated to rehabilitate once an individual is off work sick (Black, 2008). It could be argued that the approach is

therefore false economy, as productivity has already been lost, sickness absence has begun with escalating costs coupled with the social isolation from the workplace, thus impacting further on psychological well-being and the potential for long term sickness absence (CIPD, 2018). Although the spotlight is continuously being shone on 'productivity', employers are failing to recognise the potential and wider benefits of investing in early interventions (Irvine, 2011). However, this is likely to be due to 'not knowing where to start' coupled with a lack of training about CMHPs in the workplace and/or tools for managers to manage individuals with CMHPs (Kawachi and Berkman, 2001).

Summary

The literature presented above shows that there has been an ongoing need to understand the definition of an early intervention and what early intervention approaches could look like (Buck, 2011). However, this would require an innovative approach of constructing theory '*with*' those individuals who are most affected by CMHPs and their management (Nielsen, et al., 2010, LaMontagne, 2014), as opposed to studying incident or prevalence rates of CMHPs across a workforce which tends to be the underpinning of epidemiological studies (UK Government, 2017). Furthermore, Nielsen et al (2010), advocated the instigation of participatory action research that combines a collaborative bottom-up and top-down approach by using employee/manager knowledge and expertise to assist with the shaping of intervention research. Ultimately, the aim of this study is to explore and understand '*how early is early'* when making workplace interventions for CMHPs, therefore I now turn to a discussion on how early management interventions have been presented within an ever-growing body of literature.

2.7.3 Early management intervention, or is it?

It has been well established amongst the literature that early interventions for CMHPs are the most effective way to target both individual and organisational level factors in order to reduce the incidence of mental illness (Giga, et al., 2003, LaMontagne et al., 2007b, Memish et al., 2017). As outlined in the definition of early (workplace) CMHPs discussions, interventions have tended to focus on primary, secondary and tertiary levels, although tertiary interventions

by nature are reactive and implemented supporting rehabilitation when an individual has had a period of CMHP illness, thus in its true sense cannot be defined as an 'early' intervention (Seymour and Grove, 2005, Hill, 2007, Waddell, 2008, LaMontagne, 2014, HSE, 2016, Vargus-Prada, 2017).

However, over several decades it has been acknowledged that the types of early interventions referred to in the literature for individuals with CMHPs in workplace have evolved. As an example, 'early' primary or secondary intervention approaches have traditionally been adopted with LaMontagne's, (2014) integrated approach becoming an assumed model for CMHP interventions (Seymour & Grove, 2005, Marmot, 2009, Wagner et al., 2016, Joyce et al., 2016, Nexø et al., 2018). Likewise, when combining the strengths of medicine, public health, and psychology, the model provides the potential to optimise both the prevention and management of mental health problems in the workplace (LaMontagne et al., 2014). Moreover, the integrated approach draws on evidence and principles from within the fields of public health (including occupational health and safety) and organisational psychology (LaMontagne et al., 2014). In support, Nexø et al., (2018) noted that workplace interventions should involve the interplay between organisational, workplace environment and individual factors. Furthermore, to achieve the desired outcomes it has been suggested that the focus of primary 'work-directed' interventions should aim to prevent the incidence of work-related MHPs with secondary 'employee-directed' interventions aiming to prevent the progress of subclinical and diagnosed conditions such as anxiety and depression (LaMontagne et al., 2014, Wagner et al., 2016, von Thiele Schwarz et al., 2020, Ipsen & Bergmann, 2021).

On the other hand, Dame Carol Black's (2008) 'Fit for Work' review suggested that early interventions for CMHPs can support an early return from sickness absence, although it could be argued that intervening when an individual is sick is not an 'early' intervention but a reactive one. Despite the growing body of literature indicating that the determinants of CMHPs are embedded in both the psychosocial and the physical work environment (Memish et al., 2017), primary 'early' interventions that are designed to be preventative in nature, have tended to aim at improving the health of the organisation workforce per se.

Furthermore, these primary early interventions across organisations are mainly aimed at reducing the incidence of CMHPs by focusing on modifying workplace environmental conditions at source (Bhui et al., 2016, Nielsen, 2017, von Thiele Schwarz et al., 2020) and addressing the problem, via an occupational health support/clinical intervention (Marmot, 2009). Moreover, literature suggests that many human resource and occupational health and safety managers have cited referral to an employee assistant programme (EAP) or occupational health support as an 'early' intervention for those with existing CMHPs and have been adversely impacted by the workplace environment (Memish, et al., 2017). As a consequence, the literature has tended to be dominated by organisational prevention interventions to address poor work organisation and design, workloads, control, unsuitable job roles, and poor interpersonal relationships (Cox, et al., 2000, Martin, et al., 2014).

The concept of 'good work' has appeared to become an established orthodoxy within UK policy circles, (Waddell & Burton, 2006, Black, 2008, Marmot, 2010), therefore it is generally accepted that the complex interactions between psychological, social and organisational factors are likely to impact on whether an individual remains in work or falls into sickness absence (Vikerstaff et al., 2012, Simpson et al., 2015). However, a central organisational response to managing the complex and multi-faceted relationships between individuals with CMHPs and the workplace has been the development of policy, thus diverting focus away from primary 'early' interventions (Vikerstaff et al., 2012, Simpson et al., 2015). Therefore, to address the imbalance, attention is drawn to the multi-level or integrated approaches that focus on organisational workgroups and/or individual interventions as suggested by other academic studies (Martin, 2014, LaMontagne, 2014). According to Martin, et al (2014), interventions have rarely considered a multilevel approach, noting that the single-level focus of occupational health has tended to over-emphasise secondary and tertiary interventions. This therefore supports the standpoints of LaMontagne (2014), Joyce et al (2016), Nexø et al., (2018) with the authors suggesting that there is considerable scope for further studies that examine interventions at more than one or two levels, thus capitalising on multi-level approaches (Martin, et al., 2013, Bacharach & Bamberger, 2007).

As previously discussed, LaMontagne's (2014) integrated approach to workplace mental health outlines the intervention principles of 'prevent, promote and manage' thus aiming to address CMHPs amongst the workforce regardless of cause (LaMontagne, et al., 2014). Despite the suggested intervention practices noted above, Bhui, et al., (2016) concluded that the body of literature did not identify management practices as an intervention, their findings highlighted the need for managers to be approachable, communicative and supportive in order for an intervention to be effective. (Bhui, 2016, Hesketh, 2020).

Although there has been an increasing amount of literature surrounding early interventions and designed to prevent, detect and manage CMHPs in the workplace, these have tended to emerge independently from a variety of professional disciplines such as medicine, public health and psychology (Memish, 2017, LaMontagne, et al., 2014, Alexander & Campbell, 2011, Martin et al., 2009a, 2009b, Ipsen & Bergmann, 2021). Evidence has also shown that early interventions that aim to assist individuals to remain in the workplace are particularly important for those in work with a CMHP (Vikerstaff, et al., 2012). However, the gradual emergence of mental wellbeing policy, strategy and guidelines had begun to blur the lines with active workplace management and implementation of early interventions taking a back seat. For example, Black's 'Fit for Work' review (2008) and WHO (2005) guidelines had focused on returning to work following sickness absence, and the burden on society and costs. However, the guidelines from the National Institute for Health and Care Excellence (NICE, 2009) began to shift mental wellbeing into the spotlight by recommending the adoption of an organisational wide approach to the integration of policy and practice with all those that are concerned with managing people.

Aligning with the UK national strategies and initiatives, NICE (2009) defined mental wellbeing as being "*a dynamic state in which the individual is able to develop their potential work productively and creatively, build strong and positive relationships with others and contribute to their community*" (NICE, 2009, pg.8). The social attitudes to workplace wellbeing had also begun to change with workplaces implementing systems that address work-life balance, flexible working, time management, stress management and health promotion,

thus clouding the need to model early interventions on a range of multidisciplinary organisational, individual and social factors (NICE, 2009, Dietrich et al., 2012, Bhui, 2016, Vakkayil et al., 2017). Additionally, the workplace wellbeing agenda has focused on workplace health programmes where the overarching interventions have focused on addressing both mental and physical health promotion. However, evidence suggests that the capacity to target prevention interventions for CMHPs and their effectiveness are under researched and therefore not reliable in terms of beneficial outcomes (Joyce et al., 2016).

Furthermore, the ever growing body of literature (LaMontagne, 2014,Bhui et al., 2016, Martin, et al., 2016, Memish, et al., 2017, Vakkayil, et al., 2017, Gray et al., 2020) makes clear that stakeholders, such as employers, employees, trade unions and occupational health professionals have an interest in work and health and agree that keeping an individual with a CMHP in work can be a complex process and where guidelines for early interventions are often one dimensional (Waddell, 2008, Vikerstaff, 2012). It is therefore not surprising that the growing number of guidelines and the emerging variants from a range of sources have proved to be confusing for managers who are faced with implementing the practicalities of early interventions for those with CMHPs. Evidence has shown that managers have problems when deciding what intervention is best suited to the work setting and employees alike (Memish, et al., 2017). A review of workplace intervention guidelines carried out by Memish (2017) had found significant variances in content and quality that indicated a distinct lack of stakeholder engagement within their development. Moreover, it was also found that intervention guidelines were individual focused, rather than providing practical tools or implementation advice designed to assist workplaces to prevent, manage and detect CMHPs (Memish, 2017).

Therefore, because of the continuing organisational focus and work-related stress interventions, it could be said that this presents a blinkered vision, and where assumptions are made that CMHPs such as anxiety and depression are developed outside of the workplace and therefore do not concern the employer. However, if this were true it confirms a lack of recognition and understanding that not all CMHPs are caused by the work environment and can often stem from

life adversities such as bereavement or relationship failure (McManus, 2012). Given the heterogeneity of employees presenting with CMHPS, the social constructionist approach in this study therefore seeks to understand their experiences that may go some way to the influencing of change thus offering a different perspective to the existing literature (Burr & Dick, 2017).

In short, the discussions appear to confirm that there are disparities between policy, guidelines and interventions amongst professional bodies, despite the consensus that there is an upward trend in the levels of CMHPs across society in general. However, what appears to be clear is that public policy continues to focus on the potential economic benefits of early interventions for CMHPs, with a view to the lessening of the financial burden on society. Furthermore, the same could be said for workplaces where interventions tend to be focused on productivity and reducing sickness absence (McDaid, et al., 2011). I therefore now turn to discussion of the literature in terms of the economic drivers for early workplace interventions for CMHPs.

2.7.4 Economic drivers and early workplace interventions

Although an ever-growing body of literature suggests that the most cited rationale for workplace intervention is to improve the quality of life and productivity of workers to reduce sickness absence, disability and presenteeism (Goetzel and Ozminkowski, 2006) this is mainly with a view to reduce costs and increase efficiency within the workplace. In addition, research evidence has continued to focus on the negative impact of work on an individual's health, failing to recognise that employers can benefit, in terms of reducing costs, lost productivity and staff turnover as previously discussed, by supporting an individual to remain in work by instigating proactive approaches, thus maximising on the positive benefits that work can offer to an individual's mental health and wellbeing (Hill, et al., 2007). Although a wide range of evidence exists in terms of mental health and employment, the majority has tended to focus on severe mental illness such as bi-polar disorder and schizophrenia and tends to come from a social policy perspective, as evidenced by policy reviews and reports presented by Waddell and Burton (2006) and Black, (2008). Where studies have indicated that there is strong evidence to support focused workplace interventions for individuals with a CMHP (Pomaki, 2012) they

continue to highlight gaps in research evidence in terms of comprehensive approach to promoting and supporting mechanisms that may address both individual and organisational level factors (Seymour and Grove, 2005, Hill, 2007).

Similarly, Black's (2008) 'Working for a healthier tomorrow' and the subsequent government response introduced a range of initiatives, prompted the Royal College of Psychiatrists (RCPsyc, 2008) to publish the 'Mental health and work' report, although this was largely based on worklessness and stigma. The follow up report drew on an evidence base of randomised controlled trials of work schemes for those with mental illness (Waddell & Burton, 2013) acknowledging the continuum and the moving from mental wellbeing to mental illness and on to long term sickness absence. Moreover, the evidence failed to address the potential for implementing workplace interventions at an early stage, despite the overarching aim being to provide an evidence base for policy development for vocational rehabilitation. Instead, the review focused on the core objective of occupational or work rehabilitation directly related to employment outcomes, "*stating whatever helps someone with a health problem to stay at, return to and remain in work"* (Waddell & Burton, 2013, *What works, for whom, and when, page:10*). The authors went on to argue that work is the most important social and economic goal and suggested that to be successful any approach needs to be an interactive process, requiring participation, motivation of the individual and the workplace (Waddell & Burton, 2013).

In brief, from the many studies discussed in terms of CMHPs and early workplace interventions (Pomaki, 2012, Waddell & Burton, 2013, Fenton, 2014, LaMontagne, 2014, Memish, et al., 2017), there are continuing suggestions that to understand the interactive process of the individual and the workplace requires further exploration from a socially constructed perspective, which I now discuss.

2.7.5 Early workplace interventions and social constructionist enquiry

To date there have been distinct weaknesses in current published guidelines for the management of CMHPs in the workplace (Memish, et al., 2017). Concluding

that the weaknesses has been mainly due to a lack of stakeholder (employee and manager) consultation and engagement, Memish (2017) recommended that stakeholder engagement should be considered in future development of guidelines to encourage uptake, commitment and implementation (Memish, 2017, Joyce, 2016, LaMontagne, 2014). This, therefore, gives rise for the justification for a social construction approach to assist with the understanding of the phenomenon from a practical level.

Nevertheless, although social and occupational health and wellbeing policy and practice has continued to develop, further research exploring factors that either facilitate or hinder implementation of early interventions continues to be identified as high priority. The gaps identified focus on the promotion, prevention and support for those with CMHPs in the workplace (La Montagne, 2014, Joyce, 2016). Therefore, building on these foundations from a social constructionist perspective, the aim of this research is to understand what drives early interventions and why they are deemed important in order to address the gaps identified.

Additionally, it has been acknowledged that little is known about how to tailor early interventions in a variety of occupational settings across the working population which instigated Memish, (2017) to challenge the integrated approach presented by LaMontagne (2014). The authors suggested that LaMontagne's (2014) model did not address interventions for enhancing personal resilience, changing organisational culture or outlining how to promote and enhance protective factors within the workplace, thus not considering the legal aspects such as associated health, safety and discrimination legislation such as the Health & Safety at Work etc. Act, 1974 (HSW,1974), and Equality Act 2010.

However, on the other hand, there was acknowledgement that provision of practical tools such as training, awareness and clear implementation advice could also enable those with CMHPs and those managing individuals with CMHPs to feel more confident when instigating interventions (Memish, et al., 2017). Therefore, it could be suggested that guidance to promote positive aspects of work alongside employee strengths and positive capacities could have been

developed with those that experience CMHPs and managers who manage those individuals (LaMontagne, 2014, Joyce, 2016, Ivandic, et al., 2017, Saju, et al., 2019, Hesketh, 2020).

Consequently, the '*how early is early'* debate has continued to grow in importance with many arguing that a proactive approach to mental health in the workplace could benefit employers as well as employees (LaMontagne, 2014, Fenton, 2014, Joyce, 2016, Wagner, et al., 2016, Ivandic, 2017, Hesketh, 2020). Furthermore, Vargas-Prada (2017) concluded there are inconsistencies in the definitions of what 'very early' and 'early' interventions mean that current evidence remains inconclusive in terms of the timing of the interventions – nevertheless, the question therefore remains '*how early is early*?'.

Summary

As outlined in the literature there is a dearth of qualitative studies in terms of early workplace management interventions (Hill, 2007, Joyce, 2016, Memish, 2017, Hesketh, 2020) As recent emerging evidence shows, organisations need to do more to support their employees with CMHPs and at an early stage. It is suggested that individual and organisational approaches should go hand in hand, however, the evidence shows that not enough is being done to close the gap between proactive (early) and reactive (rehabilitation) interventions (Seymour and Grove, 2005, Hill, 2007, Waddell, 2008). It is, however, acknowledged that to ensure success of interventions, managers and employees would have to 'buy into' any suggested approaches or strategies (Memish, 2017). To do this the appropriate course of action is by enabling a social constructionist approach that explores how employees and managers contribute to co-producing a perceived social reality and shared knowledge about workplace health and wellbeing (Berger and Luckman 1966).

Currently interventions broadly focus on the workplace environment and not on personal factors that may contribute to the impact on those already diagnosed or presenting with a CMHP who are in work. Adding to the debate, is that employers need to do more by supporting and using appropriate intervention methods and techniques to help those with CMHPs to remain in work (McManus, 2012, Waddell & Burton, 2013, Memish, 2017)

The literature identifies a clear gap in research, highlighting a pressing need to understand what is meant by early interventions and '*how early is early'*? The literature, thus far, also identifies gaps in terms of what targeted early intervention strategies could be implemented to benefit the manager, employee and the organisation enabling a proactive management approach. In addition, the literature identifies a high priority and a need to explore what barriers exist that may hinder proactive interventions to be instigated.

Based on Memish's, (2017) suggested approach there is a clear window of opportunity to socially construct knowledge, building on LaMontagne's (2014) 3-thread approach of '*protect, promote and manage'* beginning with the social discovery of how managers and employees within the organisation define common mental health problems, how they view early interventions, and what they might look like within the workplace. However, Martin, et al., (2014) suggested a multi-level approach moving away from a single-level individual focus aiming to provide a framework for a multi-level concept and the relationships between the psychosocial work environment, employee mental health and related organisational interventions (Martin, et al 2014). Furthermore, Jenny & Bauer (2013) presented the Organisational Health Development (OHD) model that "*……is both the on-going reproduction and the targeted improvement of health in organisations as social systems, based on the interaction (process dimensions) of individual and organisational capacities (structural dimensions)"* (Bauer and Jenny 2012, p. 135).

Building on these frameworks therefore provides the opportunity through a PAR design to explore within the social context of the workplace the relationships between the psychosocial work environment, managers understanding and approaches and how these impact on early employee interventions.

Furthermore, there is a need to explore, through social discourse, whether managers would be more confident with implementing interventions and adjustments at an early stage if they were equipped with appropriate skills and tools, couple with gaining understanding in what would further enable them to interact more proactively with employees who are diagnosed or present with a CMHP. This research therefore seeks to address these issues which now leads

me to discuss the literature that surrounds the role of workplace managers when faced with employees with a CMHP.

2.8 The Role of Workplace Managers

In general, and over several decades, employers and managers have gradually recognised the rising scale and impacts of poor mental health within the workplace (Nicholson, 2018). However, evidence is limited as to the effectiveness of workplace interventions for CMHPs, thus the growing interest in how and when interventions and guidelines could be improved and actively shared amongst employers (Nicholson, 2018). Managers therefore play a central role in determining the effectiveness and outcomes of interventions for CMHPs in the workplace which implies that managers are a vital ingredient when exploring, developing and instigating interventions (Bryan, et al., 2018). On the other hand, it has been suggested that managers are often reluctant to instigate interventions or support an individual experiencing CMHPs, believing that they do not possess the confidence or skill sets (Johnson, et al., 2015, Bryan, 2018). In support, Houdmont et al., (2019) identified from their study that when faced with an employee requiring support with a CMHP, line managers competencies were lacking and needed development (Houdmont et al., 2019). Although Houdmont's (2019) study examined the HSE's line management competencies when managing workplace stress, the authors findings were in parallel with the findings from previous studies (Houdmont et al., 2019). Furthermore, research has continued to identify that whilst attention has been given to mental ill health in individuals the field of workplace management of CMHPs has lagged behind (Follmer & Jones, 2018, Hennekam et al., 2021).

This discussion therefore turns to the literature that focuses on manager attitudes, knowledge, competencies and emotional intelligence as being strong predictors of their behavioural responses and the proactive or reactive outcomes of CMHP interventions (Bryan, 2018, Nicholson, 2018).

2.8.1 Management Attitudes and Approaches

Several studies have indicated that managers approaches and attitudes to CMHPs in the workplace are central to determining the occupational outcomes of

employees with CMHPs (Bryan et al., 2018, Dimoff & Kelloway, 2018, Farmer & Stevenson, 2017, Greden, 2017, Dimoff & Kelloway, 2018, Karanika-Murray et al., 2018, Christensen et al., 2020). The findings have generally agreed that managers confidence, attitudes and behaviours to discussing CMHPs with their employees indicate low mental health literacy (Bryan et al., 2018, Dimoff & Kelloway, 2018).

Highlighting the importance of good mental health within an individual's organisational life being of great importance, Schott (1999) outlined three clusters of issues that managers face. Schott's (1999) view was that most management training programmes were woefully inadequate and deficient in the area of CMHPs. Although it is not expected for managers to become experts in psychology, it is believed that managers have a responsibility to recognise and become informed about the rudiments of CMHPs (Schott, 1999). Going further, Schott (1999) argued that incorporating knowledge into manager training provides a powerful stimulus to communication with employees, thus promoting an enlightened proactive organisational culture (Schott, 1999). Furthermore, concerns have continued to be highlighted that little exists in terms of qualitative studies that explore managers views in terms of what their training needs are, given that managers are the front-line supervisors that are often the orchestrators and drivers of organisational change (Dimoff & Kelloway, 2018). Therefore, the social contexts in which people live, their beliefs and attitudes in terms of CMHPs do not exist in a vacuum (Barnes, et al., 2008). The social norms surrounding early interventions and CMHPs rely on what psychological, social economic factors and where barriers exist within the workplace employees could be unjustly disadvantaged by a lack of managers understanding of CMHPs (Barnes, et al., 2008).

Despite the prevalence of CMHPs having been extensively researched (Barnes, 2008, Dawson & Tylee, 2001, Rogers and Pilgrim, 2005, Bryan et al., 2018, Dimoff & Kelloway, 2018), there remains a dearth of studies that qualitatively explore within the social context of the workplace, the lay perspectives and needs of workplace managers in order to understand what needs to be put in place to better equip them to recognise and instigate an early response to an emerging CMHP (Schultz & Gatchel, 2016, Houdmont et al., 2020, Hennekam et

al., 2021). In addition, studies would need to explore with managers any barriers they face in terms of improving their skills, confidence and behaviours towards instigating early interventions for those with CMHPs (Bryan, et al., 2018, Houdmont et al., 2020, Hennekam et al., 2021).

A study undertaken by Milligan-Saville et al (2017) found that a simple manager mental health training programme could generate meaningful individual and workplace benefits by improving manager confidence in communicating with employees about CMHPs. In addition, the study being a randomised control study focused on quantifiable data thus presenting a cost benefit analysis for the reduction of sickness absence and an early return to work. Despite the study identifying success in training managers in understanding the key features and effects of CMHPs in the workplace alongside the development of effective skills for discussing mental health matters with employees, (Milligan-Saville et al., 2017), an opportunity was missed to explore if manager training could instigate early interventions to prevent sickness absence in the first place.

Irvine, (2011) highlighted in her study that further research was needed into understanding how CMHPs are conceptualised by lay individuals such as managers, and what would be beneficial to them to support the instigation of early interventions and provision of effective workplace support. However, in order to prevent sickness absence, as previously discussed this would be completely dependent on disclosure (Irvine, A. 2011).

2.8.2 Does providing managers with CMHPs awareness training support the efficacy of implementing early interventions?

Debate has been ongoing about the best strategies for early intervention and management of common mental health problems in the workplace (Hill, et al., 2007, LaMontagne et al., 2014). A research gap identified by Henderson et al., (2011) suggested that much more needed to be done in the development of effective strategies to assist an individual to remain in work and subsequently return to work where there has been a spell of sickness absence. More recently, it has been identified that certain workplace strategies and practices have the potential to have a positive or negative impact on CMHPs which include providing managers with the knowledge and skills to effectively manage CMHPs

(Gayed et al., 2018). Furthermore, Dimoff & Kelloway (2019) suggested that despite the financial burden of poor mental health most managers hesitate to provide support to their employees struggling with CMHPs because they do not know how to (Dimoff & Kelloway, 2019).

There is a growing consensus amongst the extensive body of literature that managers have key roles to play when determining the outcomes of employees who become unwell due to a CMHP (Milligan-Saville, 2017, Kuoppala, 2008, Harvey, 2014, Day et al., 2019). In addition, managers being familiar with workplace practices and the environment are therefore more likely to be able to implement reasonable adjustments at an early stage, thereby potentially preventing an individual going off work long term sick. On the other hand, an inappropriate or delayed response could have the opposite effect (Milligan-Saville, JS, (2017) although this would be dependent on whether a positive relationship between manager and employee exists (Tinline & Cooper 2019). Nieuwenhuijsen K, (2008) undertook a review of randomised control trials (RCT's) and from the 11 studies found that standardised, symptom-based treatments for CMHP did not contribute favourable to occupational outcomes when implemented in isolation. However, the study concluded that CMHPs could be improved by increased involvement of the workplace itself which includes manager support (Joyce S, 2016). However, more recently academics have argued the importance of a positive psychology approach, particularly in a wider participatory multilevel intervention approach where change is implemented in workplace policy, practices and procedures (Christensen et al., 2017, Nielsen & Christensen, 2021)

A primary concern of CMHPs and work is whether organisations adequately train and equip managers to recognise problems to support individuals in the workplace, thus supporting and managing an individual with a CMHP at an early stage which in turn creates resilience both for the manager and the individual (Cox et al., 2009, Gayed et al., 2018, Bryan et al., 2018,). It is therefore suggested that managers do not understand, or have not in fact been trained in, the understanding of common mental health problems and what triggers them. Do managers indeed recognise that there are distinct differences between work related stress and clinically diagnosed depression for example, although one

could exasperate the other? Although it has been acknowledged that to ensure success, managers and colleagues would have to 'buy in to' any suggested approaches or strategies (Henderson, 2011, Martin et al., 2018, Nexø et al., 2018).

Studies suggest that where managers are furnished with appropriate training and tools, this could facilitate a management intervention to be made at the earliest opportunity (Joyce, 2013, Stansfeld et al 2015, NICE & PHE, 2009, 2022). Joyce, (2013) suggested that organisations should take a proactive approach in supporting employees with mental health problems and that competency training should be given to ensure managers can support an individual with a CMHP in the workplace wherever necessary. However, these studies were based on a return-to-work support or reducing work stressors process thus suggesting a reactive approach rather than a proactive one as the employee had already had a spell of sickness absence. Tsutsumi (2011) also concluded that providing managers with mental health awareness training had shown to have had a favourable effect on employee's mental health in the short term; although, the training would need to be regularly repeated to ensure that it remains effective.

On the other hand, surveys such as the absence management survey (2015) and the employee outlook survey (2016) carried out by the CIPD had showed inconsistent results where the former suggested that 30% of organisations given training to help managers effectively manage and support employees with common mental health problems (CIPD, 2015) and the latter reported that just 10% of employees say their employer does provide line manager training in this area (CIPD, 2016). However, since this time there has been continued calls for employers to provide managers with appropriate training and to equip them with skills to have conversations with employees about CMHPs (Carmichael et al., 2016, Quirk et al., 2018, Scantlebury et al., 2018, National Institute for Health and Care Excellence & Public Health England, 2022)

2.8.3 Emotional Intelligence and its place in the workplace

Based on the debate so far, it could be suggested that the linking together of manager attitudes, approaches and knowledge gives rise to the concept of

emotional intelligence (EI) and the integral part it could play in early workplace CMHP intervention strategies. In broad terms, EI has been growing in significance since the early 1990's and is a skill that managers need to possess to thrive in the modern workplace (Jain, 2018, Chadha et al., 2017, Goleman, 2001). It is also posited by researchers that leaders and managers need to possess the elements of EI in order to deal with all stakeholders within the complexities of the organisation environment (Bar-On, 2006).

Although, Salovey & Mayer (1990) coined the term 'emotional intelligence' the general consensus within the literature is that the term was popularised by the writings of Goleman (1995). The emergence of EI conceptual models and often referred to within the expanding body literature, are the works of Goleman, (1995), who categorised 25 competencies under five broad headings of self-awareness, self-regulation, motivation, empathy and social skills, aligning psychological and organisational management theory. Known as the emotional competencies model Goleman, (1995) classified the first two categories as personal competencies with the others attributed to social competencies. Mayer and Salovey (2004) introduced the ability-based four-dimensional model, that aimed to drive leadership skills and the Bar-On's emotional and social intelligence (ESI) model that determines how people effectively express themselves and understand and relate to others (Eketu & Ayondu, 2017). The research literature also suggests that employee performance, and job satisfaction are often influenced by relations with their direct line managers, indicating that managers who possessed high EI produce increased positive attitudes and behaviours within the workplace (Goleman, 2002, Robbins, 2001, Carmelli, 2003, Ruestow, 2008).

Nevertheless, EI has begun to play an important role within the workplace, being conceptualised as an effective tool for problem solving through interpersonal effectiveness within the social environment of work. (Kunnanatt, 2004, Ruestow, 2008). Furthermore, based on the existing literature, it is believed that EI can have a positive impact providing desirable outcomes in terms of management behaviours that facilitates effective relationship management and empathy. This is particularly pertinent where managers have the ability and skills to recognise emotional strain in employees in order to interact and support an individual at

an early stage (Goleman, 1995). As a result, this is likely to be particularly important to those that present with a CMHP, where individuals are then more likely to feel that they are understood, supported and valued (Ruestow, 2008). It could also be suggested that managers are more likely to be more effective at creating cohesive teams within a positive work climate thus generating cooperation and trust through the development of interpersonal relationships (Goleman, 1995, 2001, George, 2000).

In the broader context of management, there is a tendency to focus on technical competence, however, where a role requires the management of people, the assessing of personal and social competencies tends to be overlooked (Goleman, 2001). Social competence in managers requires them to have empathetic awareness of others, coupled with the skills to effectively respond to individuals, and in a way that considers their feelings, needs and concerns, and is particularly important where an individual has a CMHP and may have reduced resilience (Collins & Cooper, 2014).

On the other hand, despite EI having been a much-debated subject (Thorndide, (1921), Guilford, (1956) Gardner, (1983), Mayer et al., (1990), Salovey & Mayer, 1990, Zeidner et al., 2001) a counter argument exists. For example, it is not clear how time consuming and effective it would be to assess manager EI competencies in addition to the required occupational skills and abilities. Neither is it clear what affect various levels of EI would have on managing CMHPs in the workplace. Furthermore, the motivation and actions of managers in addressing CMHPs in the workplace would also be influenced by the culture within the organisation itself. Therefore, it is unknown if the possession of EI skills would help or hinder managers in being able to identify, understand and effectively interact with their employees. Moreover, there does not appear to be any evidence to indicate that managers with high EI would be being able to identify the nuances of employees' with CMHPs, their emotional reactions, thus enabling them to instigate interventions at the earliest opportunity (Prati, et al., 2003, Ruestow, 2008).

It is widely accepted that when individuals interact, the quality of the relationship will be determined by the contributions each makes, and how these

contributions are received by the other. In terms of CMHPs in the workplace there must be a degree of trust between the individual and the manager which is essential for the development and maintenance of a sound interpersonal relationship. This raises questions of whether emotional intelligence (EI) in managers would be the answer to engaging and managing those that present with CMHPs?

The basic premise behind EI is about building and being aware of not only one's own emotions but those of others in order to build working relationships. However, it is suggested that other management competency theories and models point towards being more appropriate and are likely to assist with the development of manager behaviours, confidence and attitudes. For example, a widely used model for manager and leader development is the Johari Window which has been seen as a beneficial tool for helping individuals to improve how they are perceived and understood by others. The model had been designed to enable understanding in addition to several other factors that are believed to enhance manager competencies. These factor include supporting training, self-awareness, personal development, improving communications, interpersonal relationships, group dynamics, team development and inter-group relationships (Luft, 1961).

A more recent concept is Mental Health Literacy (MHL) and is a term coined by Jorm et al., (1997) who defined the concept as the "*knowledge and beliefs about mental disorders which aid their recognition, management or prevention"* (Jorm, 1997, pg: 182-186). Although, Moll et al's study highlighted that despite the development of a variety of vignette-based tools to aid such knowledge acquisition, none had been applied in a workplace setting, therefore the validity and reliability of implementing the construct in a workplace setting has yet to be tested (Moll et al, 2017).

In addition, other models that are in existence aim for broader based manager competencies, with one of these being the under-utilised UK Health and Safety Executive (HSE, 2007) line manager competency framework. The framework had been developed following a comprehensive literature review and explored the connection between manager behaviours and the impact on employee

wellbeing. In terms of the manager competency framework, more recent HSE research (Houdmont et al., 2019) found that a list of definitive manager behaviours had not been developed. Although the research focused on manager competencies for managing of stress, it is suggested that developing the model further could also support early interventions for CMHPs in addition to stress. Houdmont's (2019) study found that low mental wellbeing and work attitudes were associated with low manager competencies, thus highlighting a development need and suggested that the framework offers the foundations for the targeting of managers for development (Houdmont, et al., 2019).

Summary

The extent to which any suggested early interventions that prevent or alleviate common mental health problems such as stress, anxiety or depression is still unclear with studies being limited. Vargas-Prada (2017) recommended further research to address a key factor in that there is a need for a consensus amongst stakeholders and policy makers on what constitutes 'early' intervention – 'how early is early' and what can assist individuals to ensure maximum gain for both the individual and the workplace.

As more recent emerging evidence shows, it is clear that organisations need to do more to support their employees with mental health problems (Dimoff & Kelloway, 2019, Nielsen & Christensen, 2021, von Thiele Schwarz, NICE & PHE, 2009 & 2022). However, the evidence presented above appears to show that although it is broadly acknowledged that the workplace can help support good mental health there is not enough being done in order to close the gap between falling out of work through mental health illness and on to the welfare system (Harnois & Gabriel, 2000, Dwyer et al., 2019). This then raises the question whether employers could do more by supporting and using intervention methods and techniques whilst an individual is still in the workplace thus helping them to remain in work. It is therefore reasonable to suggest that where managers are furnished with the right training and tools which enables them to identify emerging symptoms and instigating early support and actions, thus equating to an 'early' management intervention at the earliest opportunity.

The debate therefore continues as whether, by equipping managers with the skills to be able to talk to the employee and understand how work impacts on their condition and vice versa; could lead to them being confident in implementing adjustments that are agreeable and workable to both parties. However, what is clear is that managers need to be able to understand where an individual has disclosed that they have a mental health problem that has been caused by issues outside of work and where it is likely that organisational problems may adversely impact on the individual's mental health further. The question, therefore, is whether equipping managers with the skills to be able to effectively communicate with an employee will assist them to be empathetic and understand how work impacts on their condition and vice versa. Furthermore, does this indicate that by providing the 'skills and the tools' would then lead to them being confident in implementing adjustments that are agreeable and workable to both parties? However, it is clear that this would purely rely on the employee feeling confident enough to disclose that they have a CMHP problem to their manager. A fundamental point, therefore, is the identification of the barriers that may exist which prevents individuals disclosing a problem, coupled with other workplace barriers which prevent managers from implementing proactive workplace interventions to support those in work with CMH conditions. It could therefore be suggested that the linkages between manager competency models and their associated skills could indeed come to the fore, models such as the HSE line manager competency framework would support manager to develop their EI capabilities which would be of benefit for managing emotions in the workplace. This would be particularly important where individuals present with a CMHP. However, on the other hand there is a dearth of literature that pays attention to management competencies and how these affect the management of CMHPs within the social context of the workplace (Shaffer & Shaffer, 2005).

In reference to LaMontagne's (2014) paper in which the authors aim was to develop a framework described as an integrated 3 thread approach to protect, promote, and address mental health in the workplace irrelevant of the cause. The authors argued, that by integrating the three threads, the intervention would achieve the greatest population mental health benefits. However, it was identified that there would be a need for both organisation wide, and individual

approaches, to mental health and wellbeing, and suggested that the approach would align to the existing systems approach to reducing job stress (LaMontagne, 2007 & 2014, Karanika-Murray & Biron, 2015). Additionally, the Martin et al., 2014 multi-level concept is one that also aims to bring together the complex interactions between psychological, social and organisational factors that are likely to impact on workplace mental health.

Although any approach would have to be fully supported by the organisation to ensure success, which then raises a further question. It is acknowledged that organisational resilience is a core construct of positive organisational behaviour therefore could it be that by supporting and managing an individual with a common mental health problem at an early stage create resilience both for the manager, the individual, the team and the organisation? (King et al., 2016, Bowers et al, 2017, Morgan et al., 2017, Hartmann et al., 2019). Moreover, it has been suggested that a participatory process is key to building organisational resilience and its ability to address the issues surrounding workplace CMHPs (von Thiele Schwarz et al., 2017, Nielsen & Christensen, 2021)

However as previously mentioned, to be successful an individual would firstly need to feel confident to disclose a problem thus enabling the possibility of an early intervention, which now leads to the final section in this chapter and a discussion of the literature in terms of disclosure and the barriers that might arise.

2.9 Barriers to Disclosure - do they exist and what are they?

This section debates the disclosure of a CMHP and whether barriers exist and if so what are they? Despite work being beneficial for mental health and notwithstanding the ongoing public campaigns towards positive approaches to mental health and illness, many individuals prefer not to disclose a problem (Brouwers, et al., 2019, Grice, et al., 2018). Whether or not to disclose a CMHP in a workplace environment is not a black and white decision, which is not surprising based on previous discussions, particularly in terms of the lack of knowledge and understanding from others (Corrigan, 2012). Although it is acknowledged that, for many years the issue of mental ill health and employment have been high on the social policy agenda (Irvine, 2011), prejudice and discrimination, however, has continued to remain in the spotlight

as the main barriers to disclosure (Corrigan, 2012). Over several decades public health messages have continued to focus on terms that are often seen as a negative such as mental illness or conditions as opposed to a positive term such mental 'wellbeing' or positive mental psychology. Such complexities and ambiguities are therefore likely to have a bearing on the decision to disclose a CMHP (Irvine, 2011).

The body of literature that refers to disclosure tends to sit in two camps, one existing within social policy with a focus on disability and social inclusion whilst the other is situated within the sociological literature and social stigma (Irvine, 2008). However, when drawing on the combined contributions, they provide an overview of how CMHPs and disclosure are, and have been, experienced in the workplace (Irvine, 2008, Irvine, 2011). What also needs to be considered alongside the social inclusion and stigma debates are the multiple understandings or misunderstandings of CMHPs which tends to influence the decision an individual will make to disclose a CMHP or not. The dilemma that many employees can face when deciding to disclose is the how, when, and to whom, fearing that they will be disadvantaged or discriminated against by both their colleagues and managers (Czabala et al. 2011; Little et al. 2011; Ahola et al. 2012; Brohan et al. 2012, Mendel, et al. 2013).

Additionally, the perceived lack of understanding of CMHPs coupled with poor attitudes and behaviours of managers is likely to create a negativity that can be deep seated. For example, this would be particularly poignant where assumptions are made by others that a CMHP will have long-term negative effect on work performance and sickness absence (Mendel, 2013). However, it has been suggested that implementing an early intervention at the point of disclosure would benefit both the individual and the manager, thus not jeopardising work performance or sickness absence (Henderson, et al. 2012).

The literature appears to confirm that the workplace can be a hindrance to disclosure, giving rise to multiple concerns that become dominant in the minds of an individual when deciding whether to disclose a CMHP or not (Stratton et al., 2018). Furthermore, despite the growing awareness across society where it is considered that the workplace can be a contributor to supporting mental

health, employers continue to hold negative attitudes towards those with CMHPs (Brouwers, et al., 2019, Uçok, et al., 2012, Corrigan, et al., 2008). As a result, preparing to disclose a CMHP may raise many conundrums in the minds of individuals and where it is probable that several factors would influence the thought and decision-making processes (Brunner, 2007a). Stratton's (2018) study suggested that disclosure has primarily been driven by the negative aspects and where a disconnect exists between organisational policy and culture. Other factors that could have some bearing on decision making would also include ethnic culture and beliefs, organisational and management cultures, societal cultures as well as the emotional impacts to the individual. Based on the fact that 'once it is out there it is out there', once a disclosure has been made it cannot be withdrawn or 'unsaid', thus confirming that a disclosure to an employer is a difficult one to make (Henderson, et al. 2012).

In support, studies have shown that the different social and 0psychosocial demographic factors within the workplace are highly likely to affect a decision to disclose (Corrigan et al 2015b, Waugh, et al., 2017). The existing body of literature has therefore continued to find that the lack of disclosure of a CMHP in the workplace are primarily driven by the deep-seated concerns held by individuals. It is thought that the fear of stigma and discrimination continues to have a significant bearing on an individual making the decision to disclosing a CMHP (Lorenzo, 2013). Notably, Brunner (2007a) conceptualises disclosure as a process rather than an 'event', making the distinction between understanding of 'what is it' and the mechanics of 'how it happens' (Brunner, 2007a). Similarly, Ragins (2008) suggested that disclosure is on a continuum that can take place in either a work or non-workplace setting. Further influencing the mechanics of 'how' a disclosure is made, either voluntary or involuntary (Irvine, 2012, Goldberg et al., 2005) is likely to be based on the potential 'favourable' or 'unfavourable' circumstances that are present at the time of an individual deciding to make a disclosure (Irvine, 2012, Ellison et al. 2003).

Furthermore, from a workplace perspective, conflicting ethical values and beliefs that arise between an individual and a manager is also thought to have a significant bearing on the decision process (Brohan, et al., 2012). Although it could be suggested that this links back to the emotional intelligence (EI) debate

and where the lack of recognition of CMHPs means that line managers are likely to be unresponsive to a disclosure, thus aborting any attempts to instigate early interventions (Rathmore, et al., 2017).

However, on the other hand, there is a belief that disclosure can improve workplace relationships as it provides a platform for authenticity (being oneself) with the workplace environment playing a part in the prevention of adverse outcomes through the provision of work adjustments (Brouwers, et al., 2019). Similarly, due to the complexities and understandings or misunderstandings of 'mental health' there can be situations that where disclosure may be on a partial or gradual basis. For example, an individual may discuss a problem with others and the 'difficulties' they may be facing and arising from a work or home situation. Although this is not deemed to be a specific disclosure of a CMHP it does support the thinking of Raggins, (2008) and the disclosure continuum by taking the first step to disclosure by the subtle waving of a warning flag. However, the 'early' call for intervention is often missed due to the 'blurred boundaries' that exist between normal everyday stress reactions and the mounting emotions of mental distress (Irvine, 2012). Indeed, adding to the problem, can be the individuals themselves, who, due to the combination of their own lack of insight into CMHPs and the lack of acceptance of the difficulties they are facing, thus erecting their own barriers to disclosure (Irvine, 2012).

Despite the enactment of the Equality Act, 2010 that prohibits unjustifiable and unfavourable treatment of those with mental health problems, disclosure continues to be embedded in the wider societal, interpersonal and employment contexts (Brohan, et al., 2014, Troth & Dewa, 2014, Waugh, et al., 2017). Moreover, over the last decade studies have shown that societal awareness of mental illness has increased, the awareness has not been translated into the workplace by way of greater employers' knowledge of CMHPs (Brohan et al., 2012, Troth & Dewa, 2014, Waugh, et al., 2017). Undoubtably, an early disclosure enabling the provision of early support through a period of reduced mental health will ultimately depend on the better understanding of CMHPs amongst employers and employees (Irvine, 2012). Furthermore, the systematic review of qualitative literature in terms of disclosure, undertaken by Brohan and colleagues' (2012) found little evidence that considered the disclosure of CMHPs

from the perspectives of both an employer and employees in a workplace setting. The authors therefore went on to suggest that further qualitative research was needed within the social setting of the UK workplace, that explores, from the viewpoints of individuals and managers, barriers to a CMHP disclosure, general attitudes and behaviours along with the knowledgebase and application of the Equality Act, 2010 (Brohan, et al., 2012).

2.9.1 A lost voice or silent disengagement?

Given that attention is continually being drawn to encouraging those with a problem to disclose, societal views have not necessarily aligned with the changes in promoting the benefits of disclosure (Lorenzo, 2013). However, based on discussions of the literature thus far, the decision to disclose a CMHP in a workplace context appears to be multi-layered thus making decision making and support by managers more difficult (Henderson, et, al. 2012). Furthermore, when compared to a physical illness or injury that can be 'seen', 'mental health problems or illness' have tended to have been described as 'unseen or invisible'. The invisibility of a CMHP thereby gives an individual more 'control and choice' over disclosure and remaining silent about a CMHP (Irvine, 2011, Stanley et al. 2007a, Brunner, 2007a).

Whilst discussing disclosure of CMHPs, Brohan & Thornicroft, 2010 focused their attention on stigma and discrimination, highlighting that the disclosure of a CMHP in the workplace can lead to poor behaviours by managers and colleagues towards the individual. Moreover, the prejudicial beliefs and behaviours of others can therefore be discriminatory towards an individual with a CMHP (Brohan & Thornicroft, 2010, Corrigan et al. 2001). In the same vein, Corrigan & Deepa (2012) noted that the social stigma that is associated with CMHPs will therefore involve labelling and stereotyping. In view of this, Corrigan & Deepa (2012) suggested that, in the mind of the individual, the 'silence' is likely to be associated with the social stigma that represents prejudice, discrimination and stereotyping. However, whilst these issues have dominated research and have been studied extensively over many years, what is not so widely reflected in the literature is self-stigma, internalising and dis-engaging, with the silence thus depicting a 'lost voice' (Corrigan & Deepa, 2012).

Drawing attention to the underlying assumptions of stigma in the workplace Krupa, (2009) described these as being four-fold, firstly, it is believed that those with CMHPs will be unable to rise to the demands of the job. Secondly, the belief that the individuals will be unpredictable. Thirdly, believing that work is unhealthy for individuals with CMHPs. Fourthly, providing employment is an 'act of charity'. In addition, Follmer & Jones's (2018) systematic review revealed persistent negative stereotypes of employees with CMHPs amongst the general public, employees, managers and supervisors (Follmer & Jones, 2018).

It is therefore not surprising that where these behaviours exist, individuals decide not to disclose a CMHP preferring to remain silent, adding to the issue is the likelihood that the individual would 'disengage' from managers and colleagues. It would therefore be suggested that a good starting point would be for a wider societal understanding of the stigma attributed to CMHPs and how this directly affects those who experience them (Follmer & Jones, 2018) Furthermore, there needs to be an understanding that due to public stigma directed at those with CMHPs it can lead to an individual applying 'self-stigma' which further contributes to non-disclosure (Corrigan et al., 2005)

In complete contrast, Brohan & Thornicroft, (2010) argued that the myths as highlighted by Krupa (2009) could be dispelled by the improving of knowledge, attitudes and behaviours of organisations, managers and occupational health professionals. The authors went on to suggest that all have key roles to play, particularly at the core of the organisation in terms of facilitating employees to make a disclosure at an early stage allowing for reasonable adjustments and early interventions to be made that are in line with personal needs (Brohan & Thornicroft, 2010). It could therefore be suggested that multi-level models such as positive participatory interventions could go some way in negating the issues identified (Nielsen & Randall, 2013, Nielsen & Noblet, 2018, Nielsen & Christensen, 2021).

Further studies, such as Clement, et al. (2014) highlighted that the self-stigmatisation, internalising and remaining silent of CMPHs is likely to negatively impact the general wellbeing of the individual. Secondly, the psychological stress that arises from an individual being preoccupied with 'keeping the CMHP secret'.

With this in mind, when combined, these factors can snowball thus creating a 'domino effect' that pushes an employee into sickness absence or presenteeism (presenting at work when sick). Finally, the deliberate choice of the individual to remain silent and not seeking help presents further challenges for managers thus negating the ability to implement early interventions and support (Lane et al. 1995, Pachankis, 2007, Wheat, et al. 2010, Buck et al. 2011). According to Corrigan & Deepa, (2012) the path of self-stigmatisation and internalising of a CMHP leads to an individual having reduced self-esteem and self-efficacy. The authors go on to suggest that where an individual is open and honest to others in terms of CMHPs, it can decrease the associated negative effects of self-stigmatisation that in turn, can have a positive effect on their general quality of life. It would therefore be true to say that once the stress of the 'keeping the secret' diminishes, this would in turn encourage an individual to approach the social world of work with a sense of optimism (Corrigan et al. 2010, Corrigan & Deepa, 2012).

However, further expanding on the 'failure to disclose' debate, evidence suggests that much of the literature emphasises on the lack of knowledge and where managers within the workplace are unaware of the prevalence of mental illness (De Lorenzo, 2013). Studies have found that large numbers of employees choose to keep CMHPs hidden, their voices therefore going unheard, thus equating to a 'lost voice' (Dewa et al., 2004, De Lorenzo, 2003, Corrigan et al. 2010). De Lorenzo, (2003) argued that despite the widespread knowledge of concealment of a CMHP little attention had been paid to how this could be managed within the workplace (Baldwin, 2004). Further studies have also shown that the problem of concealment of a CMHP, appears to be more common than disclosure (Munir et al., 2005) although these studies also indicated that this also applies to other chronic illnesses (De Lorenzo, 2003). However, a factor that has been overlooked is where an individual disengages within the workplace thus contributing to building the 'perfect storm' and where they either fall into sickness absence or presenteeism. In terms of individuals and workplace disengagement, Pech & Slade, (2006) raised concerns arguing that the first step to avoiding disengagement is to understand and satisfy the individuals psychological needs within the workplace. A crucial component is therefore the development of trust between individuals and managers, and where it is thought

that management behaviours and expertise could relate positively to gaining trust (Perry & Mankin, 2004, Pech & Slade 2006).

Central to the overall debate, a key aspect is that despite the prevalence of CMHPs, stigma, self-stigmatisation and internalising continues to be in existence, and often viewed through a negative lens by the broader society (Irvine, 2008, Corrigan & Deepa, 2012). Therefore, it is not surprising to find that individuals within a workplace are often reluctant to divulge or share information about a CMHP, fearing a negative response (Milliken, et al. 2003, Ryan & Oestreich, 1991). It is also thought that the issues of non-disclosure are multi-factorial, therefore it is possible that these prevent individuals from having positive interactions with the immediate work environment, managers, colleagues and occupational health support (Buck, et al., 2011).

Linked to the previous discussion of manager knowledge and confidence, a major drawback is the apparent lack of mental health literacy amongst workplace managers, the wider workforce, and society which is likely to inhibit the instigation of innovative practices to address CMHPs within the workplace. (Milliken, et. al., 2003). The term mental health literacy (MHL) being a construct arising from Health Literacy and where Jorm et al., (1997) refined the meaning as knowledge and beliefs that aid understanding, interaction, intervention and management of mental health (LaMontagne, et al., 2016).

Furthermore, MHL has continued to evolve, being described in more recent years, as a multi-dimensional concept which now includes factors such as understanding of positive mental health, decreasing stigma and enhancing help-seeking efficacy (Kutcher, et al., 2016, Moll et al., 2017). Therefore, with a view to improve MHL across society, Mental Health First Aid (MHFA) training was developed to address the gaps in public knowledge, stigmatisation and the provision of support (Kitchener & Jorm, 2002). Subsequently, Kitchener & Jorm's (2004) randomised controlled trial of MHFA training concluded that MHFA effectively contributed to participants MHL. However, since this time, from a workplace perspective, the 2017 evidence review carried out by the UK HSE, (2017) found that no conclusive evidence had been found that supports Kitchener & Jorm's (2004) view. The review found limited evidence that the

training content has been effectively adapted for the workplace, and limited evidence that the training lead to sustained improvements in the ability to support those experiencing mental ill health. Moreover, no evidence was found that improved organisational management of CMHPs (HSE, 2017).

Summary

On one hand, it has been argued that there is improved knowledge in terms of CMHPs, although the literature shows that the issues of managing CMHPs in workplace are multi-faceted. A priority therefore is to explore and identify improvements that can be made in order to facilitate positive approaches that contributes to current knowledge and guideline development – the 'what to do and how' (LaMontagne, 2014). Workplace stakeholders such as employees, managers and workplace health and safety professionals are therefore best placed to contribute to the identification and the closing of the gaps which this study seeks to address.

On the other hand, it is evident that several barriers exist thus preventing disclosure at an early stage, it is also clear that this is impacted by the lack of mental health literacy and stigma. General knowledge, negative attitudes and behavioural responses towards those with CMHPs are likely to create a culture of self-stigmatisation and non-disclosure (Bryan, 2018).

2.10 Discussion of the literature

Overall, the literature identifies a clear gap in research, highlighting a pressing need to understand what is meant by early interventions and '*how early is early'*? The literature, thus far, also identifies gaps in terms of what targeted early intervention strategies could be implemented to benefit the manager, employee and the organisation enabling a proactive management approach.

Furthermore, what is clear from the literature is that organisational policies and practice, need to recognise and understand the concept of CMHPs, how they affect individuals differently and are invariably caused by issues outside of work thus impacting the workplace and vice versa. More importantly, to be successful in the wider context of the workplace, development and implementation of policy, practice and interventions would need to include discussion and input of

employees, managers, human resources, and health and safety professionals perspective in order to explore their social realities and understandings of CMHPs. As noted by Martin et al., 2014 and LaMontagne et a (2014) multi-level or integrated interventions are rarely taken into account in practice, which further supports the moving away from the consistent focus on the individual in isolation thus omitting to pursue group and/or collective resources (Martin et al., 2014, LaMontagne, 2014).

A starting point, therefore, is to explore how managers and individuals come to understand how mental health is defined within the workplace and to identify any variations that exist between the interface of employees and the management hierarchy. Furthermore, as highlighted by LaMontagne et al (2014) and Martin et al. (2014) interventions focusing on the interplay between individuals, workgroups, organisational and the broader societal factors, and being multi-level, suggested that the approaches could support both employee mental health and the psychosocial work environment. From the body of evidence presented it is clear that organisations need to do more to support their employees with mental health problems. However, the evidence discussed appears to show that there is not enough being done in order to close the gap between initial disclosure, understanding of CMHPs, early interventions and ongoing management support.

Although, organisational support and culture would be a significant factor coupled with understanding what barriers exist that prevent managers to instigate proactive workplace interventions to support those in work with CMHPs, several questions remain unanswered. The literature shows that there is a clear need to explore whether managers would be more confident with implementing interventions and adjustments at an early stage if they were equipped with appropriate skills and tools. At the same time there is a need to gain an understanding of what would further enable managers to interact more proactively with their employees who are diagnosed or present with a CMHP. Likewise, LaMontagne, (2014) had identified a need to engage with workplace stakeholders to further understand what factors enhance or hinder proactive engagement and implementation of interventions.

Finally, whilst this chapter has attempted to provide a summary of the literature relating to early workplace interventions for CMHPs, it is clear that there is a dearth of literature that gives attention to the experiences of employees within the social context of the workplace (Shaffer & Shaffer, 2005). The review has also identified gaps in the literature that consider the linkages with workplace mental health literacy, emotional intelligence and stigma particularly where individuals present with a CMHP. Follmer & Jones (2028) identified a need for rigorous and holistic qualitative studies that gather information from employees exploring their experiences of CMHPs in the workplace whilst considering the stakeholders and organisation perspectives.

To this end, I now turn to the next chapter and a discussion of the literature in the context of UK policy and mental health.

Chapter 3

Review of the Literature from a UK Policy Context

3.1 Introduction

The previous chapter discussed the key concepts, theory and definitions of early workplace interventions for CMHPs; therefore, it is now important to discuss the key drivers of the intervention literature that exists within the UK policy arena. Despite increasing national policy, workplace mental ill health has continued to be a much-debated topic in the realms of workplace interventions, the last two decades have seen a growing trend in national and international workplace mental health policy and strategy development (WHO, 2000, National Institute for Clinical Excellence, (NICE) 2009). Furthermore, The Organisation for Economic Co-operation and Development (OECD, 2011) suggested that although the UK has been very good in testing innovative schemes and approaches, successful pilots disappear very quickly without being brought into existing policy structures and guidelines (OECD, 2011). Therefore, this chapter is situated in a debate of the literature from a UK mental health policy context and how it relates to workplace policy and practice.

Presenting an ideal conduit for the improvement of public and workforce health, this study is situated in a public sector Local Government Setting (Local Authority (LGA)), therefore it is important to understand the literature that drives public and workforce mental health. This chapter thus commences with a discussion of the development of UK policy and occupational mental health development and how it impacts on public sector organisational workforces. Furthermore, Local Government organisations in particular contain several important levers within their structures with several public and community focused functions within them. These include public health, housing, social care and education, all of which have the potential to improve mental health and wellbeing, not only within the workplace but from within the communities in which employees live and function (LGA, 2010). Moreover, the public sector are often seen as being in a unique position, where the organisations are invariably large employers, or some cases the largest within the communities in which they

are situated (Waddell & Burton, 2006, LGA, 2010, Karanika-Murray & Weyman, 2013).

The chapter concludes with discussion of workplace health and wellbeing strategy, policy and organisational impacts. In addition, participatory action research and organisational change is reviewed to identify what other research studies have used this approach as opposed to previous literature which has largely explored these issues from an organisational development (OD) and workforce productivity and effectiveness perspective (Institute for Employment Studies, (IES) 2008).

3.2 Background

From a variety of studies, it is now well established that there is a clear rationale for steps to be taken to reduce what is commonly referred to as the 'economic burden' of mental ill health in the UK workplace (DWP, 2005;2008, Black, 2008, DWP and DoH, 2009, HSE, 2004;2008, Farmer & Stevenson, 2017). The UK, has seen rapid development of a range of national strategies and initiatives over the last two decades that include the Health, Work and Wellbeing strategy (Hill et al., 2007, DWP, 2005) Dame Carol Black's review of 'The Health of Britain's Working Age Population - Working for a healthier tomorrow' (Black, DWP, and the DoH, 2008) was followed by the Mental Health and Employment strategy (DWP and the DoH 2009) and Mental Wellbeing at Work (NICE, 2009).

More recently, a range of guidelines have emerged within the UK (NICE, 2015, Farmer & Stevenson, 2017, Business in the Community (BITC) 2017, CIPD & MIND, 2018, CIPD, 2019) however, to what extent these guidelines have been established and have shown to be effective within workplaces remains unknown, although CIPD and MIND suggest that almost seven hundred businesses have signed the Mental Health at Work commitment to implement Farmer & Stevenson's (2017) 'Thriving at Work Framework' (CIPD & MIND, 2019). Furthermore, a review of published guidelines carried out by Memish et al., (2017) set out to, firstly, determine the quality of the existing guidelines for workplace CMHPs and secondly, to assess the comprehensiveness as to CMHP prevention, positive promotion and protective factors. However, Memish (2017) highlighted that the burgeoning guidelines for workplace CMHPs alongside the

differences of national and local community access to knowledge and resources, made it confusing and difficult for employers to decide which strategy, policy and guidelines applied to their workplace setting (Eccles, 2017, Memish, 2017). Considering the evidence so far, there appears to be a fragmented process of strategy, policy and guideline development, thus the discussion now looks at the drivers for, development of national policy and guidelines for CMHPs and implementation and impacts on to the workplace.

3.3 The Development of United Kingdom (UK) Workplace Mental Health Policy & Guidelines

As noted, from the publication of 'The Health of the Nation' strategy in 1992 (DoH, 1992) through to the most recent 'Thriving at Work' review of mental health and employers (Farmer & Stevenson, 2017) there has been an increasing focus in terms of development of strategy, policy and regulation and demonstrated through an HSE commissioned review of literature in terms of work related stress - 'Health Risks Review' (Cox, 1993). In turn, this led to the launch of the HSE Stress Management Standards in 2004, which focused on the management of the primary sources of work-related stress and where effectively managed can produce a high level of health and wellbeing and organisational performance (HSE, 2004, McKay, et al., 2004, Edwards & Webster, 2012). The standards, being widely used across a range of industries continue to be viewed as a risk based and good practice model for interventions for work-related stress. Sitting within the existing UK regulatory framework, the standards thus assist organisations to meet their legal obligations under the Health and Safety at Work etc. Act (1974) and the Management of Health and Safety Regulations (1999) Working Time Regulations (1998) etc (McKay, et al., 2004, Edwards & Webster, 2012). Furthermore, since this time, interventions and support for mental health problems have further shifted towards legislative drivers, for example The Equality Act, 2010 aims to prevent discrimination against those with mental health problems.

However, despite a plethora of literature being in existence in terms of the workplace mental health strategy, policy and guidelines (Black, 2008, NICE, 2009, HSE, 2006, Jenkins et al., 2008, Leka, et al., 2008, Pomanki, et al., 2010, Lund et al., 2010, Patel et al., 2010, Nexø et al., 2018, Memish, et al., 2017),

there is a dearth of evidence from within the public sector as to their relevance, how they have been implemented and to what degree they have been effective (LGA, 2010). Furthermore, due to the wide differences in public sector organisational structures and cultures across the UK, it is also likely that implementation processes would result in variable approaches being applied to policy and practice, thus making it difficult to quantify implementation effectiveness. Notably, the issue is not just confined to the UK, reviewing ninety-four policies from across Europe, Leka et al., 2015 found several gaps in the wider context of national and workplace policy. Additionally, the authors recommended that consideration should be given to the harmonisation of key pieces of legislation with clear interpretation of legal provisions, supported by relevant national level policy and initiatives to achieve preventative actions and positive outcomes for workplace psychosocial risks and their management (Leka, et al., 2015).

As previously indicated, UK policy continued to develop, the Government commissioned studies such as 'Is work good for your health and well-being?' (HSE, 2006, and 'Working for a healthier tomorrow' (Black, 2008), however, instead of focusing on the workplace, the main aim was to improve employment outcomes through 'work rehabilitation' from 'worklessness'. This is evident in the case of Black's (2008) report which aimed to reduce the welfare bill by moving those with CMHP off the benefits system back into work, rather than putting research evidence into practice within the workplace itself (Seymour, 2010).

In a bid to further develop policy, 2008 saw the UK government commission a scientific evidence base review '*What Works for Whom and When'* that focused on vocational rehabilitation for common health problems including mental ill health. However, the overarching aim was to review the cost effectiveness of interventions following long-term sickness absence with rehabilitation being defined as, 'whatever helps someone with a health problem to stay at, return to and remain at work' (Waddell, Burton & Kendall, 2008). Although, it is not disputed that economic impacts of poor mental health in the workplace and society in general are substantial, at the forefront of government bodies and employers alike, there has been the increasing focus on reducing the costs associated with both sickness absence and presenteeism in relation to those

diagnosed with common mental health conditions (McDaid, 2007, Munir, 2009). However, any positive economic and social impact and effectiveness of national strategy and policy implementation appear to be debatable, and where it is recognised that measuring the prevalence of mental health problems has often proven to be difficult where estimates of the scale and cost calculations vary considerably for a number of reasons (Lelliot et al., 2008). For example, the 2014 Adult Psychiatric Morbidity Survey (McManus, et al.,2014) had found that for those surveyed, common mental health disorders had increased, being prevalent in 1 in 6 adults compared to 1 in 4 in same survey undertaken in 2007, however, a cautionary note is that the data was estimated, thus potentially being unreliable (Stansfield et al 2016). Nevertheless, data gathered from both the Labour Force Survey (LFS) 2016, and Annual Population Survey (APS) 2016, the Office of National Statistics (ONS, 2016) found that mental health problems (including stress, depression, anxiety) attributed to 15.8 million working days lost to sickness absence.

Likewise, the HSE's annual statistics for the period 2019/20 had shown an upward trend, estimating that 17.9 million days were lost to stress, anxiety and depression (HSE, 2019), therefore to what extend national policy and guidelines are effective in the workplace remains unclear. In addition, in terms of effectiveness, national policies are voluntary instruments and not bound through legislative regulation which in turn would instigate wider adoption into workplace practices, thus being more likely to provide consistent measurable data. On the other hand, regulation has been seen as effective in driving health and safety standards but less so in terms of psychosocial prevention and promotion of CMHPs in the workplace, notwithstanding the implementation of the HSE stress management standards (HSE, 2006, Leka, et al., 2015).

As previously stated, there has been widespread agreement that workplaces of all types are valuable conduits for the promotion and implementation of public policy. On the other hand, despite this and as noted above, the UK has continued to focus on rising costs where people 'fall out of work' on to the welfare systems thus effecting the increasing disability and sickness benefit payments. However, the 2011 '*What Works at Work'* strategy attempted to shift the focus by making recommendations on how employers could address mental

health in the workplace (Curran et al., 2007, Eagan et al., 2007, Waddell & Burton, 2006, Karanika-Murray & Weyman, 2013). Further publication of the various policy frameworks thus resulted in the emergence of various sets of practical guidelines, although it was identified that greater transparency was needed of the drivers and incentives, including political interests in order to improve the validity of the guidelines (Nexø et al., 2018). Furthermore, Memish, (2017) questioned whether the scientific evidence from the plethora of policies could in fact be translated into useable practical and proactive guidelines in order to prevent CMHPs within the workplace (Memish, et al., 2017). To better understand the content and quality of the published guidelines a variety of academic reviews found that the suggested interventions were either focused on return-to-work pathways, designed for use by health professionals or were a set of occupational health and safety guidelines that were not specific to CMHPs (Memish, 2017, Leka et al., 2015, Dewa et al., 2016, Cates et al., 2006).

Moreover, most of the guidelines reviewed had either recommended interventions that would not be feasible from a financial and human resource perspective or deemed to be limited when considering complex interventions within the organisational context (Nexø et al., 2018). However, the debate continues to grow in importance and prominence with many arguing that a proactive approach should be taken to mental health and wellbeing in the workplace that in turn could benefit employers as well as employees (Fenton, 2014).

In terms of the national focus on the management of employees CMHPs and the workplace, there appeared to be a shift in focus in the late 2000's, where the Department of Health commissioned the NICE to undertake research to develop guidance in order to support national strategies, policy and legal duties (NICE, 2009). The emergent guidance was therefore intended to support any employee who experience CMHPs, recommending that employers take a strategic approach in the promotion of employee mental wellbeing alongside a systematic approach to creating opportunities for managing mental ill health (NICE, 2009). However, although the study focused on promoting employee mental wellbeing per se, there appeared to be little consideration for the wide range and variety of UK employment sectors and occupations (Graveling et al., 2008). Moreover, despite

the stakeholders during the fieldwork querying the evidence suggesting that it was unclear how the guidelines should be implemented and by whom, it is not therefore surprising that it has been reported that there has been a distinct lack of support from employers, particularly where usable practical tools for implementation were not forthcoming (NICE, 2009, Adams et al., 2015, Memish, et al., 2017).

On the other hand, despite government policy continually being aimed at minimising lost time at work and associated costs resulting from mental illness, it is now being recognised that there are a myriad of issues that can contribute to CMHPs and mental ill health in the workplace (Hassard, et al., 2018). In support, the more recent Farmer-Stevenson (2017) review suggested that focus should be on CMHPs that are often 'brought to' and 'experienced in work' but where work is not necessarily the causal factor (Farmer & Stevenson, 2017). Further expanding on Farmer's (2017) concept is the acknowledgement that workplace factors such as poor employee engagement, conflict, continual staff turnover, poor recruitment practices, stigma, 'leavism' (taking leave instead of sickness absence) further impact on those with existing CMHPs (Farmer & Stevenson, 2017, CIPD, 2018, CIPD, 2019). Moreover, exposure to psychosocial workplace risks such as poor organisational culture, and ineffective leadership and management have been consistently linked to mental ill health and remain salient characteristics of the modern workplace, (Stansfield & Candy, 2006, Bonde, 2008, Leka & Jain, 2010, Hassard et al., 2018).

Summary

Overall, the evidence presented indicates that despite the continual development of national policy and guidelines in terms of CMHPs in the workplace, however, these are invariably voluntary instruments. As noted, unlike the HSE stress management standards, which is enshrined in legislative risk management, it is unclear from the literature how or if national policy and guidelines have been implemented and embedded within organisations (Eccles, 2017, Memish, 2017). Furthermore, the UK has continued to focus policy on the negative connotations of workplace mental health and illness and the 'burden' to society (Waddell & Burton, 2006, Black, 2008, Waddell, Burton & Kendall, 2008, Seymour, 2010). However, from a workplace context, it is widely recognised that workplace

mental wellbeing is linked to the interaction between the individual and the workplace environment, culture, and the nature of the work (Hill, et al., 2007). Although research has increasingly indicated that CMHP interventions have tended to be organisational-based and predominantly focusing on the individual with the aim of increasing an individual's resilience (Murphy and Sauter, 2003; Caulfield et al., 2004; Lamontagne et al., 2007). This is evident from Memish's (2017) work who concluded that there was significant disparity in the content and quality of guidelines reviewed, and where a particular focus was detection and treatment as opposed to prevention and protection. Particularly noteworthy is that the authors highlighted the lack of stakeholder consultation in development of guidelines that had shown to be a consistent weakness (Memish, et al., 2017).

To this end, despite there being legislative requirements to risk manage workplace CMHPs as well as a wide range of UK national policy and guidelines, the UK has no national workplace mental health policy that provides a common understanding of what constitutes a mentally healthy workplace (Memish, et al., 2017). Moreover, Nexø (2018) highlighted an important point in their review that is directly related to this study, where the authors did not identify any guidelines that were exclusive to detecting CMHPs early, recommending that the evidence base needed improving particularly in terms of innovative approaches to combining prevention, detecting, and managing CMHPs (Nexø et al., 2018). Finally, thus far the discussion has focused on UK national mental health strategy, policy and guidelines, therefore it is now necessary to discuss occupational mental health development.

3.4 Occupational Mental Health Development in the UK Workplace

As discussed above, during the 20th century the conceptualisation and development of occupational mental health regulation policy and guidelines has taken many twists and turns. This section provides a brief view of occupational mental health development within the UK workplace looking at how, over time this has evolved and where it may link to national legislation, policy and guidelines (Harrison & Dawson, 2016). Within this section the term 'occupational health' is used which refers to a range of disciplines involved in improving

mental health and work, such as occupational psychologists, physicians, and workplace health and safety professionals (Harrison, 2015).

The origins of occupational health and occupational medicine date back to 1821 and the seminal works of Charles Turner Thackrah (1821) who authored '*The Effects of Arts, Trades and Professions on Health and Longevity*' where he described industrial diseases and the damaging results of work. As a result of his work, Thackrah became known as the 'Father of Occupational Medicine' (Fingret, 2000, Thackrah, 1821). Despite this early publication, literature into occupational mental health is limited, and it was not until 1915 that interest had started to grow in the psychological effects of work, where it was recognised amongst munition workers that a reduction in production was linked to the increasing long working hours, thus directly contributing to fatigue (Fingret, 2000). However, over several decades, there had been an increasing recognition of the need for industrial standards and best practice in terms of occupational mental health which consequently led to the formation of the Association of Industrial Medical Officers (IMO) in 1935. However, the rapidly changing face of the workplace had in turn placed further demands on the IMO's, thus driven by the decrease in manufacturing but with an increasing focus on the service sectors shifted the focus from industrial diseases and taking into account all types of work. (Miller, 1997, Fingret, 2000).

Although early research had focused on workplace pressures produced by the physical environment (Baron & Bell, 1976), the late 1960s and early 1970s started to see a growing interest of the psychological aspects of work (Miller, 1997). Notably, occupational health physicians (OHP), psychiatrists and psychologists reported that they were frequently encountering CMHPs in their practices, with anxiety and depression being the most prevalent (Fingret, 2000, Miller, 1997). However, Schilling (1984) questioned whether occupational health physicians could effectively achieve the objectives of prevention rather than treatment of occupational ill health as described by Thackrah (1832). Schilling (1984) suggested that primary prevention of occupational ill health is an important function of the workplace itself by identifying the manifestation of work-related ill health, thus enabling risk reduction through elimination or control. Furthermore, rapid changes were being encountered within workplaces

such as technological advances, shifting workforce demographics (increasing female and part time workers) etc. instigating Schilling to further suggest that it was likely that the changes could trigger increases in psychological and stress induced problems. Moreover, to be successful, a broader approach to mental ill health prevention would be necessary and workplaces and occupational health physicians adapting accordingly (Morris, 1982, Schilling, 1984).

As noted above, the focus began to shift towards consideration of the psychosocial workplace environment and its impact on psychological health and occupational wellbeing (Schilling, 1984, Standsfeld & Candy, 2006, Stansfeld et al., 2009). The shift in thinking subsequently led to theoretical discussions of the nature of stress and the introduction of Karasek's (1979) model of job demand-control (DCM) adopted (Cox & Griffiths, 2010, Leka & Houdmount, 2010). The DCM had considered that the imbalance of high psychological demands of the job combined with low opportunity for individual control was detrimental to mental health thus triggering a stress reaction (Karasek & Theorell, 1990, Warr, 1994, Mackay, et al., 2004). Moreover, further elaboration of Karasek's model captured the attention of many researchers in the 1980s and 1990s where it was recognised that supportive managers, supervisors and co-workers could contribute to positive mental health outcomes (Karasek, et al., 1992, Mackay, et al., 2004).

Over time, the debate thus switched the spotlight on to translating earlier theory into practical methods with a view to reduce the risks from stress for the benefit of both the individual and the organisation (Karasek, 1979, Caplan, 1987, Mackay, et al., 2004, Stansfeld & Candy, 2006, Cox & Griffiths, 2010). However, despite the roots of 'stress' being traced back to Hans Selye (1958) and his seminal works '*The stress of life'* there continued to be much debate and disagreement in terms of terminology and definitions of workplace psychosocial conditions and psychological responses, with stress often being viewed through a negative lens (Fingret, 2000). Furthermore, whilst debating 'stress' Selye (1958) questioned whether stress was a cause or effect, going on to suggest 'stressor' as the cause and stress as the effect, which is a definition that is now generally accepted (Selye, 1958, Fingret, 2000).

As previously indicated, the continued interest in workplace stress had instigated several debates and the rapid development of theories and practice in terms of the adverse effect of work conditions that result in mental ill-health (Griffith, et al., 1996, Leka & Houdmount, 2010, Cox & Griffiths, 2010). However, a renewed focus took place in the late 1980's where the HSE undertook the '*Health Risks Review'* in order to identify the leading causes of occupational ill health, ranking workplace stress as a significant problem in the workplace behind musculoskeletal disorders (McKay et al., 2004). The outcome of the review and a subsequent literature review (Cox, 1993) thus led to the HSE introducing the concept of a control cycle approach to risk management in terms of workplace stress, developing a hazard-based taxonomy which formed the basis of the HSE's publication 'stress at work guidance' (Cox, 1993, HSE, 1995, Mackay et al., 2004). Moreover, the HSE went on to develop the renowned risk based work-related stress management standards which were designed to assist employers to comply with their duties under the law (Mackay et al., 2004).

Following the introduction of the HSE stress management standards in 2004, the growing body of literature shifted interest towards examining whether some occupations were more susceptible to the risk of stress and CMHPs than others (Stansfield et al., 2003, 2009). However, given the changing face of work, a range of studies emerged (Bourbonnais et al., 1996, de Lange et al., 2003, McCaig, 1998, Stansfield & Candy, 2006) that considered the linkages between psychosocial characteristics and the impacts on CMHPs, but neglected to consider the impacts across different occupations (Stansfeld etc al., 2003, 2009). However, Stansfeld et al., (2009) argued that it remained unclear from the published studies whether some occupations were associated with higher or lower prevalence of CMHPs, notwithstanding that high psychological demands could contribute to a higher risk of developing a CMHP in some occupations such as managers that have consistent high targets to meet. However, the authors acknowledged that difficulties would likely arise whilst studying large populations of workers across a range of occupations (Stansfeld, et al., 2009).

More recently, Harvey et al., (2017) posited that the exact nature of the relationship between certain types of occupations and the development of CMHPS remains contentious (Harvey et al., 2017). Their systematic review

sought to link work to CMHPs however the authors identified three broad categories that could contribute to the development of CMHPs in the workplace as opposed to specific occupations, namely imbalanced job design, occupational uncertainty, and the lack of value and respect in the workplace (Harvey et al., 2017). However, the review found moderate evidence from multiple studies that several risk factors, such as the imbalances between job-control, effort-reward and job role stress, bullying and low social support in the workplace, continue to underpin the development of CMHPs in the workplace (Harvey, et al., 2017). Similarly, a previous review undertaken by Noblet & LaMontagne, (2006), had pointed out that chronic exposure such as work overload, poor supervisory support and low input into decision making have been cross-sectionally and prospectively linked to a range of debilitating health outcomes, which include CMHPs (Noblet & LaMontagne, 2006).

Latterly, the HSE (2015), accepting that since their inception, the management standards had not reduced sickness as expected suggesting that the standards (HSE, 2012) focused on the stressors in the work environment and placing less emphasis on the biopsychosocial factors (interactions between biological, psychological and social factors) which determine the manifestation and outcome of wellbeing (Kendall, et al., 2015, HSE, 2015). Furthermore, it was recognised that CMHPs are extremely common and subjective, thus accepting that conventional risk management, healthcare and occupational health approaches, although necessary, are not sufficient to tackle CMHPs in the workplace. Moreover, the HSE (2015) had commissioned the review in order to develop a 'toolbox' to bridge the gap between preventative interventions, occupational health and healthcare provision, spanning all layers of the biopsychosocial model (Kendall, et al., 2015, HSE, 2015).

Additionally, the researchers aimed for the 'toolbox' concept to be user-centred, assuming fulfilment of health and safety legislation relating to CMHPs and the use of relevant primary occupational health prevention approaches (Kendall, et al., 2015, HSE, 2015). Whilst clarifying the who does what, how and for whom the concept, although focused online managers responsibility, further recognising that it provides options and a broad approach for key stakeholders

such as health and safety professionals, human resources, occupational health providers and trade unions (Kendall, et al., 2015, HSE, 2015).

Similarly, Harrison's (2016) report identified the need to produce guidance for occupational health practitioners to maximise health outcomes. Harrison & Dawson (2015) further acknowledged that there was a need for experts and practitioners in a variety of disciplines to work collaboratively, noting that there is a clear overlap between disciplines such as health and safety, occupational health, and human resources. Furthermore, the author recommended the development of competency frameworks for multi-professionals to ensure a holistic approach in the provision of preventative activity that ensures a working environment that is conducive to good health (Harrison, 2016). The literature has shown that the evolving role of occupational health physicians, under its different guises, has provided the impetus for recognising that they hold key positions in developing employers awareness of mental ill-health at work (Miller, 1997, Harrison, 2016). Notably, the role of occupational health practitioners has continued to work within organisations in order to make a positive contribution to the concept of health risk management and includes a wide range of workplace health risks in addition to CMHPs (Harrison & Dawson, 2015).

However, what is clear is that over time the body of literature in terms of the role of occupational health practitioners has tended to focus on clinical diagnoses and outcomes and less on core topics such as psychosocial work environment, occupational psychology and early workplace interventions (Funk, 2002, Leka & Houdmont, 2010). Moreover, their role has become somewhat blurred with the growing concept of workplace health and wellbeing as organisations will often turn to occupational health practitioners to obtain guidance on the wellbeing of their employees (Leka & Houdmont, 2010).

In summary and as previously indicated, since the early 20th century the evolution of occupational medicine and workplace health has continued, although a new paradigm had begun to emerge where the health risk management extends to health and includes the medical aspects of sickness absence, rehabilitation and workplace health promotion, thus questioning the implications for future occupational health provision (Harrison, 2015). In light of the

paradigm shift in occupational health practice, it has been further suggested future development of occupational health practice would need to include a broader-based population equipped with core knowledge and skills and competencies, to support the biopsychosocial model of practice that underpins clinical practice and work outcomes (Harrison, 2016).

3.4.1 Occupational Mental Health Guidelines - How have they been translated in the UK Workplace?

Thus far, the literature reviewed has recognised a need for standards and best practices for the management of occupational mental health. However, the continual publications of national policy and guidelines alongside the rapidly changing world of work thus present further challenges for organisations in the management of psychosocial hazards and psychological health risks to employees (Leka & Houdmont, 2010). Although from the literature presented, consideration had been given to the wider context of psychosocial hazards and the changing world of the work environment as evidenced by the development of the HSE stress management standards (HSE, 2004, 2006). Despite the continual development and publication of national policy and guidelines, the HSE standards being embedded in risk-based legislation thus focuses employers attention on to the ever-growing risk of litigation (HSE, 2004, 2006). In turn, this causes employers to be more concentrated on organisation-wide intervention processes, rather than being attentive to the outcomes and the benefits that may result from proactive and preventative initiatives, programs or interventions (Black & Frost, 2011).

By the same token, a consistent weakness highlighted had been the distinct lack of stakeholder consultation and engagement during guideline development thus resulting in the tendency for employers to ignore them (Memish, et al., 2017). A noteworthy point is where the HSE (2015) acknowledged that there was a need for a new 'toolbox' concept, to address not only CMHPs but the wider determinants of common health problems in the workplace such as musculoskeletal disorders etc. (Kendall et al., 2015, HSE, 2015). Additionally, during the development of the common workplace health toolbox, the HSE drew on qualitative subjective experiences and concerns from key stakeholders such as a range of subject experts and end-users (Kendall et al., 2015, HSE, 2015).

In recent years evidence has indicated that employers have found that in practice it has been found difficult to implement policy, guidelines and organisational improvements for mental ill-health (Leka & Nicholson, 2019). The evidence suggests that this is partly due to the ever-changing dynamics of the workplace where organisations have had to evolve and adapt to various challenges. In recent years, organisations have been faced with ageing workforces, mergers and major restructures and more recently the impacts of Brexit and the COVID-19 pandemic. Employers have also been grappling with the rise in presenteeism (working when unwell), leavism (working while on leave or holiday to complete work commitments) and also relates to taking work home when it cannot be completed during a normal working day (CIPD, 2019, MIND, 2020, Cvenkel, 2021).

Leka & Nicholson (2019) suggested that as the workplace is becoming more diverse through technological advances, climate change and higher job insecurities it is important to consider these global drivers for change within the modern workplace when implementing policy and guidelines for CMHPs. It was also felt that organisations would need to have a full understanding of the changes required, whilst strategically aligning and integrating approaches based on the risk management ethos of prevent and protect, and adapting approaches to ensure inclusivity (Leka & Nicholson, 2019).

In terms of private and public sector workplaces it has often been the public sector who have been viewed as the leading light when implementing mental health legislation and national strategy and policy, however against the backdrop of the plethora of economic challenges, progress has often been hindered (LGA, 2010, Farmer & Stevenson, 2017). However, irrespective of the industry sector, it is clear that additional challenges such as the rapid technological advances, increasing numbers of zero-hour contracts, the increase of part-time workers and low pay, ageing workforces, and the privatisation of public sector bodies have consequently contributed to the rising incidence of occupational stress and CMHPs within workplaces (Fingret, 2000, Black & Frost, 2011). It is evident from the literature that ultimately psychosocial hazards that go unmanaged within an organisation would therefore be highly likely to adversely impact the psychological wellbeing of workers (Cox, et al., 2000).

3.4.2 Occupational Mental Health Development in the Public Sector

As far as public sector workplaces are concerned, it has been widely published that CMHPs are the main reasons for long term sickness absence with stress being cited as the most common cause for both manual and non-manual employees (Pearlin et al. 1981, Stansfeld, 2009, LGA, 2016, CIPD, 2018). However, despite the wide variations across public sector organisations in the management of CMHPs and sickness absence management, there has been recognition that good management practices invariably resulted in low sickness absence (Pearling, 1981, Stansfeld, 2009, CIPD, 2018, Gayed et al., 2018). On the other hand, the LGA survey reported in its 2015 survey that stress, anxiety, depression and fatigue were the biggest causes in sickness absence in local authority (Council) settings for the period 2014/15 with a similar picture being seen in 2016/2017. It was however recognised that a variety of factors exist within local government workplaces that further contribute to the adverse effects on workers mental health. The LGA for example suggested that sickness absence in local government was only part of a complicated narrative and where local government had been impacted by the continual challenges of ensuring that government initiatives and targets are met. When combined with the instigating of efficiency savings against the backdrop of the politics have driven continual budget cuts and austerity measures had impacted on to sickness absence (CIPD, 2018, LGA, 2019).

As indicated, over several years all public-sector workforces in the UK have been in a state of flux and on a treadmill of constant organisational and workforce changes with no real period of stability (Seymour, et al. 2005, CIPD, 2018, LGA, 2019). In turn, this has continued to trigger reactions amongst the workforce leading to anxiety, depression, fear, reduced performance, and increased presenteeism as described in the DCM concept of excessive demands with no individual control of the continual changes (Karasek, 1979, 1992, O'Driscoll & Brough in Leka & Houdmount, 2010, CIPD, 2018, LGA, 2019). It is evident that when combined, the plethora of issues created a perfect storm leading to local government organisations facing a staffing crisis, putting key services at risk thus further impacting the mental health and wellbeing of the workforce. It is therefore not surprising that stress has continued to be cited as the main reason

for leaving public sector employment (Coffey et al., 2009, Audit Commission, 2002, HSE, 2005, Nicholson, 2018). Despite the local government increasing its efforts to address CMHPs in the workplace, Henderson, et al., (2013) found although the knowledge of CMHPs had improved there had been no increase in formal workplace policy and practices being adopted (MIND, 2008, Lelliot, et al., 2009, Henderson, et al., 2013). On the other hand, by 2009/10 some encouraging improvements had started to emerge in terms of preventing and managing CMHPs in the workforce, with employers acknowledging that additional guidance was needed to ensure consistency amongst knowledge, attitudes and behaviours (Henderson, et al., 2013).

Prominent academics such as Seymour and Grove, 2005, Stansfield et al., 2009 and the CIPD, 2011, argued that certain public sector occupations such as teachers, nurses, care workers, social workers, probation officers, police officers and youth workers could be at greater risk of developing CMHPs than others. This comes as no surprise given the work characteristics, the degree of responsibilities and the higher psychological demands attached to those professions are likely to pose a higher risk of impacting negatively on, or contribute to the development of a CMHP. Low control and high demands coupled with the often-unpredictable behaviours such as being subjected to violence and aggression from those with whom they have regular contact is likely to have a further adverse impact on their mental health. It would therefore seem feasible that intervening early in cases such as these could support the individuals through those testing times thus enabling them to remain in work (Sanderson & Andrews, 2006, Stansfield et al., 2009, CIPD, 2011).

Summary

This section has provided an overview of the literature relating to the development of workplace and occupational mental health. Notably, there appears to be a consensus within the literature of the psychosocial hazards that exist in the workplace, if not effectively managed, can adversely impact the psychological wellbeing of workers (Cox, et al., 2000, Stansfield et al., 2009, Henderson, et al., 2013, Nicholson, 2018, LGA, 2019).

It is also evident that over the decades' occupational mental health research has evolved alongside the changing face of work, from identifying fatigue as having a negative impact on mental health in 1915, through to the development of Karasek's, (1979) DCM model and the HSE stress management standards in 2004, that took a risk management approach and continues to be embedded within workplace regulations.

Furthermore, it has been acknowledged that workplaces and occupational health practitioners need to take a broader approach to the prevention and management of CMHPs whilst evolving and adapting to ever-changing social and worker needs. In addition, occupation types have been associated with several factors that have the potential to have a negative impact on employees mental health. For example, factors such as increased demands, and low control and flexibility often being driven by bureaucracy, unrealistic targets, unmanageable workloads, accelerating change and challenge and insecurity have been cited as contributing to adverse impacts on CMHPs (Coffey et al., 2009, Beresford & Evans, 1999). However, the general consensus appears to be that well-designed work is likely to minimise the risks related to occupational stress and has continued to have a sustained focus over many decades. On the other hand, it could be argued that these foundations could be built upon by utilising the knowledge and principles of work and organisational psychology. The implementation of an holistic approach whilst paying attention to the building blocks of change management, operations management and occupational health could therefore support those with CMHPs and enable preventive and sustainable mental health (von Thiele Schwarz et al., 2021).

Despite the sustained focus on occupational stress, in recent times job stress research began to plateau and where studies have emerged and the term 'workplace wellbeing' has come into use. However, the concept of health and wellbeing is a sub-category of public health and differences exist between workplace and public health contexts (Karanika-Murray & Weyman, 2013). Therefore, in the next section, I discuss the literature that exists in terms of workplace health and wellbeing and the organisational impacts on CMHPs.

3.5 Workplace Health and Wellbeing and Organisational Impacts

The second half of the 20th century saw the emergence of workplace 'wellbeing', with academics turning their attention to how wellbeing in the workplace could be promoted and improved (Donald, Johnson, Nugyen, 2019). As the issues that impact on the wellbeing of workers can be wide-ranging and complex, a challenge for wellbeing programs is understanding how the underpinning theory determines and shapes the outcomes. However, several theories exist, for example, a feature of positive psychology suggests positive emotions as being a key characteristic that underpins wellbeing, (Diener, 1984, Fredrickson, 2001, Donald, Johnson, Nugyen, 2019), others have focused on the Maslow (1943) theory of 'self-actualisation' and achieving ones full potential (Donald, Johnson & Nugyen, 2019). In recent years, the general concept of workplace wellbeing has been confused by a variety of terms being used and include workplace health and wellbeing, occupational health, organisational health and workplace health and safety (Day, Kelloway & Hurrell, 2014). However, for this discussion, the term workplace health and wellbeing will be used. It is therefore important to understand how health and wellbeing has been defined and conceptualised within the literature.

The term 'health' has been shown to be a difficult construct to define and often synonymous with the absence of disease (Emmet, 1991, Danna & Griffin, 1999). WHO initially defined health as 'the state of complete physical, mental and social well-being, not merely the absence of disease' (WHO, 1948). Although consistent with the biopsychosocial model that considers physiological and social factors of health and illness, it did not escape criticism being accused of linking health explicitly with wellbeing, being idealistic and would largely be unachievable (Noack, 1987, Noblet & Rodwell, 2010 pg:160 in Leka & Houdmont, 2010. Crinson, 2007 & Martino, 2017 (PHAST) 2020). However, subsequent broader definitions recognised that health should not be an endpoint, instead of viewing health as a means to an end and a resource that enables the undertaking of everyday activities that contributes to achieving a high quality of life (WHO, 1984, Noblet & Rodwell, 2010 pg:160 in Leka & Houdmont, 2010). Although more contemporary views have focused on the positive and dynamic interactions between people and their social environments,

thus introducing an element of control over the wider determinants of health (Fenton, et al., 2014). Huber et al., (2011) acknowledged that the elements of health are subjective, meaning health differs between individuals and is dependent on the context and needs of the individual (Hubert, 2011, Crinson, 2007 & Martino, 2017).

Equally, wellbeing has been defined in many different ways, although they tend to relate to individual experiences and quality of life (Institute of Occupational Safety & Health, (IOSH), 2006). Providing extensive reviews of the concept of wellbeing, Warr, (1987, 1990) suggested that wellbeing is conceptually similar to health and a multi-dimensional construct (Warr, 1987, 1990; Daniels, et al., 1997, Danna & Griffin, 1999). With the term subjective wellbeing essentially reflecting an individual's self-described wellbeing (Diener, 1994), it is often assumed that the absence of illness indicates 'wellbeing or wellness', thus being referred to as a positive state as opposed to a neutral one (Crinson, 2007 & Martino, 2017).

However, in a similar context to psychological health, wellbeing or wellness is not a static state and is individualistic (Dodge et al., 2012). Therefore, could be more realistic to assume the dual continuum concept for mental health and wellbeing, where mental health is strongly related to, but separate from, mental wellbeing. For example, an individual could have been diagnosed with a CMHP but experiences a high level of wellbeing, due to the CMHP being controlled or managed, furthermore, the dual continuum concept is consistent with the definitions as discussed (Barber, 2012). Moreover, despite the differences in defining wellbeing, amongst academics, there is a general consensus that wellbeing is a multi-dimensional construct (Diener, 2009, Michaelson, et al., 2009; Stiglitz, et al., 2009, Dodge et al., 2012).

Similarly, from a workplace perspective, Guest & Conway (2004) defined health and wellbeing as six constructs that include manageable workloads, being able to exert control over the work, manager and peer support, positive relationships, clear role, and having an involvement in change. Therefore, with the intention to address primary prevention of injuries and/or ill health in the first instance, WHO (2010) thus defined a healthy workplace as "*one in which workers and managers*

collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers" (WHO, 2010 pg:16). However, in line with Guest & Conway's (2004) definition, consideration needs to be given to identifying health, safety and wellbeing concerns within the psychosocial work environment that includes workplace culture and acknowledging that the health and wellbeing of workers will extend into the communities in which they live and work (Guest & Conway, 2004, Jain, Giga, & Cooper, 2008, Noblet & Rodwell, 2010).

Intrinsically linked is workplace health promotion, initiatives, and interventions, and are widely recognised within the public health arena as mechanisms for 'prevention rather than cure' thus being focused on preventing physical and mental ill-health problems as opposed to treating problems once they have manifested themselves (Pescud, et al., 2015). Furthermore, in a bid to understand the drivers for workplace health and wellbeing, Lomas, (2019) posited a multi-dimensional multi-theoretical approach identifying three broad categories and eleven drivers - *"psychological drivers (deploying strengths, managing emotions, aligning purpose, and personal and professional development), physical drivers (health and safety, workload and scheduling, and job content and control), and socio-cultural drivers (relationships, leadership, values, and reward and recognition)*" Lomas (2019, pg:24).

Over several years, it has generally been agreed that workplaces are an ideal setting for public health promotion initiatives as the workforce provides access to a wide section of the adult population (Ipsen, Karanika-Murry & Nardelli, 2020). Furthermore, health and wellbeing initiatives have an important role to play in both individual workers and the broader workplace performance context (Guest, 2018, Pfeffer, 2019, Ipsen, Karanika-Murray & Nardelli, 2020). However, whilst responsibilities for occupational health and safety are embedded in legislation, the lines become somewhat blurred in relation to activities and initiatives that sit under the wider concept of health and wellbeing (Pescud, et al., 2015). Moreover, employers have tended to apply a broad brush 'one size fits all' approach for health and wellbeing, driven by the wider public health agenda rather than putting the focus on occupational health (Black, 2008, Karanika-Murray & Weyman, 2013).

On the other hand, Young & Bhaumik's, (2011) survey identified a consensus amongst employers that organisations have a responsibility to encourage a good level of physical and mental health amongst their workers (Young & Bhaumik, 2011, Pescud, et al., 2015). However, highlighting a note of caution, a wide range of employers had cited that the costs of investing in workplace health and wellbeing (WHAW) potentially outweigh the benefits by providing a low return on investment (Young & Bhaumik, 2011). In contrast, the CIPD, (2019) Health and Wellbeing at Work report suggested that in order to initiate positive outcomes for WHAW activity, any investment would need to be rooted in a supportive and inclusive workplace culture supported by positive management and leadership (CIPD, 2019). However, despite the acknowledgement of the need to address defining influences on workplace health and wellbeing, it comes as no surprise that there continue to be mixed understandings, and as previously indicated the subject occupies a broad domain with considerable variations in the meaning and definitions relating to workplace 'health and wellbeing' (Danna & Griffith, 1999).

Additionally, there is increasing knowledge and understanding of how to combat workplace illness and disease, although this does not appear to be the case in terms of the work contexts that can foster positive health, wellbeing and organisational functioning (Day, Kelloway and Hurrell, 2019). Furthermore, a great deal of evidence exists within management and organisational literature that suggests that involvement of employees is associated with positive and beneficial health and wellbeing outcomes for both the employees and the organisation (Dwyer & Ganster, 1991, Steptoe, 2001, Day & Jreige, 2002, Gibson, et al., 2007, Grawitch et al., 2009, Day, Kelloway and Hurrell, 2019) However, despite the growing attention, a noteworthy point is that employees involvement has rarely been studied in a healthy workplace context and where it is therefore further argued that employees have a pivotal role to play in shaping the organisational framework for health and wellbeing (Grawitch et al., 2009).

In terms of responsibility for workplace health and wellbeing, where it sits within an organisation remains a contested viewpoint, although in the UK the function invariably sits within occupational health and safety legislation frameworks (Fenton, et al., 2014). However, occupational health providers are often tasked

with the responsibility, thus the efforts are likely to be channelled through and responded to via a medical treatment and rehabilitation approach. Although, it is accepted that the emphasis on the various elements of health and wellbeing are likely to be very different. As discussed earlier, health and wellbeing is multi-dimensional and needs to take into account a variety of physical, social, emotional, developmental and environmental elements, with all elements of the workplace having the potential to impact on health and wellbeing (CIPD, 2007, Juniper et al., 2011). Furthermore, there is a general agreement that occupational health and safety practitioners (OHSP) and workplace health practitioners (WHP) often have opposing views to health and wellbeing thus resulting in silo working environments (Goetzel et al., 2008, Karanika-Murray & Weyman, 2013).

On one hand, the OHSP's perspective concurs with Guest & Conway's (2004) definition, where health and wellbeing is rooted in addressing issues within management systems, design of work and the development of holistic interventions (Guest & Conway, 2004). However, on the other hand, it has been well documented that the views of a workplace health practitioner are often limited to healthy lifestyle initiatives that ignore the interplay between behavioural risk factors and negative work environments, thus offering little to address the impacts of CMHPs, job stress or musculoskeletal disorders (HSE, 2000, Allender, Colquhoun & Kelly, 2006, Noblet & Rodwell, in Leka & Houndmont, 2010, Karanika-Murray & Weyman, 2013).

Moreover, despite individuals having control over their lifestyle choices, studies have indicated that socio-economic conditions and negative psychosocial working conditions are likely to influence and contribute to a cycle of unhealthy behaviours and lifestyle choices (Eakin, 1997, Green, 1988, Polanyi et al., 2000, Noblet & Rodwell, in Leka & Houndmont, 2010). Additionally, Goetzel and Ozminkowski (2006) stated that: '*When workplace health promotion initiatives are grounded in behaviour theory and effectively implemented ensuring evidence-based principles and measured accurately they are more likely to improve employees health, wellbeing and performanc*e' Goetzel and Ozminkowski (2006) pg: 310). It is therefore suggested that this approach

would be more attractive to employers (Fenton, et al., 2014, Harvey et al., 2014).

The literature in terms of workplace health and wellbeing continues to grow with contemporary workplace health and wellbeing promotion being guided by a more holistic focus by identifying social, political and economic factors that can contribute to the health and wellbeing of individuals, workplace and communities (Noblet & Rodwell, in Leka & Houndmont, 2010). An example is the socio-environmental model posited by Labonte (1992) who recognised that physiological and behavioural risk factors can be directly and indirectly influenced by work-related factors such as stress, unsafe working conditions, lack of social support etc., (Labonte, 1992, Noblet & Rodwell, in Leka & Houndmont, 2010). Furthermore, LaMontagne et al., (2007) suggested that taking a systems approach would be more effective, where primary interventions such as eliminating, reducing and controlling risks for CMHPs are made, as opposed to tertiary interventions which are the least effective, and where the CMHP has declined to mental illness (LaMontagne et al., 2007, Fenton, et al., 2014).

However, in terms of healthy lifestyles, Fenton and colleagues (2014) explored the evidence base that exists in terms of workplace health and wellbeing and CMHPS's looking at the reasons for introducing workplace health and wellbeing promotion schemes. Notably, the scoping review covered one hundred and five articles, reviews and meta-analyses from across a wide range of countries with only twenty-eight related to mental health and workplace wellbeing. In addition, the authors found that the studies had focused on cost reduction, potential litigation issues, safety issues and risk, decreased productivity and sickness absence, in addition to being able to reach a captive and accessible population group (Stansfeld & Candy, 2006, Brouwers et al., 2009, Martin et al., 2009, Knapp et al., 2011, Dewa & McDaid, 2011, Addley et al., 2014). Furthermore, when reviewing the outcomes of individual lifestyle promotion schemes that aimed to improve nutrition, physical activity or smoking cessation, with Fenton et al., (2014) finding that studies in the UK showed little or no positive effects or benefits reported (Leslie et al., 2002, McEachan et al., 2008).

Similarly, Allender, et al., 2006 found that due to multiple aims, unclear objectives and unpredictable results, employees tend to approach initiatives with caution particularly that a spotlight is shone on employees working and private lifestyles (Allender et al., 2006). Moreover, Labonte (1992) suggested that traditional healthy lifestyle oriented promotional activity that emphasises on individual lifestyles thus diverts attention and resources away from underlying high-risk conditions and ignores the holistic and socio-environmental determinants of health (Labonte, 1992, Raphael, 2003).

In more recent times, a plethora of workplace health and wellbeing promotion, initiatives and interventions have emerged that endeavour to improve mental health and healthy lifestyles (Jorm & Kitchener, 2002, NICE, 2014, Hillage et al., 2014, Nicholson, 2018). Although, employers attitudes to such programs are likely to depend on organisational culture and the motivation for making the investment, often aiming to improve sickness absence, vocational rehabilitation, and return to work schemes. Furthermore, as discussed previously, workplace health promotion often puts itself into a silo focusing on overall wellbeing and healthy lifestyles. However, aside from physical health, healthy diet, alcohol consumption and smoking cessation, other contemporary activities have emerged and taking a more prominent position within the workplace mental health promotion. These initiatives include counselling provision, mindfulness, building employee resilience, mental health first aid (Jorm & Kitchener, 2002, Nicholson, 2018).

A noteworthy point, however, is that the literature has shown that for employers, outcomes have been difficult to measure and there is little evidence that confirms direct or indirect costs or benefits to the organisation (Bevan, 2010, Black, 2008, Nicholson, 2018). Moreover, this could explain why few organisations are investing in such programs (Black, 2008). However, it is suggested that workplace promotion, initiatives and interventions are more likely to be effective in organisations that have an holistic overview of the workplace and giving consideration to working practices alongside employee consultation and engagement (Waddell & Burton, 2006, Vaughan-Jones & Barham, 2010, Bevan, 2010). This is particularly important where employees are seen as active participants in the development of interventions thus ensuring that stakeholders

are made aware of key issues and concerns and what changes need to be made and how (Angelis et al., 2020).

From the literature presented thus far, it is evident that workplace health and wellbeing continues to develop, although some confusion remains of the terms, definitions and theories. Furthermore, gaps and division continues to exist between health and wellbeing theory and practice, although it could be suggested that further qualitative studies such as this could go some way to bridging the divide (Noblet & Rodwell, 2010).

In addition, the evidence points to ongoing debates as to the conceptualisation of 'health' and 'wellbeing', although it is widely agreed that health is shaped by a broad range of factors such as individual, social and economic, and their underlying determinants (Braveman & Gottlieb, 2014). Nevertheless, evidence shows a wide agreement that workplaces have an important role to play when preventing and supporting positive health (WHO, 2008, Stevenson & Farmer, 2017). Often public health, occupational health and safety and human resources have tended to use the workplace as a convenient venue for reaching large numbers of working adults, identifying those who are at risk of experiencing lifestyle related diseases, and encouraging them to adopt healthier patterns of behaviour as opposed the taking a more holistic approach (Local Government Association, 2010, Young & Bhaumik, 2011, Noblet & Rodwell, 2010). Although from the literature presented, confusion remains prominent in the minds of employers, where it is evident that a wide range of employers view workplace health and wellbeing as another investment that is not beneficial with the costs often outweighing the benefits. Although the caution on investment had been indicated by smaller organisations as opposed to medium and larger employers (Young & Bhaumik, 2011).

However, on the other hand the evidence presented shows that there is a general consensus amongst employers that they have a pivotal role to play within the workplace and have a responsibility to encourage good mental and physical health and wellbeing of its employees. Although, criticisms have been directed at the health and wellbeing function, suggesting that despite workplaces being seen as having a profound influence on employees physical, mental and

social wellbeing, these factors have been largely overlooked, with health and wellbeing promotions often being limited to individualistic lifestyle-focused approaches (LaMontagne, Keegel, & Vallance, 2007, Noblet, 2003, Shain & Kramer, 2004, Noblet & Rodwell, 2010). It is therefore suggested that the aim of a workplace settings-based approach should focus on and create work settings that protect and promote healthy behaviours (Noblet & LaMontagne, 2006, Noblet and Rodwell, 2010).

Furthermore, a clear gap existed where there was a need to engage with employees in the development of workplace initiatives and interventions and where health and wellbeing practitioners have omitted to involve them during the process. A case in point here, is that employees being the end users, had their own subjective views of workplace health and wellbeing and therefore were recognised as key stakeholders. Moreover, it is suggested that by empowering employees and other organisational stakeholders it would be more likely to firstly, develop an holistic approach, and secondly would more likely be successful. The literature further points criticisms at health and wellbeing researchers, where qualitative studies are limited and have negated to include employee views whilst developing health and wellbeing theory and practice, thus providing an opportunity to implement an participatory action research approach with a view to instigate organisational change.

Summary

To summarise, the literature thus far shows that there is consensus amongst the literature that organisational culture and practices reflect the wider interactions between employees and their work environment, thus contributing to the determinants of their mental health and wellbeing (Cox, et al., 2000, Waddell & Burton, 2006, Karanika-Murray & Weyman, 2013, Nicholson, 2018). Therefore, in order to achieve organisational goals, it is important to advocate a dynamic and holistic approach to understand the association between the relationship of the workforce and the organisation and how they can contribute to the development of action and change (Waddell & Burton, 2006, Vaughan-Jones & Barham, 2010, Bevan, 2010). This leads the discussion to a review of the evidence that exists around organisational change, its impact on CMPs and the

role that Participatory Action Research (PAR) can play in fostering positive organisational change.

3.6 The role of Participatory Action Research in Organisational change

Against a backdrop of rapid technological innovation, shifting demographic and social trends, restructures and mergers, reactive and unpredictable organisational change is likely to be triggered (Graetz, 2000, Burnes, 2004, Todem, 2005). The management of organisational change is therefore an ever-present feature both at operational and strategic levels being defined as '*a process of continually renewing organisational direction, structure and capabilities in the face of ever-changing needs and expectations of external and internal customers'*, (Moran & Brightman, 2001 pg.111, Burnes, 2004, Todnem, 2005). However, the literature in terms of change management is wide and where a diverse range of methodologies have been employed with varying degrees of rigour with contributions from several academic disciplines such as psychology, business policy, social policy (IIes & Sutherland, 2001). Therefore, because this study is qualitative and employs a participatory action research approach, the wider body of evidence that exists in terms of organisational change will not be discussed. Instead, this section draws on existing literature in terms of participatory action research, workplace mental health and wellbeing and its role in facilitating organisational change.

The literature thus far has shown that organisational commitment and culture have key roles to play in the management of mental health and wellbeing at work. Therefore, to ensure a positive outcome, organisations would need to be fully committed to the PAR study whilst exhibiting a positive culture by supporting and encouraging stakeholders such as employees to collaborate and act as change agents (Hamelin Brabant, et al., 2007). Moreover, a positive culture is likely to have a major influence in how well the resulting actions are implemented and whether there are positive or negative effects and outcomes on mental health and wellbeing (Schurman, 1996, McViar et al., 2013). In support, Ipsen et al., (2020) suggested that organisational interventions are in essence action for change, although to ensure sustainability these would need to

be comprehensive and integrated into daily operational practice (Nardelli & Broumels, 2018, Ipsen et al., 2020).

Consequently, PAR is an important research concept when attempting to understand how employees experience their workplace, including the way jobs are designed, how they are managed, the quality of the work environment and how employees assess the social value of their work. The underlying principles of PAR thus treats participants as informed and reflexive agents who participate in all aspects of the research process with the aim of contributing to action for change (McTaggart, 1997, Reason & Bradbury, 2006, Kindon et, al., 2007, Bhui, et, al., 2019).

Nevertheless, there continues to be a lack of rigorous UK based qualitative research that employs a PAR approach to explore the commitment and desire to change culture towards early workplace interventions for CMHPs (McVicar et al., 2013, NICE, 2014, Hillage, et al., 2014, Pescud, et al., 2015, Bhui, et al., 2019). On the other hand, despite the evidence being limited, PAR has shown to be an important vehicle to resolving organisational problems (Bleijenbergh et al. 2021). McVicar's (2013) study found that successful PAR studies were those where organisations had committed to and sought to collaboratively target specific issues and identify what might be learned in order to increase the likelihood of improvement and change (McVicar et al., 2013). By the same token PAR integrates values, beliefs and experiences of the participants which are core to enriching the development of interventions, outcomes, knowledge generation that can result in problem solving and change (Bhui, et., al, 2019).

Furthermore, within the realms of public clinical mental health settings service users have increasingly become more involved in research. This holistic approach to stakeholder engagement thus goes beyond consultation and fully integrates them into the research process (Winter & Munn-Giddings, 2001, McVicar et al., 2013). However, the approach does not appear to have been replicated within private and public sector workplace settings despite PAR being acknowledged as being rooted in the engagement of a wide range of stakeholders that can be both internal and external to an organisation (Staddon, 2013, Bhui et al., 2019).

Notably, the mental health research framework published by the UK DoH, 2017 acknowledged the importance of involving people with mental health problems at all stages of research (DoH, 2017). Although the focus was on the wider public mental health and social care services the DoH (2017) called for better research designs to increase diversity and co-production of knowledge in order to promote consistency amongst the literature. This therefore suggests that a PAR approach could be effective within the context of the workplace (UK DoH, 2017). In addition, the DoH framework recognised that for substantive changes to be made, that it would be important to understand the 'human side' from research and where the subjective views could contribute to making meaningful advances in knowledge and theory. (Levin & Greenwood, 2008, UK DoH, 2017). Moreover, Braum et al., (2006) had previously argued that during the decades prior to the 1990s most health research had tended to take an objective and positivistic stance and suggested that very little research had employed a subjective, dynamic and participatory approach such as PAR, (Braum et al., 2006).

Arguably, PAR is ideally situated to create knowledge and theory in order to solve problems through subjective discourse, being in opposition to quantitative research that is objective and reliant on measurement and statistics. Notably, PAR utilises evidence-based principles that emphasise collaboration through engagement and active discourse with stakeholders who become partners in the research with a view to facilitate organisational change (Goetzel & Ozminkowski, 2006, Fenton, et al., 2014). A noteworthy point is, the presence of stakeholders in the PAR process lends itself to them uncovering strengths and weaknesses bound within the context of the organisation and taking ownership of the resulting action steps, thus providing a greater consensus for change (Walton & Gaffney, 1991, Danley, 1999). Moreover, PAR allows for stakeholders to ensure that their subjective and first-hand experience are not misconstrued or rendered meaningless, through the iterative and reflection process, thus having direct influence of the research as the end-users and the change agents (Danley, 1999).

Summary

In order to move from a status quo position to action for change PAR engages stakeholders in a participative and collaborative approach, concerning itself with identifying problems with a view to solve them through subjective discourse and within the situational context of the organisation (Greenwood, 1984). It is certainly true that the engaging of stakeholders throughout the PAR approach is key, thus allowing them to actively participate in, contribute to, and facilitate changes that can be beneficial for them as the recipients, and the wider organisational culture (Schien, 1996, Burnes, 2004, Valentine, 2016). Moreover, the process is holistic, flexible and adaptable, with dynamic moderation through the cycles of reflection and iteration in the natural setting of the workplace (Levin & Greenwood, 2008), thus illustrating that PAR is particularly important where an organisation has a desire to improve its practice and performance through planned change (Day et al., 2017). In addition, PAR, aims to improve health, reduce inequalities and remove implicit or unconscious bias towards those with CMHPs, by involving those stakeholders whose subjective views and experiences can inform and facilitate action to change in organisational policy and practice (Braum et al., 2006, Yeates & Amaya, 2014, Valentine, 2016).

However, to be successful PAR is dependent on the context and culture within an organisation. Change, albeit large or small scale, has the potential to significantly impact on employees' psychological health and wellbeing and for that reason it is critical for organisations to understand the impacts on to employees (Hylton, 2004, Valentine, 2016, Day et al., 2017). Therefore, PAR is well suited to bring about change in a real-world environment, through full collaboration with all decision makers, allowing for practical judgements to be formulated 'in situ' thus legitimising action and change (Levin & Greenwood, 2008).

3.7 Discussion of the literature

This chapter has attempted to provide a summary of the key drivers of the intervention literature within a UK policy area. The review has included development of UK policy and occupational mental health and how these impact on public sector workforces. In addition, the review considered workplace health

and wellbeing strategy, policy and organisational impacts, concluding with a brief discussion of participatory action research and organisational change.

Notwithstanding the HSE stress management standards which is enshrined in risk management legislation, the evidence has shown that despite several attempts at developing change in national policy and guidelines in terms of CMHPs and the workplace, the instruments produced have primarily been voluntary, with implementation being sporadic or have simply been ignored (Eccles, 2017, Memish, et al., 2017). The evidence presented also suggested that due to the volume of guidelines being produced for managing CMHPs in the workplace there appeared to be a fragmented process of strategy, policy and guidelines development and publication. In turn this has given employers cause to be confused as to what applies to their workplace setting and how to implement successfully (Eccles, 2017, Memish, et al., 2017). Furthermore, the evidence pointed to disparities and weaknesses in the content and quality of guidelines where the focus has tended to be on detection and treatment of CMHPs as opposed to prevention and protection (Memish, et al., 2017). Therefore, the overarching focus has tended to be on government targets for cost effectiveness of work rehabilitation and worklessness as opposed to being preventative and proactive that aim to target the operational levels of an organisation (McDaid, 2007, Munir, 2009).

Over time there had been a growing recognition that workplaces are best placed and are valuable conduits for promoting and implementing public policy. However, the evidence has shown that the subsequent development of guidelines for the management of those with CMHPs had lacked clarity and the provision of tangible implementation processes (NICE, 2009, Adams et al., 2015, Memish, et al., 2017). Blurring the lines further has been organisational management and occupational mental health practitioners who have been criticised for being focused on the individual and rehabilitation and not taking a broader approach in the prevention and management of CMHPs whilst adapting to the ever-changing world of work (Coffey et al., 2009, Beresford & Evans, 1999).

A notable and consistent weakness within the body of literature has been the lack of stakeholder consultation and collaboration when developing CMHP guidelines (Memish, et al., 2017). The evidence has shown that although academics and experts in the field of occupational mental health have contributed to the development of guidelines and interventions a clear gap continues to exist in studies and guidelines where there has been little or no collaboration or input from those who experience CMHPs (Harrison & Dawson, 2015, Harrison, 2016).

The literature has also shown that the attention of researchers, organisations, its management and occupational health practitioners has been diverted by the introduction of the term 'workplace wellbeing' and where the general concept had been confused by a variety of evolving terms (Day, et al., 2014, Donald et al., 2019). The literature suggests that similar to psychological health, wellbeing or wellness is not a static state but is individualistic with academics tending to agree that wellbeing is a multi-dimensional construct (Diener, 2009, Michaelson, et al., 2009; Stiglitz, et al., 2009, Dodge et al., 2012). Again, a general agreement has emerged that workplaces are an ideal setting for the development of initiatives and provides access to a wide section of the adult population (Ipsen, Karanika-Murry & Nardelli, 2020).

In conclusion, the evidence presented has shown the emergence of a clear and consistent theme that signals collaboration as being key when carrying out research studies in the development of national policy, guidelines and workplace mental and physical health interventions. However, it is suggested that whilst organisations and government continue to treat organisational performance as a priority, the proactive and preventative support for CMHPs would likely take a back seat which means that mental health and wellbeing would continue to be addressed in an ad hoc manner (Hasle et al., 2019, Ipsen et al., 2020).

The clear need to move away from the individualistic stance and towards a comprehensive multi-faceted, settings-based model is evident amongst the literature reviewed. Moreover, it is suggested that a collaborative approach provides the potential to make valuable contributions to research and practice as well as identifying opportunities to address issues in a systematic manner which

ultimately links with positive organisational culture and change (Cox, et al., 2000, Waddell & Burton, 2006, Karanika-Murray & Weyman, 2013, Nicholson, 2018). Moreover, there is a growing evidence base amongst management and organisational literature that suggests that the involvement of employees is key and is associated with positive and beneficial mental health and wellbeing outcomes for both themselves and the organisation. However, a noteworthy point is that employee involvement in shaping action and change for CMHPs in the workplace has rarely been studied (Dwyer & Ganster, 1991, Steptoe, 2001, Day & Jreige, 2002, Gibson, et al., 2007, Grawitch et al., 2009, Day, Kelloway and Hurrell, 2019).

Chapter 4

Participatory Action Research Design and Social Constructionist Enquiry

4.1 Introduction

This Chapter discusses the epistemological stance that I adopted and provides justification for the research design that underpinned this qualitative study. To ensure that my epistemological and analytic position is clear, the terms 'social construction' and 'socially constructing' are used as my philosophical position. As this study did not aim to prove or disprove hypotheses or to test theory, I employed a participatory action research (PAR) design in order to achieve the primary research aims and objectives as previously set out. The primary aim of PAR was to generate rich and detailed data from which understandings of the experiences of participants would contribute to answering the key research questions (Braun & Clarke, 2006).

The instigation of PAR attempted to explore, understand and address what constituted 'early' when instigating interventions for CMHPs and specifically the question "*how early is early?*". Because PAR by definition is participatory and exploratory in nature, I sought to address the research problem through stakeholder collaboration, discourse and reflection in to socially construct an in-depth understanding of the phenomenon in a real-life context (Crotty, (2003:3). Furthermore, because the term '*early*' is a subjectively constructed concept, the '*how early is early'* question as a concept suggests a need to explore its subjective negotiation with the social actors involved.

The origins of this research stems from my Master of Science (MSc) dissertation where I had identified a gap in knowledge in terms of early workplace interventions for CMHPs. When implementing early interventions for CMHPs I had been left with the question "*how early is early*", which subsequently led me to the PhD to explore this unanswered question in more depth.

4.2 Discussion of the epistemological positioning that drives the practical methods of data collection and analysis

Societies' perceptions about common mental health problems have tended to be influenced by medical and psychological models (Choudhry et al., 2016). Ongoing debates have continued amongst psychiatry, psychology, clinicians and researchers alike in terms of how multiple factors such as thoughts, experiences, and emotions can influence the development of CMHPs that lead to functional impairment in individuals (Clark, et al., 2017, WHO, 2018). Through a social constructionist lens and grounded in social inquiry I aimed to explicate the processes by which people come to describe, explain, or account for their experiences of CMHPs and early interventions in the workplace (Gergen, 1985).

My social constructionist positioning centred around learning about the distinct way a person viewed CMHPs within their world (McCann, 2016). For this study constructed narratives from focus group discussions were elicited from both employee and manager participant groups within the social world of the organisational workplace (Schwandt, 2003, Berger & Luckmann, 1991). My intention had been for PAR to provide the vehicle that facilitated an in-depth understanding of how CMHPs and early interventions were socially constructed by employees and managers in the workplace. This approach ensured that the emphasis was focused on social interactions and discourse, giving rise to the emergence of rich, detailed knowledge and concepts that were shared with others with a view to informing and influencing organisational change (Burr, 1995, Berger & Luckmann, 1991, Andrews, 2012).

It is well known that several attempts have been made to homogenise CMHPs by applying universal causes, classifications and diagnostic systems across different groups, thus repeatedly medicalising CMHPs (Marsella & Yamanda, 2010, Andrews, 2012). The continuing overreliance on positivistic models of diagnosis for CMHPs are not representative of reality and in complete contrast to my philosophical standing and were rejected (Conrad & Barker, 2010, Walker, 2006). My social constructionist standpoint supported the obtaining of socially constructed rich data from the social actors who provide realistic viewpoints of the phenomenon being studied (Galbin, 2014).

Furthermore, when considering early interventions for CMHPs, '*early*' is a social construct thus "*how early is early*?" implied that participants who experience CMHPs would be best placed to negotiate the concept through social discourse. Therefore, taking a social constructionist stance where the reality of CMHPs is a social construct, PAR thus focused on the participative, dynamic and reflective psychological constructs of the 'mind', 'self' and 'emotions' to understand the cultures and impacts of positive and/or negative behaviours towards early interventions for CMHPs within the social setting of the workplace (Gergen & Davis, 1985, Galbin 2014, Gergen & Gergen, 2012). This study allowed for managers and employees to construct versions of their realities, views and experiences in terms of CMHPs and early interventions, whilst acknowledging that to ensure success of interventions, managers, and employees would have to 'buy into' any suggested approaches or strategies

The process therefore began with the discovery of how managers and employees within the organisation defined common mental health problems and how they viewed early interventions – '*how early is early'*. In line with my methodological approach my aim was to capture attitudes, thoughts, feelings and beliefs in a social setting through the lens of those most likely to be impacted by any change in approach and those who were best placed to co-create ideas and knowledge to ensure success. The social constructionist stance that I took endeavoured to understand the extent to which managers and employees were aware of CMHPs in the workplace and what interventions they believed could be implemented and when.

4.3 Participatory Action Research Design

In this section I discuss in more detail what led me to determine that PAR was the most appropriate approach for this study. For further justification I discuss the strengths, weaknesses and perceived limitations of PAR and social constructionism.

PAR was chosen because it is rooted in a set of principles and practices of originating, designing, conducting, analysing and acting on a piece of research. In line with my social constructionism standpoint, the aim was to ensure inclusivity by brokering collaboration with a range of stakeholders whilst holding

the view that it could contribute to organisational change (McNiff & Whitehead, 2006). With my philosophical standpoint being in complete contrast with that of positivistic, scientific and quantitative methodologies, the primary goal was to focus on obtaining a deep understanding of the research problem in a real-life context through the lens of social collaboration and discourse with active participants from across the chosen study site (MacDonald, 2012). The workplace setting itself also acted as a lever to effective participant engagement and provided the vehicle for psychosocial intervention research (McVicar, et al., 2013).

Despite social constructionism often being accused of lacking the ability to change things (Bury, 1986, Andrews, 2012), studies have shown that the benefit of employing PAR negates and outweighs these criticisms. The PAR study design was intended to enable participants within the study to co-produce knowledge that would be needed for problem solving and the instigation of action for change (Greenwood 1993; Cornwall and Jewkes 1995). In addition, I viewed PAR as offering a flexible, cyclical, iterative and reflective process that could enable a collaborative inquiry into organisational and social policy and practice.

It has been suggested that qualitative methods are not as precise as that of quantitative methods (Maanen, 1979). Similarly, quantitative methodologies inherently overlook the uniqueness of individuals and the benefits that they bring to workplace mental health research thus not producing the depth of understanding that would be required to instigate change (Cresswell, 2007, Schein, 2011). I therefore chose a PAR design because of its participatory nature and due to subjective reality differing from person to person the principles of the design allowed for the co-creation of new knowledge. In addition, PAR allowed for the sharing of experiences amongst the participants that otherwise could not be provided by quantitative methods (Scotland, 2012). Furthermore, PAR reflected my position within the research both as an academic researcher and workplace practitioner by creating knowledge within the 'real-life' organisation and the generation of new workplace-based knowledge for scientific communities (Cassell & Symon, 2004, Totterdill, 2015, Davenport, 2016).

PAR, being influenced by the understanding of history and culture with its context embedded in social relationships, thus empowered the participants to collaboratively develop knowledge and understanding of early CMHP interventions, how they were practiced within the workplace and when (Baum, et al., 2006). In contrast, quantitative methods are primarily concerned with drawing comparisons, showing statistical correlations or testing hypothetical generalisations. Furthermore, quantitative researchers regard the world as made up of observable, measurable facts though their assumption that "*social facts have an objective reality*" (Glesne & Peshkin, 1992, p.6&7). PAR, at its heart is situated in a 'real world setting', and concurs with the views of Denzin & Lincoln, (1994) who stated that: "*Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin and Lincoln, 1994: 2.).*

Furthermore, PAR recognised the values of participants as social beings within a political, economic and social context advocating a procedure that allowed for employees, managers and the wider organisation to have a greater say in how the research was conducted and how it affected them in a work context (McTarggart, 1991, MacDonald, 2012, Baltina & Senfelde, 2015). The approach embodied the philosophy "*that people would be more motivated about their work if they were involved in the decision-making about how the workplace was run*", (MacDonald, 2012: p37, Lewin,1944)

The term 'action research' being a core element of PAR allowed for the exploration of social problems. In this case the focus was on CMHPs in the workplace and the organisational support (or a lack of) for those who experience them and contributed to action for change. PAR also supported a more accurate and authentic means of constructing social reality by way of a systematic process of collaborative inquiry (Selenger, 1997) which further enabled and instigated personal and social change. The key elements of the PAR process being cyclical, iterative and reflective had triggered a sense of ownership amongst participants, thus facilitated the social construction of a shared purpose with a view to influence change (Freire, 1970, Tetui, 2018).

Despite PAR increasing in popularity and being well developed in the world of teaching, clinical nursing and community mental health, it has been less popular in organisational settings (McNiff & Whitehead, 2011). My many years' experience within the workplace setting has shown me that the organisational world is complex in many ways. However, the understanding of the realities of those who experience CMHPs, and how and when to instigate early workplace interventions are equally, if not more, complex which led to the question of '*how early is early*'. My intention had been that by utilising PAR and enlisting participants from within the organisational setting would ensure that the workforce would be actively engaged in the process of socially constructing the concept of '*earliness*'. Therefore, my intention was to engage, facilitate and build relationships and trust with the participants as I viewed them as being best placed to contribute to and provide ideas that could guide future actions and practice in terms of early workplace interventions for CMHPs (Whyte, Greenwood & Lazes, 1989).

Moreover, research in the world of organisational behaviour and change has tended to centre around quantitative surveys, devoid of other methods and thereby constricting social scientists in their understandings (Whyte, Greenwood & Lazes,1989). Participants in the PAR process were also able to contribute to the replacing of conventional theories, practices and bodies of knowledge with new ones (Potter, 1998; Shotter & Lannamann 2002, Hibbard, 2005).

The PAR approach employed in this study sits in sharp contrast to studies in which participants are treated as passive subjects. The subjective stance taken in this study therefore built on the thinking of Whyte et al (1989) and sits alongside the original work of Lewin (1944) who proposed that to understand and change social practices, researchers need to include participants from the real social world in all phases of the study to help create new knowledge and learning. Consequently, "*there are no single, objective reality, there are multiple realities based on subjective experience and circumstance*" (Wuest, 1995, p.30).

With the emphasis being on collaboration, PAR is in synergy with social construction in that it seeks to socially construct knowledge, meaning and theory with those persons who are directly affected by the research problem (Minkler,

2000, Gergen & Gergen, 2008). However, that is not to say that PAR and social constructionist enquiry comes without criticisms, therefore the following section provides an overview of how the strengths, weakness and the perceived limitations were addressed in this study.

4.4 Addressing Strengths, Weaknesses and Perceived Limitations

A criticism often levelled at PAR is that the contexts, situations and interactions encountered in one study cannot be replicated beyond their immediate circumstances. It is also often argued that PAR is limited to small scale studies leading to the questioning of its credibility and generalisation. Qualitative approaches used in PAR are also criticised for a lack of statistical power with such methods being described as 'soft' (Young, 2006, Gobo, 2004). Based on my experience of PAR I identified an increasing drive for the utilisation of PAR and social construction of knowledge, particularly amongst those involved in health research, and mainly because of its ability to enlighten understanding leading to the generation of knowledge for social change (Young, 2006). Although these views are predominately shared with clinical/nursing researchers, it had been my intention that the weaving together of PAR and social constructionism would strengthen and effectively develop theory and contribute to driving 'local' organisational change that could be generalised and replicated across a variety of other work sites.

To further substantiate my stance, my social constructionist positioning led me to concur with Whyte et al., (1994), who argued that the continuous active participation of organisational stakeholders contributes to the solving of practical workplace problems by providing opportunities to generate new information and ideas. In turn, the recognised strengths and the benefits of the opening up of collective minds and voices could inform and lead to changes in practice as well as advancing theory (Whyte, Greenwood, Lazes, 1994).

To achieve the aims and objective of this study my intention was to engage with participants through social collaborative discussion through the PAR process. PAR thus provided the platform that brought together those employees whose voices can often be marginalised and lost within the hierarchy of an large

organisation. In addition, PAR provided the foundations to elicit and draw on shared experiences from participants to obtain in-depth understandings of the complexities of CMHPs and early interventions within a workplace setting (Cresswell, 2007).

An element of PAR and particularly critical to this study was the horizontal enablement and participation of cross-functional organisational managers that explored early workplace interventions for CMHPs (Boonstra, 1997, Bradshaw & Boonstra, 2008). This was particularly relevant to those managers whose voices had invariably gone '*unheard*' due to the complexities of the organisational structure and where different departments and teams have often worked in silo's and would not typically interact or collaborate. Moreover, I held the view that due to their positioning within the organisation, managers were powerful participants who would provide the horizontal (transformational) and vertical (transactional) knowledge inflows that are often associated with the facilitation of organisation change (Pettigrew, 1977, Bradshaw & Boonstra, 2008, Camargo-Borges & Rasera, 2013, AlGhanem et al., 2019).

Whilst the academic world has continued to criticise social constructionism as being a philosophical framework that lacks the ability to change things (Bury, 1986), I was drawn to the developing school of thought that social construction does not focus on taken for granted assumptions. Furthermore, it fitted well with PAR and allowed for participants to discuss their experiences to address areas that are not always addressed by other methods (Burr, 2015). Thereby, being distinct from other forms of qualitative research, the social constructionist positioning and PAR design was utilised as the catalyst to provide rich qualitative data required to contribute to and inform a process of improvement and change whether it be individual, organisational or community level (Wilkinson et al., 1997).

The fundamental aim of the social construction/PAR approach had been to contribute to the improvement and change of practice as well as the generation of theory by focusing on individuals and the organisational systems within their own social contexts (Whitehead et al., 2003). Therefore, social construction through the instigation of PAR further advocated a clear 'need' to explore

through immersive social discourse, the research question '*how early is early'* when instigating early interventions for CMHPs. Moreover, the approach was a flexible cyclical method which created a feedback loop through the iterative and reflective process which led to further cycles of inquiry (Whitehead, 2003).

The next section now discusses PAR and CMHPs in the workplace and the contested reality of CMHPs.

4.5 PAR in the Workplace Mental Health Context

For many years, PAR has been utilised within a range of settings and recently an emerging approach for health-related research (Baum, 2006, Polit & Beck, 2012). With its roots in education, organisational development, social science and the care fields, PAR has become more established in applied health research, thus being a useful research design that promotes the inclusion of the end users during the development process and action for change (Strickland, 2019).

More recently, PAR has been a design that has been more frequently used in mental health research, however, this has mainly been in response to the survivor movement and where demands have been made for '*voices*' to be heard in the running of services for mental health (Baum, 2006). Some would argue that PAR has been under-utilised, particularly within the workplace and in relation to early interventions for those with CMHPs such as anxiety and depression (McDonald, 2012). This is despite the workplace having been widely recognised as a social determinant of health, and where workplace factors such as relationships with colleagues and managers have important effects on worker health and well-being both inside and outside of work (Feltner et al., 2016 & Henning et al., 2009).

Since workers spend a large portion of their day in the work environment, a key factor is the physical and psychosocial aspects of the workplace itself and how it has been seen as an ideal place to help support those with CMHPs, whilst influencing individuals to maintain their sense of efficacy and resilience that may be affected by both work and non-work factors (Shain & Kramer, 2004, Tetui, 2018). It is however, unfortunate that the PAR studies that do exist have

continued to be dominated by organisational stress factors as opposed to utilising PAR and the bringing together of those within the workplace who have been diagnosed with or have experienced a CMHP (Tsutsumi et al., 2009, McVicar et al., 2013). In addition, despite being focused on workplace stress, McVicar's (2013) review of workplace interventions had found that where there had been a moderate to high level of collaboration with worker participants within an organisation. The psychosocial interventions had provided positive outcomes which in turn benefited both the individual and the organisation (Jordan et al., 2003, Lamontagne et al., 2007, McVicar, et al., 2013). McVicar (2013) suggested that PAR has the potential to facilitate a high level of engagement and collaboration with all those stakeholders who are integral to the research problem as opposed to undertaking a simple consultation process. It would therefore be suggested that the utilisation of PAR in a workplace setting had been key in supporting social engagement and collaboration in exploring early interventions for CMHPs, not only with those who experienced them but with a range of organisational stakeholders who have the ability to provide support and instigate change (Strickland, 2019).

From my social constructionist perspective, my position was that the utilisation of PAR would be critical to ensure the social engagement of those within the workplace to socially construct meaning of '*how early is early'* in terms of early interventions for CMHPs. In addition, the participants would ultimately be the ones who would most benefit from early interventions and included managers and others within the organisation who would become the vehicles for implementing change. In this study, PAR, therefore facilitated the exploration of the phenomenon from a range of perspectives and viewpoints from across a wide range of different departments that, due to the nature of their professions would not ordinarily or automatically come together. The participants explored the current state of interventions and understandings of policy and practice, identified what early interventions would be desirable, co-constructed how tangible outcomes could be implemented and what organisational change would be required. However, the realities of CMHPs and how they are seen is a contested concept which I now discuss.

4.5.1 The Contested Reality of Common Mental Health Problems

Over several decades the terms mental health and illness has been researched discussed, debated and theorised by a variety of ontological and epistemological standpoints and are terms that remain as contested concepts (Herron, 1998). As far back as 1958, Jahoda argued that "……*there is hardly a term in current psychological thought as vague, elusive and ambiguous as the term mental health* (Jahoda. p.3). Despite truths, meanings and experiences of CMHPs being socially constructed and shaped by cultural and social systems of how individuals come to understand and live with CMHPs (Conrad & Barker, 2010), models such as the unipolar and bipolar models have continued to look through the mental illness lens as opposed to a mental health lens (Trent, 1992). For example, the DSM-5 diagnostic model has been controversial and highly criticised and where the British Psychological Society (BPS, 2011) had raised several concerns over the continued 'medicalisation' and 'labelling' of CMHPs. The BPS (2011) further argued that the development of the model should have taken into account specific experiences, problems or symptoms from those who experience them and not based on previous theory (BPS, 2011). Further critics of the model argued that DSM-5 risked medicalising normal psychosocial factors such as bereavement, unemployment, relationship breakdowns etc.

Clinicians went on to further criticise DSM-5 and pointing out that the model did not reflect the realities of their patients which suggests there is a contested reality concept of CMHPs. In support, the BPS, 2011 argued that there should be a recognition and understanding of 'normal' experiences, problems and symptoms stating that mental health and wellbeing stems from frameworks that understand, experience and learn from the world in which they are experienced (BPS, 2011). Adding to the contested reality concept the BPS, (2011) argued that CMHPs such as anxiety and depression are often intermittent and a normal response to certain conditions that many people live in or experience thus requiring some understanding and intervention and not conceptualised as a symptom of an illness (BPS, 2011).

In addition, several attempts have been made by psychologists to homogenise classifications and diagnostic systems for mental illness (Marsella & Yamada, 2010, McCann, 2016). Despite the underlying aim of increasing the awareness

and understanding of CMHPs the language used has often been negative and focused on diagnostic perspectives which further fuels the contested reality of CMHPs (Keyes, 2005, McCann, 2016). Furthermore, CMHPs can differ from person to person with psychological terminologies, frameworks and models not being representative of reality for those that experience them thus remains a contested concept (Herron & Mortimer, 1999).

Furthermore, Herron & Mortimer (1999) argued that mental health, mental illness and stress are commonly used interchangeably and often with negative connotations. The authors went on to suggest that the contested nature of these conditions should be seen as an opportunity rather than a problem and that implementing social exchange and discourse would likely influence the development of holistic concepts, frameworks and models (Herron & Mortimer, 1999). In support, Entwistle et al. (1998) presented the view that obtaining accounts and perspectives from those that experience CMHPs is likely to increase the emphasis on obtaining socially constructed evidence in order to enhance the quality of understanding and knowledge, thus increasing acceptance and ensuring effective interventions.

Several other factors contribute to the contested reality of mental health and illness and include the cultural context where understanding, attitudes and beliefs can often vary from culture to culture (Choudhry, 2016). However, shaping the attitudes, beliefs and knowledge of mental health and illness is the personal experiences of those living with and interacting with others that may experience CMHPs. My social constructionist positioning and the PAR approach in this study therefore provided the opportunity to understand the differing experiences and views regarding CMHPs, in order to understand '*early*' workplace interventions and '*how early is early*' when instigating interventions.

Summary

In this chapter I have discussed my social constructionist positioning and the participatory action research (PAR) design that drove the practical methods of the data collection and analysis. Strengths, weaknesses and the perceived limitations of PAR and social constructionism has been discussed, moving on to

discussion of the utilisation of PAR in a workplace mental health context and the contested realities of CMHPs.

The next chapter introduces, and provides detail of, the research design and the practical methods employed for the data collection and analyses. In addition, the chapter discusses the single site local government setting in which this study has been situated and provides an overview of local government structures in the UK.

Chapter 5

Research Design

5.1 Introduction

The purpose of this chapter is to introduce and discuss the research design and the practical data generation and analyses methods employed in this qualitative PAR study. As outlined by Denzin & Lincoln, (1994), methodology "*focuses on how we gain knowledge about the world*" (Denzin & Lincoln, 1994: pg:99), with the methodological choices impacting on the outcomes of the study.

According to Denzin & Lincoln (2005), research methodology is determined by the nature of the research question and the subject being explored. At the outset it was recognised that a natural alignment existed between the research questions, research objectives, and PAR. Being underpinned by social constructionism the research question of "*how early is early?"* when implementing early workplace interventions for CMHPs thus shaped how data was collected and analysed in this study (Tie et al., 2019).

Furthermore, the study aimed to explore and understand the research question through subjective discourse, within a workplace setting. The chosen methods therefore facilitated the construction of rich data from the lived experiences of participants including those with CMHPs.

This chapter provides discussion of the qualitative research design before moving to an outline of the study site setting. Because the study had been situated in a UK local government setting, an overview of the UK local government and its structure is discussed, along with site setting itself and justification for selecting a single site.

5.2 Research Design

For this study a qualitative research design was chosen because it sought to explore the research question from subjective points of view within the social setting of the workplace and ensured that the relevant and valid data were generated, collected and analysed. Because of its methodological approach I

had chosen PAR as it provided a clear and detailed framework that enabled a set of functional and practical procedures that encouraged stakeholder involvement and explored the research problem through systematic enquiry of the social phenomena in a naturalistic setting (Streubert & Carpenter, 1995, MacDonald, 2012). A key driver was the need to address the complexities of the research question and understand the way people made sense of their own concrete experiences in their own minds and their own words. The qualitative nature of this study thus focused on subjective interactions between employees that enabled deeper insights into their experiences of CMHPs and early workplace management interventions for such conditions (Berg, 2001, MacDonald, 2012).

According to Berg, (2001), social sciences have tended to depend on research methods such as surveys and the quantification of data. However, since the 1980s qualitative research designs have been making inroads in psychology research, where subjective perspectives are captured, and reality and knowledge is socially constructed thus rejecting positivistic approaches such as hypothesis testing (Howitt, 2010). Essentially, qualitative research is defined as "*an umbrella term that covers an array of interpretive techniques which seek to describe, decode, translate and otherwise come to terms with the meaning, not the frequency, of naturally occurring phenomena in the natural world"* (Van, Maanen, 1979 p:520, Merrian, 2009. Therefore, a key feature and characteristic of this qualitative enquiry is that it aimed to produce rich descriptive data of the research problem and where the phenomena under study was explored through subjective discussions (Howitt, 2010). Moreover, the subjective discourse sought to build and develop theory from within the data, thus developing an understanding from the perspectives and lived experiences of CMHPs from the active participants.

For this study I decided that the qualitative design would be advantageous in that it was focused on subjectivity rather than objectivity, essentially orientating the research towards a process of problem solving as opposed to providing statistics or outcomes. Furthermore, the participative and collaborative nature of PAR was intended to make a practical difference to participants that allowed them to highlight and provide potential opportunities for improvement and change (Zuber-Skerritt, 1992, Brewerton & Millward, 2001). Therefore, PAR

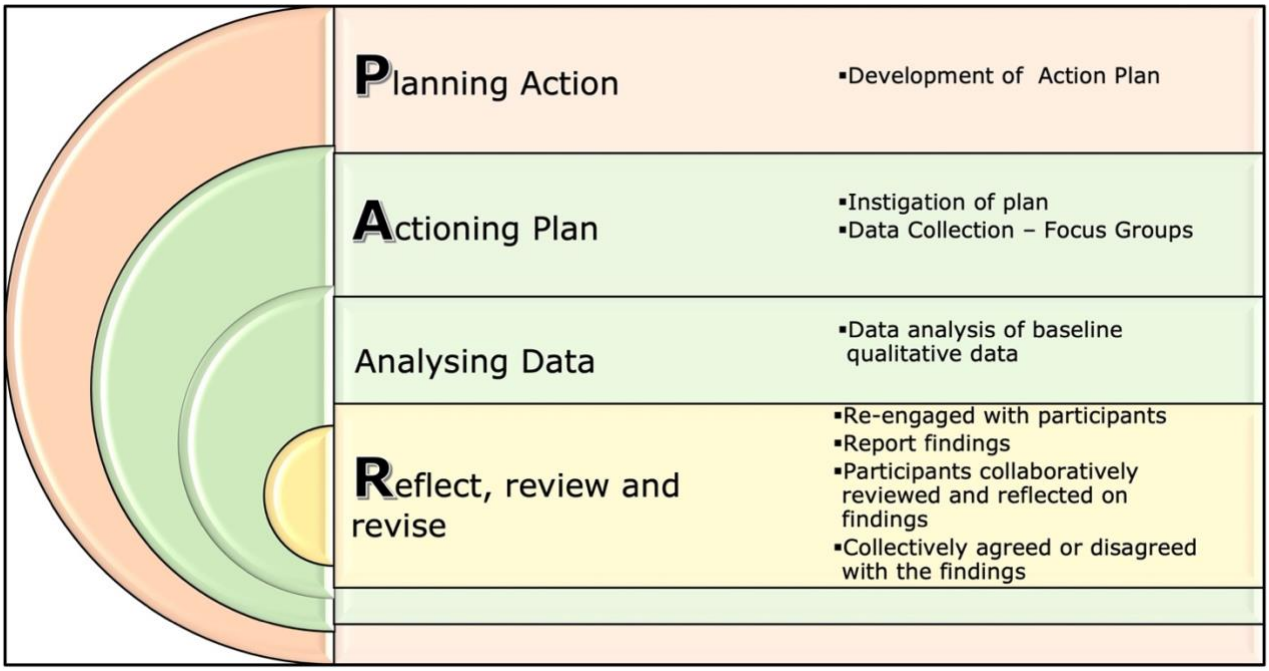
being ongoing and iterative thus explored CMHPs and subjective experiential situations, culture, and behaviours within a workplace setting (Cassell & Symon, 1994, Brewerton & Millward, 2001). The qualitative design of this study therefore sought to 'de-mystify' CMHPs and early interventions within the organisational setting of the workplace, the intention being to provide meaning, explanation and understanding to the "*How early is early*" conundrum (Barbour, 2014).

Furthermore, having been employed in local government for nearly three decades, I viewed my insider-researcher positionality within the organisation as advantageous in terms of undertaking the qualitative study. In addition, I viewed the study site not only as a convenient setting, but my position within it had provided me with extensive first-hand knowledge and experience of the governance structures, its complexities and how it operates. Discussion of the study site setting, and local government follows in the following sections.

My interest for collaborative knowledge creation had stemmed from having worked in various guises within local government and across various levels of management structures. I had considerable experience of working in collaboration with others on a wide range of topics as a group member, a facilitator and a researcher and where I would be able to draw on my professional relationships and research experiences to engage and explore the research question in detail. Moreover, I felt that the collaborative method would give 'a voice' to those individuals who potentially felt alone and isolated in their experiences of CMHPs and where trust could be built amongst the participants and myself as the insider-researcher.

To put the discussion above into context, [Figure: 1] below provides a brief overview of the core elements of the qualitative research design employed in this study. A detailed description of the operational and practical steps taken in the PAR process is presented in chapter 6.

Figure 1- An outline of the qualitative study design



5.3 The Setting in which this Study has been Situated

This study was situated in a local government organisation situated in the Southwest of England. Local Government is a form of public administration that sits at the lowest tier of central government administration and is primarily responsible for the provision of local public services. This study was situated in a large unitary Council site, otherwise known as a local authority and is the most common form of single tier local government in the UK. The local authority acts within the powers delegated by legislation, directives and/or central government. One can be forgiven in thinking that local government is complex and is true to an extent particularly for the lay person, particularly where variable terms such as local government, local authority and council are used to describe the same public body. Despite almost all local government bodies being contextually similar where they are responsible for providing for a range of vital services for people and business within their geographic areas, the structures in which they sit can often be confusing. This is more so in the case of England where structures are more varied as opposed to those of Wales, Scotland and Northern Ireland (Babbie, et al., 2001).

To put the differences into context, an overview of Local Government structures in the UK and an outline of local authority distribution of service delivery & statutory powers are provided in the following section.

5.4 Overview of Local Government Structures in the UK

Public service provision within the local government arena can vary dependent on how it is structured. Unitary or metropolitan councils, for example, are single-tier structures, with two-tier structures comprising of county and district councils structures. Regardless of the wider structures, all councils, including London boroughs, have continued to be responsible for the provision and management of all local statutory and strategic government functions within their geographical area (UK Government, 2019). The public services provided include social care, environmental health, children and families' services, education, economic development, and housing etc.

Structures within local government began to change following the publishing of the Local Government White Paper 'Strong and Prosperous Communities' (Department of Communities and Local Government, 2006) which offered councils in two tier areas (where there were separate county and district councils) the opportunity to submit proposals to reorganise the local arrangements and set up new unitary authorities. The overarching aim of the move was to modernise and simplify how public services were provided by streamlining systems where the number of different councils doing similar things were proving to be outdated, costly and confusing. Residents were often unclear who delivered what, where to go to raise issues or concerns, who their democratic representatives were and what council tax was spent on. Other organisations such as health and police authorities, local businesses and community and voluntary groups often found themselves dealing with any number of councils to achieve simple goals. To put this into context, there are 343 local government organisations within the UK, comprising of two tier and single tier structures. The single tier structure comprises of one local authority that is responsible for all local government functions. The single tier authorities include the 32 London Boroughs, 36 Metropolitan Districts such as Manchester and the West Midlands and 55 Unitary authorities such as Cornwall, Bristol and

Wiltshire. Two-tier areas are where authorities share local government functions between county and district councils.

In terms of the study site itself, being the second largest county in the Southwest, the site provides a wide range of public services to more than half a million residents and is responsible for spending a budget of more than £1 billion each year.

Presented below is a table that outline the functions [Table: 1] of a typical single tier local authority in England and the distribution of public service delivery, responsibilities and statutory powers.

Table 1- Local Authority Distribution of Service Delivery & Statutory Powers

LOCAL AUTHORITY DISTRIBUTION OF SERVICE DELIVERY AND STATUTORY POWERS	
Wales, Scotland and Northern Ireland are not included as they operate under different governance structures	
Arts and Recreation	Libraries
Births, Deaths, Marriage Registrations and Ceremonies	Licencing
Building Regulations	Markets and Fairs
Burials, Cremations & Cemeteries	Museums and Galleries
Children's Services	Parking
Coastal Protection	Planning
Community Safety	Public Conveniences
Concessionary Travel	Public Health
Consumer Protection	Social Care (Adults & Children)
Council Tax and Business Rates	Sports Centres and Parks
Economic Development	Street Cleaning
Education	Tourism

Elections and Electoral Registrations	Trading Standards
Emergency Planning and Emergency Management	Transport
Environmental Health	Waste Collection and Recycling
Highways and Roads	Waste Disposal
Housing	
Some authorities are also responsible for Policing and Fire Service Functions **The study site is responsible for the Fire and Rescue Service as well as Localism and Devolution**	

[Source: UK Government, 2019]

5.5 Single Case Setting

Several factors motivated me to situate the study within this particular single site. First, it is my place of work, therefore provided convenient access which is a large local government organisation (Unitary Council) with demographics typical of a large functioning public sector organisation in the UK. A more detailed description of the organisational make-up and operational functions is discussed in the following sections. The study site was seen to be compatible with my philosophical viewpoint and the theoretical framework and presented itself as being viable for a holistic, in-depth exploration of the overarching research question - "*How early is early*" when instigating early workplace interventions for those with CMHPs.

Whilst prominent research methodologists such as Merriam (1988) Stake (1995) and Yin (1998) have presented differing perspectives of a case study, my social constructionist positioning drew me to Stake (1995), who believed that a case study seeks to understand activity within the complexity of a single case that focuses on disciplined and qualitative inquiry. Depicting a case as a "*specific, complex, functioning, purposive and integrated system which has working parts and a boundary*" (Smith, 1978, p:2, Stake, 1995, Yazan, 2015), with four characteristics holistic, empirical, interpretive and emphatic being defined as valid for qualitative case studies (Stake, 1995, Yazan, 2015 p:139). Maintaining

his qualitative epistemological leanings, Stake (1995) believed that "*there are multiple perspectives or views within a case that need to be represented*" (Stake, 1995 p:108) and that "*knowledge is constructed rather than discovered*" (Stake, 1995, p:99) thus aligning with my social constructionist position and further confirming to me the appropriateness of the site for the study (Stake, 1995 & 2005). However, I rejected Stake's view that case study research assumes a flexible position where the problem under investigation becomes progressively clarified with no defined roadmap of data collection and analysis (Stake, 1998, p:22, Yazan, 2015). Because of the bounded context of the organisation, the theoretical framework and PAR design employed in this study provides a structured cyclical process of constructing explicit (directly stated, expressive, experience and detailed), and implicit (not directly stated, inferred, awareness, perception) data, the identification of coherent themes through an iterative process of reflection thus enabling a degree of flexibility through action and reflection (Stake, 2005, Smith, 1978).

A key factor to note is that for several years local government has been identified as having a crucial part to play in the delivery of the Government's mental health strategy and identified a need for taking action at a local level to contribute to improving mental health for all (HM Government, 2012). Going a step further, the Thriving at Work Review (Stevenson & Farmer, 2017) recommended that all public sector organisations should implement core and enhanced standards in order to support the mental health of the workforce. However, the authors confirmed that more work was needed to build the evidence base for informing those standards (Stevenson & Farmer, 2017). The study site, therefore, being a large local government organisation enabled a coming together of the workforce across departments through PAR and focus groups in order to socially construct detailed data which could contribute to the evidence base that Stevenson & Farmer (2017) alluded to. In addition, the study site, PAR and the focus groups provided the foundations, building blocks and methods needed to make sense of '*how early is early*?' by comprehensively exploring what factors either enhance or hinder proactive early workplace intervention approaches to support those with a CMHP.

It has been suggested that single case studies have become more widely used across the social sciences, presenting themselves as being viable, valuable and robust within practice-orientated field research such as education, public administration, psychology and business management (Starman, 2013, Mariotto, 2013, Ozcan, 2017). Traditionally, local government research has tended to be dominated by conventional positivistic approaches that are 'outward' facing, relying on quantitative statistics to monitor performance indicators or for justification and/or evaluation of existing public policy and practice (Sanderson et al., 2001). However, very little research exists within local government settings that looks 'inwardly' through a social constructionist lens at its own internal policy and practices such as the highly emotive subject of early interventions for those within the workforce who experience CMHPs. Often, within these settings it is assumed that quantitative employee surveys will provide the data required to improve internal policy and practice thus ignoring the subjective views and experiences from those across the workforce who could contribute to practical knowledge and organisational change and development (Stake, 1995, Coghian & Brydon-Miller, 2014).

As noted, the study site was seen as the enabler for a process of collaborative engagement where employee groups and manager groups were drawn from a wide range of different departments and teams across the organisation. My view was that bringing these groups together would allow for the social construction of knowledge of the research problem from multiple perspectives and a within the context of the local government organisation. In addition, it provided the vehicle for the social construction of rich data to inform action for change (Dyer & Wilkins, 1991).

I acknowledge that single site settings have often been subject to criticism, particularly where it has been felt that such studies are not generalisable or where developing theory cannot be replicated (Yin, 2009). On the other hand, Stake (2005) argues that a single case site allows for a more precise understanding from in-depth analysis and especially where the study is qualitative in nature. Local government organisations are often recognised as complex entities in how it they made up and how they operate. The study site is typical of other local government settings within the UK and despite being a

singular site it operates within a number of contexts such as political, economic, financial etc. The internal workings are comprehensive and made up of a wide variety of diverse sub-sections that deliver statutory public services through various departments and teams, thus aligns with Smith (1978) and Stake's (1995) definitions of a single case study. Reflecting further on Stake's thinking and because of the complexities discussed, I viewed the site and its setting to be a critical element and where multiple perspectives and views of early interventions for CMHPs would be in existence and needed to be represented and where the realities of the research questions would be constructed by individuals interacting within their social world of the workplace (Stake, 1995, Merriam, 1998).

To add strength to the replication issue, I believe that this study has captured the common characteristics and complexities not only consistent across local government sites in general but other organisations where contextual issues such as organisational and management structures, politics, culture and economic conditions are broadly similar (Aguinis & Solarino, 2019). Owing to local government having evolved over several years, governance and organisational structures have been seen as becoming more homogenous. Therefore, due to its nature, this study site provides a contribution to knowledge and where the knowledge and learning can be replicated across other organisations.

The continuous cycle of change has seen a move from smaller local district council site structures to larger regionalised or unitary sites. Although the changes have mainly been driven by austerity cuts, I further suggest that the major transformational changes that have taken place have meant that organisations have had to modernise and diversify thus casting the net to find more efficient ways of working. Instigating collaborative working with other public services, in particular, health services have led the formation of partnership working and where public services have begun to move away from the traditional heterogenous and insular organisational structures to homogenous organisational alignment, thus further contributing to replicability (Local Government Association (LGA) 2019).

A further criticism often levelled at single case settings is the lack of methodological transparency (Gerring, 2007). However, Yin (2012) argued that single case studies are the least understood of all social science frameworks and should be recognised as useful for in-depth studies of an issue or phenomenon in a natural real-life context (Yin, 2012, Crowe et al., 2011). Therefore, by employing PAR within the single case site values, the experiential knowledge created by participants in order to achieve positive change and enhances transparency and reliability (Reason & Bradbury, 2008). The defining feature for this study has been the focus on the collection of rich in-depth qualitative data within a naturalistic 'real-life' environment (Denzin & Lincoln, 2005, Given, 2012). Furthermore, owing to the subject and the issues under that have been explored, the findings are unlikely to be limited to a single study site and can be used to inform similar large and complex organisations in either a national or international context.

Finally, to my knowledge there are no other studies that currently exist within UK local government that have explored early workplace interventions for CMHPs, from a social constructionist standpoint, with the utilisation of PAR and grounded theory.

5.6 The Study Site Context and Structure

At the time of undertaking this research study, the study site was the biggest employer in the county and employed up to 5,000+ people across 17 diverse occupational service areas [Table:2]. However, these figures fluctuate on a regular basis owing to ongoing changes in job roles that can be temporary, fixed term, part-time, job shares and include retained firefighters and are often impacted further by restructures, austerity measures and seasonal fluctuations. The chart below therefore represents the organisational structure drawn from the 2019 staff engagement survey and is representative of the structure that had been in place throughout the duration of this study.

It should be noted that owing to their variable compositions, governance structures, and accessibility, local authority maintained, and academy schools were not included. Similarly, the 'arm's length' delivery service organisations were not included as the local authority were not the direct employers, thus not

directly responsible for workplace interventions or the supporting of mental health and wellbeing.

Table 2- Organisational Structure

Organisational Structure Directorates and sub-services included at the time of the study	**Employees *'n'***
Adult Social Care	**1029**
▪ Adult Care & Support	*956*
▪ Adult Transformation & Commissioning	*73*
Customer & Support Services	**1196**
▪ Assurance	*168*
▪ Commercial Services	*200*
▪ Customer Access & Digital Services	*491*
▪ Resources	*337*
Economic Growth & Development	**593**
▪ Economic Growth	*73*
▪ Housing	*96*
▪ Planning & Sustainable Development	*294*
▪ Transport & Infrastructure	*130*
Neighbourhoods	**1403**
▪ Environment	*156*
▪ Neighbourhoods & Public Protection	*409*
▪ Resilient Cornwall (includes Fire and Rescue, Emergency Planning, Community Safety)	*772*
Together for Families	**1701**
▪ Children & Family Services	*986*
▪ Children's Health & Wellbeing	*367*
▪ Education	*348*
Strategy & Engagement	**66**
Total (correct at time of extraction March 2019)	***5,988***

[Source: Southwest Council, 2019]

Chapter 6

Methods

6.1 Data Collection Method – Focus Groups

Despite substantial literature in existence for the use of focus groups, it has been suggested that some researchers have continually failed to use focus groups in qualitative studies, thus ignoring their full potential (Barbour, 2005). Although, as interest has grown in qualitative research, particularly in psychology and education, focus groups have become more prominent, and show their strength as a socially oriented research procedure (Krueger 2000). Researchers have therefore begun to explore research methods that open up new understandings of key issues, with focus groups being employed because of their versatility and the opportunities they provide for direct contact with subjects (Vaughn et al., 1996). The key aim of focus groups is for participants to collectively debate a set of social issues, describing and reflecting on common experiences and perspectives within a social context (Kitzinger, 2005).

My decision to employ focus groups was because they provide the bridge between scientific research and subjective knowledge (Cornwall & Jewkes, 1995) that capitalised on communication between the researcher and participants. Furthermore, all participants had equal access to the discussions which enabled them to safely share their own thoughts, opinions and feelings (Wilkinson & Birmingham, 2003). Notably, focus groups can often generate a wider range of views and ideas as opposed to other methods such as structured one-to-one interviews, which tend not to provide variations or the breadth and depth of narratives owing to strict and limited interview formats (Guest, et al. 2017). My intention was for the focus groups to provide rich, deep, honest and more incisive discussions, whilst encouraging group interaction through synergism, snowballing, stimulation, security and spontaneity (Hess, 1968, Wilkinson & Birmingham, 2003) as shown below in Hess's (1968) five Ss of group interaction [Table:3].

Table 3 - The Five 'S's of Focus Group Interaction

Synergism	Participants cumulatively react and build upon other participants responses
Snowballing	One participant triggers a chain of responses that can create new ideas, topics or theory
Stimulation	Group settings can stimulate others to discuss their own ideas
Security	Encourages the group participants to discuss their experiences, thoughts, feelings and opinions more freely in a secure environment
Spontaneity	No individual is obliged to have a particular view or opinion about the phenomena, but instead being able to provide a spontaneous and truthful or considered response

[Source: Hess (1968: 194), Wilkinson & Birmingham, 2003]

In contrast to other research instruments such as one-to-one interviews, the focus group method being socially oriented, thus allowed participants to listen to one another, form their own opinions, and share their perspectives with group members (Krueger 2000, Wilkinson, 1998). Furthermore, the role and relationship of the researcher and the participants is fundamentally different. For example, in the one-to-one technique, the researcher acts as an investigator, implying that the researcher takes the centre stage, questioning each participant with a prescriptive script, in addition to controlling the interview dynamics (Bloor, et al. 2001). Whilst I acknowledge that structured one-to-one interviews have their place in research, I considered that a collective consensus would not be achieved through individual interviews and because the philosophical assumptions of one-to-one interviews often lean towards constructivism, which is not social and does not concern itself with multiple constructed realities, instead focuses on what is happening within the minds of an individual (Burr, 2003).

In addition, and as previously stated one-to-one structured interviews, by their very nature, tend to glean limited responses from participants therefore not providing the 'depth and richness of data' required for this study and were therefore rejected (Gill et al., 2008). In contrast, focus groups were more likely to yield rich and detailed data, whilst uncovering aspects of understanding that relate to the social constructs of CMHPs and early interventions in the workplace, which can often remain hidden in the more conventional interview method (Liamputtong, 2009). In addition, when entering into focus group discussions,

sensitive and personal disclosures were more likely to emerge through collective discussion of those experiences, bringing issues to the fore, that might not necessarily emerge during individual interviews (Guest *et al.,* 2017). There was an overriding assumption that people in a social group context would offer valuable sources of information and were likely to provide extended and more detailed conversations with others which added to the richness of the data (Lederman, 1990). For this study, the purpose of focus groups was to explore and obtain collective understanding of the social phenomena under study within the social setting of the workplace and enabled the exploration of early workplace interventions for CMHPs whilst paying particular attention to exploring the '*how' in 'how early is early'* (Kitzinger, 1995).

As previously indicated, my choice of the focus group method aligned with the practical cycles of PAR, thus allowed for participants to interact, discuss and socially construct their realities and agreed shared meanings of early interventions for CMHPs (Berger and Luckman, 1996). According to Merton (1987) focus groups serve the purpose of exploring subjective concrete experiences, where participants seek to provide understanding of the phenomena in the world in which they live and work (Creswell, 2007, Merton, 1987, Vaughn et al., 1996).

Finally, the growing interest of the focus group method in the social sciences, particularly in the disciplines of education and psychology, has led researchers and practitioners alike to turn to the focus group method of data collection, particularly where they offer the opportunity to connect with key stakeholders bringing the researcher closer to the research topic (Clarke, 1999, Lane, 2016). Based on this, the connection with stakeholders operating in the context of the 'real world' for this study was crucial, the 'real world' being the workplace with managers and employees being the key stakeholders. Based on the combination of interactive discussions, the promotion of greater openness in responses and encouraging individuals within the groups formed opinions through the social interaction with others (Vaughn, 1996) which further garnered my interest as these linked to the action element of PAR. For this study the links between participants knowledge of CMHPs and their socio-cultural situations were critical as they derived their thoughts, feelings and mental constructs from their own

experiential knowledge (Berkes, 2004). Therefore, PAR being the overarching architect of knowledge creation, focus groups thus shone the spotlight on the participatory aspect of PAR, and provided a systematic and iterative process that explored through group discourse, participants' concepts of the realities and lived experiences of the phenomena under study.

6.2 Sampling Framework

Sampling in qualitative research studies concerns itself with the scope and the nature of the study population, questioning what study site components need to be included. Therefore, drawing on Robinson's (2014) four-point approach to qualitative sampling led me to develop the sampling framework, that consequently defined the sample population, focus group composition, participant recruitment and selection techniques, and inclusion and exclusion criteria (Robinson, 2014). The chosen study site being an existing large, comprehensive and complex, functioning local government organisation was advantageous and valuable in that it offered access to the existing workforce population. The site provided the opportunity to explore and obtain an in-depth understanding of the research phenomena from within a diverse workforce (Crowe et al., 2011). The approach ensured that selected participants would be indicative of similar large unitary local government organisations, thus adding to the breadth and depth of the information collected and increase the authenticity of the data in relation to local government settings.

Moreover, employee and manager stakeholder involvement aligned with the aims and assumptions of PAR [Figure:1], thus offering the possibility of facilitating organisational change in an iterative process that would not necessarily occur if sampling and selection were limited to one occupational group or if different techniques were used i.e., a statistically representative sample from the broader workplace setting such as a survey.

In order to explore and address the research question in detail, the sampling techniques had involved selecting participants from across the target organisational demographic as outlined in the broad demographics of the workplace population there were included in the study below [Table:4]

Table 4- Sampling Framework

The demographics of the organisation included in the sampling framework *(data correct at extraction 31/03/19)*				
Cross section sample	*Total number in organisation*	*Number of focus groups*	*Sample 'n'*	*The sampling ensures that there was a balance of occupational groups*
Overall Employee Headcount	**5,988**	**4**	**34**	Engaged with and explored the views of the research problem with those who had or had not experienced, presented with or had been diagnosed with a common mental health problem exploring common issues and barriers that may identify gaps in policy and practice. This included a selection of professionals that have regular contact with staff i.e. occupational health clinicians.
Tier 2 Directors	**4**	**2**	**12**	Explored the views of those at more strategic levels, and their understanding of common mental health problems, early interventions and what tools they would need to support them. These groups were essential in driving forward organisational policy and change in relation to common mental health
Tier 3 Service Directors	**17**			
Tier 4 Senior Managers	**69**			
Tier 5 Middle Managers	**259**			

				problems in the workplace
Tier 6 Supervisors & Team Leaders	**1,478**	**2**	**20**	These groups were those who were closer to the research problem. having day to day interaction with staff and provided views at a practical level, their understandings and exploring what barriers that they face

It was acknowledged that qualitative data is not normally generalisable and authentic for local government organisations and could be replicated in other workplace contexts.

The organisational demographics and occupational groups are shown in the study site in [Table:2]

- Because the organisation had been going through a management restructure during the study period, I decided to group the manager tiers to enable a cross organisation selection from a range of occupational disciplines. Furthermore, the widening of the groups would have risked losing managers during the process of data gathering and analysis.

[Source: Southwest Council, 2019]

6.3 Participant Sampling and Selection Considerations

Having decided the research design and selected the data collection method, the next step was considering the participant sampling and selection techniques that would be employed in order to glean rich data through focus group interactions. Therefore, with the study being a qualitative PAR design and grounded in social constructionism, the research question with the focus on the sensitive and complex issue of CMPs led me to the decision of employing the non-probability self-selection and purposive sampling and selection techniques. A systematic random sampling strategy would not have been appropriate for this study because it required information rich informants, thus making a deliberate choice based on the information that individuals possess (Bloor et al., 2001, Tongco, 2007). It was therefore particularly important to carefully consider the

participant characteristics that would be required in order for them to provide rich and in-depth and detailed information. The key factor within focus groups is interaction and discourse thus enabling participants to provide valuable insights, knowledge, understandings, commonalities and differences from their subjective experiences of CMHPs and early interventions, thus making composition an important consideration (Barbour, 2007).

Drawing on my organisational knowledge and experience I had been fully aware that some of those within the workplace would be better placed than others to provide detailed insights and information in order to answer the research question which further concreted the choices of self-selection and purposive sampling. Furthermore, this meant that whilst considering the composition and the sampling and selecting of participants I had been aware that care would be needed to ensure that the groups would not be too heterogeneous (Bloor et al., 2001). Moreover, poorly considered group composition further inhibits debate and where participants views, meanings and experiences are not then explored in depth (Bloor et al., 2001). Therefore, there was a fine balance when sampling and selecting participants to ensure that their discussions and interactions could be capitalised upon, and in turn stimulating the relationships and trust participants would have with each other whilst discussing their experiences of CMHPs and early interventions within the group context (Morgan & Hoffman, 2018).

Whilst thinking through group composition it led me to further consider the participants' characteristics, and who within the workforce would be significant to enabling the interaction that would influence, share and maximise the discussion of their emotive experiences (Crowe et al., 2015). Given that the participants would be selected to discuss and explore their experiences of CMHPs and early interventions, consideration was given to the removal of systematic bias, meaning that participants would not be selected purely because they had been 'recommended' or considered 'most suitable' by fellow colleagues, managers or group members (Powell & Single, 1996). Other critical considerations included deciding the size of the focus groups and due to the large geographic spread of the organisation, the geographic logistics were considered as instrumental when deciding where to hold the focus groups to

ensure inclusivity and accessibility. For example, it would have been remiss of me to expect participants to travel long distances in order to attend and more importantly I would have run the risk of not accessing the wider workforce population.

6.4 Participant Selection Methods

Whilst defining the qualities required in order to determine who the key participants would be, thus led me to question if every individual within the workforce would be valuable to the study and deciding if information would be best provided by a targeted population within the workforce. As previously discussed, the phenomena under study had called for informant-rich data sources, therefore I now discuss the chosen methods for sampling and selection of the focus group participants.

6.5 Self-Selection

For the first cohort of focus groups, I decided that the key informants for the study would be employees who were willing to take part in in-depth discussions on an emotive subject, and secondly because of their experiences would be the source of rich information. Working on the assumption that most adults had at some point in their lives encountered a spell of reduced or poor mental health, whether it be short term, or a longer term diagnosed CMHP, I decided that the most effective way to recruit, select and engage employee participants would be through a self-selection technique.

This meant that participants volunteered to take part in the study of their own accord, and those who showed their willingness to discuss their own experiences of CMHPs and early interventions. In addition, the self-selection meant that the participants were more likely to possess the qualities, knowledge and experiences in order to make a valuable contribution to this study (Tongco, 2007). The self-selection was intended to obtain a rich and deep understanding of the research phenomena under study and aimed for the participants to communicate their views and experiences in an articulate, expressive and reflective manner through the iterative PAR design (Palinkas, et al. 2015). My assumption had been that the self-selecting participants would share or have

very similar traits in that they may have experienced and/or have been medically diagnosed with a CMHP. Therefore, the rich information that they possessed was fundamental to the quality of the data collection which in turn contributed to the development of the theory of the '*how early is early*?' concept (Cresswell & Plano Clark, 2011).

On the other hand, I was also fully aware of the criticism levelled at self-selection, particularly in terms of self-selecting bias, meaning that individuals self-select or volunteer to take part because they have gripes or grievances to air and want their voices heard in ways that were not representative of the wider population (Bloor et al., 2001). Despite the perceived disadvantages I believed that the participants who had self-selected were more likely to hold the in-depth knowledge that was required for this study and were more likely to be committed to discussing their experiences throughout the cyclical process of PAR.

6.6 Purposive Selection

I made the decision to employ a purposive sampling technique that would be appropriate for selecting the manager-participants based on a set of pre-determined criteria (Patton, 2001, 238). Manager participants were similar in that they all managed people and were highly likely to be knowledgeable and experienced in managing individuals with CMHPs. Managers were selected from across different service areas because this allowed for me to explore their knowledge and experiences from across a variety of occupational contexts and was not based solely on one particular occupational group (Robinson, 2014). As outlined in the sampling frame [Figure:4] all managers were included in the sampling frame, deciding that the purposive selection technique ensured that for each focus group, manager-participants were selected from the same tier of management in the organisation. The approach intended to facilitate a 'safe place' for managers at the same level to interact and speak honestly and openly amongst themselves, which removed the risk of power struggles and vulnerabilities that can mute in-depth discussions amongst mixed hierarchal groups thus rendering them ineffective (Moser, 2018).

It was acknowledged and accepted that purposive selection, like self-selection can be prone to researcher bias. In an effort to reduce bias, the purposive technique was designed to meet multiple needs and interests in order to produce data that firstly, would be representative of the hierarchy within the workforce and secondly, sought to ensure that the participants represented a cross section of the organisation in order to ensure that the seventeen diverse occupational service areas were represented. Furthermore, the iterative and reflective cycles of PAR supports seeking agreement from the participants regarding any interpretations of the data based on their discussions, understandings, meanings and experiences.

6.7 Ethics

Due to the nature of this study, I fully understood that personal and emotive information would be disclosed within the focus group setting. This therefore presented a risk that participants could feel vulnerable and/or distressed when expressing of sensitive experiences and opinions in a group setting as opposed to a one-to-one interview, especially where attitudes held by an individual were found to be at odds with that of others in the group (Wellings, 2000). Following the principals of ethical conduct, I built into my research plan, safeguards that protected participants from psychological harm so far as reasonably practicable and a process of obtaining informed consent. This included outlining and clarifying how their privacy, anonymity and confidentiality would be protected within the focus groups, however I had limited ability to control what the participants discussed outside of the groups (Sim & Waterfield, 2019). Submission was make to the ethics committee and approval and authorisation to proceed was obtained from the Business Law and Social Sciences ethics committee at NTU. I discuss the ethical considerations in more detail throughout the PAR journey in the following chapter (6).

6.8 Topic Guide

The topic guide was developed to enable participants to immerse themselves in discussions and social interactions enabling them to share their social realities and experiences with others in terms of early interventions for CMHPs, going on

to explore whether a consensus of '*how early is early'* is possible (Berger and Luckman, 1996) [Appendix 6].

The development of the topic guide was primarily driven by the research question of '*how early is early'* in terms of '*early*' interventions for those with CMHPs. In order to frame the topics that I would cover during the focus group sessions, I firstly considered the gaps that I identified from the gap analysis of organisational policy, practice and training provision. Secondly, I sought the views of the developing topic guide from organisational stakeholders and professionals who interacted with employees and managers on a day-to-day basis in terms of the management of early interventions for CMHPs. I felt that these stakeholders would have useful insights and knowledge into the gaps that existed in the management of CMHPs in the workplace and early interventions, thus contributed to the topic guide further.

The topic guide had contained five overarching open questions and ten probing open questions. These included the general understanding of CMHPs in the workplace, experiences and methods of support. Other subjects included disclosure and what tools would assist employees and managers in managing CMHPs in the workplace. It had been key to ensure that I covered the topics that I needed to cover in order to answer the research question. [Appendix 6].

I had been fully aware that because the focus groups would be the sole source of data for this study, the topic guide would not follow a prescriptive question and answer format. The probes and prompts thus provided scope for me to keep the participants on track particularly where discussions started to digress. Therefore, as the researcher I needed to capitalise and build on individual and collective perspectives by encouraging participants to collaboratively engage in in-depth discussions.

6.9 Grounded Theory Analysis

I chose to employ a grounded theory (GT) approach for the analysis of the narrative data from the focus groups. However, I wish to make clear that the data analysis had drawn on the aims and principles of grounded theory and was therefore not intended to be an exemplar of grounded theory per se. The principles of the GT method allowed for a pragmatic, structured and systematic

approach to the analysis and allowed for themes to emerge from the qualitative data. In addition, through the iterative cycles of PAR the emerging themes were compared and contrasted across the groups which enabled an in-depth understanding of the subject under study (Charmaz, 2008).

So why a grounded theory approach? Essentially, it was chosen because of its flexibility, and because the open research question of "*how early is early*?" explored the actualities of the real world so that data was analysed with no preconceived ideas or hypothesis (Glaser and Strauss, 1967). The practical cycles of GT fitted with the social constructionist approach and an ideal method to draw themes from socially constructed categories that emerged from the focus group discussions. Furthermore, the practical method of GT framework employed within the PAR design enabled generalisability going beyond descriptions and allowed for me, as the researcher, to employ theoretical sensitivity to understand and give meaning to the data, whilst making sense of the lives of the focus group participants 'from the inside' as advocated by (Charmaz, 2006). Moreover, the GT method had been adopted and adapted to dovetail with PAR, thus adding to the quality of the qualitative data which is discussed in the following section [6.9.1]

Having a history with its roots originating in sociology, grounded theory has long been respected as a rigorous method of analysis for qualitative data (Glaser & Strauss, 1967). In addition, it is an analytical approach that has been increasing in popularity, particularly in health care settings mainly because it supports a practical approach to the problems that participants face (Charmaz, 1995, Holton, 2008, Silverio et al., 2019). The principles and procedures of grounded theory provided a systematic analysis that allowed for themes to emerge from the socially constructed data (Chapman et al., 2015). Therefore, not being based on statistics, the method was designed to be a systematic approach to the development of inductively derived theoretical concepts which focused on the phenomena under study (Strauss & Corbin, 1990). Moreover, for this study the method allowed for the subjective experiences and realities to be discussed by those participants, who in their own words, described their experiences, thoughts and views in terms of CMHPs in the workplace, which further confirmed the approach as an ideal method by which to analyse the rich constructed data.

Glaser and Strauss (1967) described grounded theory as something that involves the 'discovery' of theory from within the data, believing that there is something already there to be discovered (Glaser and Strauss, 1967). On the other hand, my thinking aligned with that of Charmaz (1990, 2000, 2002, 2006) who argued that categories and theories do not 'emerge' from the data but are 'constructed' through constant interaction with the data. Charmaz (2000), also argued that the approaches of both Glaser & Strauss (1998) and Corbin (1990) takes a more positivist approach by assuming an objective external reality. Charmaz's (1990) version therefore provided an ideal framework by which to understand the phenomenon being explored, drew upon themes from the socially constructed data provided by the focus group discussions and sat comfortably alongside the cycles of PAR and my social constructionist positioning.

Drawing upon the social constructionism standpoint, the pragmatic focus group interactions began to shape subjective realities, experiences, challenges and meanings of CMHPs and "*how early is early*" when instigating early interventions. Furthermore, the social context of the focus groups elicited collective opinions in a social context (Charmaz, 2008). Whist eliciting collective opinions, thoughts and experiences, I found that the selection of participants from across the range of occupational professions from within the social setting of the workplace had socially constructed the emergent theoretical framework.

The grounded theory approach driven by the cyclical processes of PAR, further allowed for a deeper exploration of the understanding of the culture, approach and behaviours to CMHPs and early interventions from within the organisational environment. This not only allowed for managers and employees to construct versions of their experiences but generated data that contributed to ideas for practical action, and positive learning. The practicalities of the grounded theory method employed had instigated a process of constant comparison of data and progressive identification and integration of meaning from the data collected. In addition, the theoretical sampling of different groups maximised the similarities and differences of information (Cresswell, 2009, p.13), which provided the

missing pieces of the jigsaw, or indeed instigated the beginning of a new one (Charmaz, 2006).

The grounded theory method aimed to draw upon social constructionist ideas whereby subjective reality, experiences, challenges and meanings were made sense of in a social context, generated the theoretical framework from the collective data of individuals and contributed to the organisational learning and action (Charmaz, 2008). It was believed that social realities shaped through experiences and interactions with others enabled the development of theoretical framework (Charmaz, 2006). By implementing the principles and procedures of the grounded theory approach thus allowed for managers and employees to construct versions of their views and experiences, that helped to understand the cultures and behaviours within the organisational environment and how these may contribute to change.

6.9.1 Quality of the Qualitative Data

Accepting that the findings of this study would be dependent on the maintenance of the quality of the qualitative data throughout the whole research process, this section discusses the data quality criteria applied throughout the course of this study. The approach I took aligned with Charmaz (2006, 2014) who proposed four criteria for GT studies which were credibility, originality, resonance and usefulness. However, with this study being a PAR design with the applied principles of GT being the method of data analysis, I have also included transferability and dependability to ensure that the quality of the data and the findings are plausible and defensible (Lincoln and Guba, 1985). I had also paid attention to reflexivity, and the process of self-reflection during the research process.

During this study a number of research activities had been undertaken to check and review the data thus ensuring the data quality. These activities involved the systematic collection and simultaneous analyses of in-depth, descriptive, conversational qualitative data from two cohorts of focus groups. In addition, the iterative and reflective cycles of PAR and GT allowed for the prolonged engagement with the participants.

Dependability - Data Consistency, Corroborating and Confirming the Findings with Others

The criterion of dependability had been accomplished through PAR and GT where the iterative cycles provided a consistent audit trail of data collection, analysis, reflection and review. The iterative cycles had ensured that the data collection and analyses was robust, truthful and accurately constructed and reconstructed so that it represented the participants views and experiences. Furthermore, PAR and GT had allowed for the participants and organisational stakeholders to follow the whole research process where they reviewed, corroborated and confirmed the findings (Lincoln and Guba, 1985).

The PAR and GT audit trail also facilitated dependability, where the findings and the resultant theoretical model were grounded in the data collected and not based on my own preferences or viewpoints. In addition, the analytical dependability and overall trustworthiness of the data had been achieved through the maintenance of a rigorous code book, that established a comparison process, ensured that the thematic findings were consistent, and were consequently confirmed and corroborated by the participants themselves.

Resonance

The criterion of resonance was achieved by using the detailed and direct conversational quotes which maximised the richness of the data, and to ensure that the emergent insights were based on the participants views and experiences. Furthermore, resonance was further attained by ensuring that the constructed themes and sub-themes not only represented the participants views and experiences, but offered them deeper insights into their own lives, CMHPs and early interventions. In addition, the iterative cycles had also provided valuable insights to others, such as the direct organisational stakeholders and the gatekeeper, with whom I had regular meetings and had instigated action for change.

Credibility & Originality - Establishing Credible & Original Results

The purpose of the credibility criterion was to establish if the research findings represented original and plausible information drawn from the participants and was an authentic interpretation of their original views and experiences (Lincoln and Guba, 1985). In addition, I acknowledged that, where any discrepancies or inconsistencies existed, the credibility and originality of the research findings would be thrown into doubt.

Credibility was achieved by ensuring that the focus groups were facilitated by myself, and that the topic guide was followed in order to maintain consistency and quality of the data. The focus group interviews were audio recorded and the focus group participants were encouraged to share in-depth, their views and experiences of CMHPs and early interventions. Therefore, in order to strengthen the credibility & originality of the data, the focus group interviews were transcribed verbatim, the transcripts were then analysed, compared and contrasted, reviewed and fine-tuned. Furthermore, the iterative and reflective cycles of PAR and GT also sought to overcome bias and error from the data analysis, and was achieved through presenting back the interpretations, analytical themes, sub-themes and conclusions to the participants, who through fresh eyes were able to review and reflect on the context of the findings.

Originality was achieved through my own memo-writing and reflection, and where I had continually explored the existing body of literature in order to challenge, contribute to, or refine current ideas, concepts and practice (Charmaz, 2020).

Usefulness

The usefulness of the data was achieved through obtaining the thick descriptions and insights of the phenomena under study from the participants, whose constructed themes and sub-themes led to the development of the resultant theoretical model. The findings were such, that they were useful in that they provided deeper insights into CMHPs and early interventions in the workplace, instigated action and change within the organisation, as well as being useful in everyday lives.

Moreover, the usefulness of the findings of this study have contributed to knowledge and have contributed to organisational change and are discussed in the following chapters.

Transferability - Are the Results Transferable to other Settings?

In order to achieve transferability, particularly as this study was undertaken in a single case setting, the data collection and analysis looked beyond the surface and explored the phenomena in depth. This in turn enabled a thick description and interpretation of complex views and experiences of workplace CMHPs and interventions. Whilst it was accepted that the qualitative data, meanings, experiences and behaviours are context bound, I strongly believe that the resultant theoretical model is transferable and applicable to other contexts.

Although the study had been undertaken within a complex public sector workplace setting, when presented with the themes and sub-themes, the organisational stakeholders felt that the findings would become meaningful to a range of other workplace settings. In addition, the thick descriptions had taken into account not only the immediate experiences of the participants but had also contributed to creating wider experiential understandings that in turn render the findings as meaningful and useful to others.

Furthermore, having recognised that multiple realities, personal experiences and views exist, the participants were encouraged to be honest and frank in terms of their experiences of early workplace interventions for CMHPs. Due to the fact that the PAR study was problem focused, collaborative and situational and aimed to instigate improvement and change, I believe that the findings and the theoretical model could be relevant to other groups and settings (Hart & Bond, 1995, Rolfe, 1996, Badger, 2000).

Reflexivity - "*Attending systematically to the context of knowledge construction, especially to the effect of the researcher at every step of the research process*." (Malterud, 2001 pg: 483-488).

As a qualitative researcher, I had fully acknowledged the importance of being self-aware and reflexive about my role in the process of collecting, analysing

and interpreting the data. This had been particularly relevant being an insider-researcher where reflexivity had been vital throughout the course of this qualitative study, and I was fully aware of any pre-conceived assumptions that I may have had that could have affected the research. Therefore, in order to address any potential insider-researcher bias and preconceptions, I put my professional practitioner positioning to one side and took full responsibility for facilitating the dynamic cycles of data collection and analysis as a researcher and not an employee. PAR had enabled a process of critical self-reflection which increased my ability to understand the context and appreciate the experiences of the participants, which in turn strengthened engagement and collective learning.

Regular meetings with the organisational gatekeeper, stakeholders and my university supervisors underpinned my reflexive practice. These meetings facilitated a process of reflection on the design, data collection, and the emerging themes that were unfolding from the analysis, which provided discussions of and any issues arising.

Moreover, the iterative, cyclical and systematic process PAR and the principles of GT analysis, had maintained continual cycles of review and reflection for both the participants and myself, throughout the full course of the study. I further discuss my reflections as the insider researcher in Chapter 15.

I now turn to chapter 7 and the discussion of the practical application of PAR including the planning, action and reflective cycles, before moving on to the research findings in chapters 8, 9 & 10.

Chapter 7

The practical steps of PAR

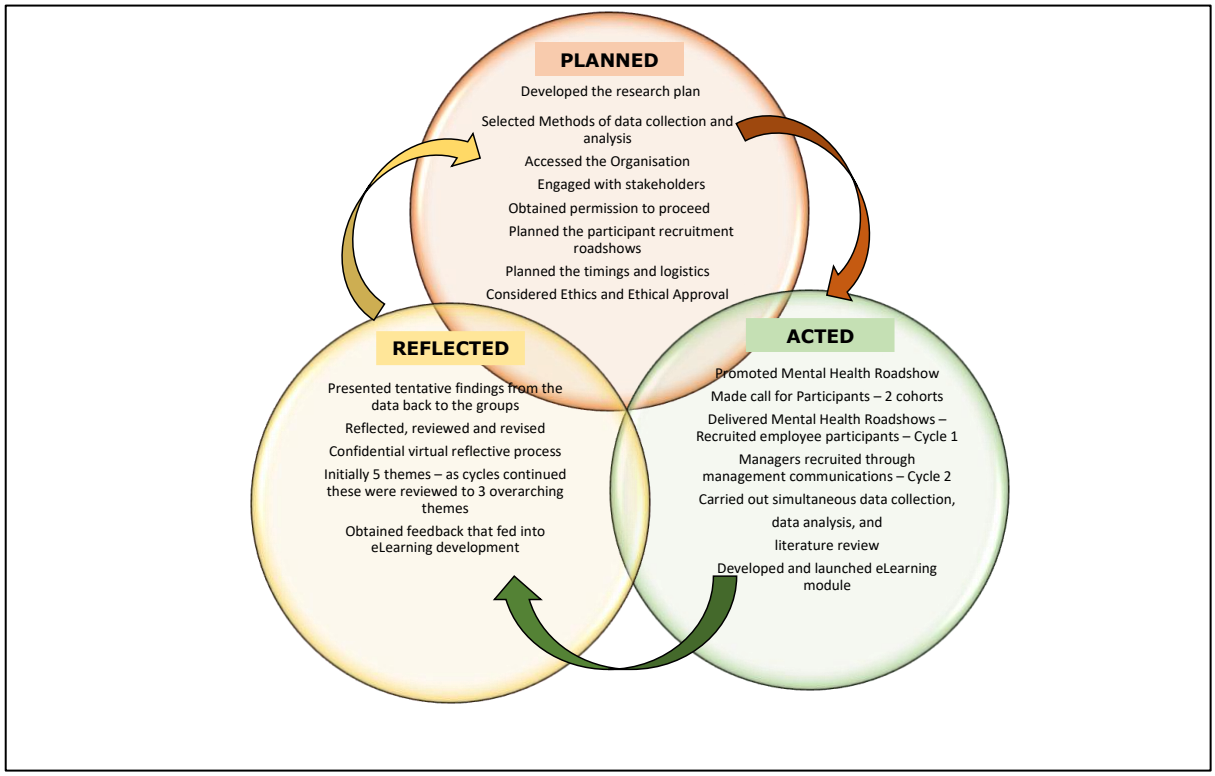
7.1 Introduction

The previous chapter has detailed the methods that were employed to collect and analyse the data. This chapter, therefore, discusses the practical steps of PAR that were taken in order to address the research question of '*how early is early'* when instigating early interventions for CMHPs, and the practicalities of conducting PAR within a large and complex organisation.

The dynamic PAR design incorporated participant discourse in the social setting of the workplace, and to allow for a deeper exploration of the phenomena under study, consisted of a series of practical cycles of planning, action, and reflection. A key principle underpinning the PAR design had been the focus on conducting the research in democratic and active ways. The practical steps of conducting the research included accessing the organisation, engagement with key stakeholders, recruitment of participants, instigation of a participative and collaborative dialogue in the focus groups, analysis of the data and encouraging critical reflection on the analyses of the data with a view to action organisational change (Whitmore, 2020). Therefore, PAR, with its emphasis being on collaboration, had allowed for the social construction of knowledge, understanding, and theory with participants functioning as organic intellectuals, who describe their social experiences and lives through language of experiences, feelings and culture, and concerned all those in the workplace as a whole and not self (Ramos, 1982, Gramsci, Kindon et al., 2006).

Below provides a diagrammatic view of how PAR was approached in each of the cyclical stages, [Figure:2] and where I worked systematically back and forth through the cycles. The sections that follow describe in more detail the phases of planning, embarking on implementation of the practical and collaborative activity, analysis, and where the initial tentative findings were critically reflected upon, reviewed, revised and validated by the participants themselves (Yeich & Levine, 1992, Savin-Baden & Wimpenny, 2007).

Figure 2–Diagrammatic Cycles of PAR



7.2 Development of the Study Plan

For this study, the PAR approach had been planned and designed to allow for systematic and collaborative subjective discourse exploring the research question of '*how early is early?*' when instigating early CMHP interventions within the social context of the workplace. Whilst fully embracing the cyclical processes of PAR, I was mindful that each cycle would not be '*stand-alone'*, but interdependent, thus creating an effective environment where the participants would engage in data generation and critical reflection of the findings as they emerged (Reason & McArdle, 2004). The importance of this was to clarify interpretations of the experiences, thoughts, feelings and meanings of the participants of the phenomenon under study. Furthermore, in order to proceed with the study, it was of paramount importance that I obtained the buy-in to the PAR process from the organisation from the outset. This was particularly important as the organisation itself not only had a vested interest in myself as the insider-researcher but had recognised need for change (Fals-Borda, 2001, Saven-Baden & Wimpenny, 2007).

7.3 Accessing the Organisation

A critical and fundamental aspect of this study was ensuring that the organisation was engaged and able to embrace change as the findings from emergence findings. Because of the access that I had to the organisation and the workforce I had been fully prepared for the study proposal to come under some scrutiny and critical questioning (Saven-Baden & Wimpenny, 2007). Furthermore, the PAR concept required close working partnerships with not only focus group participants but also those within the organisation that are empowered to change policy and practice where required (Baum, 2006). Therefore, to ensure that the study would be realistic, innovative, feasible, practical and above all achievable, the conceptual framework of PAR required the active engagement with the stakeholder gatekeepers that ultimately would be the beneficiaries of the study (White et al., 2004). Conveniently, the strategic gatekeeper of the study was my senior manager and the head of human resources and organisational development who fully supported PAR and the involvement of workforce participants that aimed to understand of the research problem from both organisational and academic contexts (Zuber-Skerritt & Perry, 2002). Furthermore, managers and team leaders from across the management hierarchy had agreed to the recruitment of employees and allowing for them to become actively involved in the iterative cycles of PAR, which allowed for the integration of conscious and deliberate thinking, reflection and interpretation of the qualitative data (Dick, 1998, Danley, 1999). Moreover, senior management support had been sought as collectively they would be acting as the 'change agents' when converting findings from the data into new or revised policy, practice and/or initiatives (Danley, 1999).

7.4 Engaging Organisational Stakeholders

Engaging with and obtaining the ongoing support and engagement of organisational stakeholders had been crucial as they had a key role to play in the facilitation of the inputs and the outputs of the PAR process, particularly from senior managers who would potentially act as the organisational change agents. Being conscious that the stakeholders would not be uniform in their position across the organisation, consideration their interests, needs and expectations had been taken into account I utilised the available communication

channels and mechanisms that had been accessible to me through my day-to-day work activities. For example, my professional role required me to attend a variety of management meetings and working groups on a frequent basis thus allowed me to sustain good stakeholder participation and engagement throughout the course of research (Reason & Bradbury, 2008).

Furthermore, my job and researcher roles not only facilitated the ongoing access and collaboration with the stakeholders, but due to their vested interest as the ultimate beneficiaries of the study they had also acted as 'critical friends' in addition to monitoring progression. The monthly meetings with the gatekeeper further assisted by keeping communicative spaces open and facilitated ongoing collaboration with organisational senior managers and decision makers as well as keeping the research project on track. The regular engagement had been crucial and assisted me to overcome any organisational barriers and obstacles as and when they arose particularly when moving through the organisational restructures and changes (Reason & Bradbury, 2008, Kemmis, 2001 & 2006). Notably, the subsequent engagement of the all-important key stakeholders thus allowed for emerging insights into the research problem to be shared in order to enable organisational innovation, learning and change (Sartori et al., 2018).

In tandem to the research planning and before embarking on the action cycle, I undertook an organisation-wide gap analysis, where I assessed the organisational 'current state' in terms of what was in place to support CMHPs and early interventions. Furthermore, this landscape view of the organisation thus enabled me to identify, observe, map and highlight any strengths and/or weaknesses in organisational policy and practice in addition to identifying and the reviewing of any available training. Although minimal practical evidence was found to be in existence at the start, the gap analysis was re-visited in subsequent cycles of PAR which enabled me to undertake further observations and reflections, thus identifying if changes in policy and/or practice were required. My observations were reported back to the gatekeeper and management stakeholders to enable them to action any required change.

7.5 Maximising Opportunities and Mitigating Risks

As discussed, a high level of commitment had been required from a cross section of organisational stakeholders being that they were the major decision makers and in prime position to action any identified changes. Therefore, my job role as a senior health, safety and wellbeing advisor allowed for me to maximise the engaging of employees and managers from across the hierarchical levels as well as nurturing the wider engagement, agreement and support from strategic managers, as without this the study would not have progressed (Smith & Markwick, 2009). Furthermore, as discussed in chapter five my organisational knowledge and experience ensured that I had full awareness of those who would be better placed than others in order to provide the detailed and deep insights into the research problem where full consideration for the composition of the groups was given during the sampling and selection of participants (Bloor, et al. 2001).

However, obtaining of the commitment of the stakeholders did not come without challenge, particularly in terms of the proposed methodology and my status as an insider-researcher. Therefore, to defend my positioning, my starting point had been to outline that my knowledge of the complexities of the organisation would afford access to participants that otherwise would not be accessible to 'outsiders' due to the subjective sensitivity of the phenomenon under study. In addition, as an insider researcher I could build trust with the participants due to the common understanding of the organisation and the issues that it faced, whereas an outsider would be more likely to be detached, less personal and less informed in terms of organisational culture, governance and occupational management systems (Rabe, 2003, Corbin, et al., 2018). In addition, my belief was that being 'on the inside' provided me with a prime position, meaning that by having the in-depth knowledge of the organisation allowed me to unravel the intricacies of the complex subject under study by having a familiarity of the social workplace norms, thus being 'tuned in' to organisational systems and the language of participants (Brannick & Coghlan, 2007). This led me to believe that participants would be more forthcoming and willing to share their subjective experiences on the assumption that there would be a shared understanding of their issues across the complex workplace environment.

On the other hand, I fully recognised that whilst my pre-understanding of the organisation provided opportunities as noted above, I also acknowledged that due to having a dual role within the organisation there would be the possibility of encountering role ambiguity and conflict. Furthermore, due to my position within the organisation I had been aware that assumptions could be made by participants that being the insider-researcher I would understand the problem 'from their side' thus risk participants failing to describe their individual subjective experiences fully and in-depth. In addition, where individuals had previous negative experiences and trust in the organisation was lost thus impacting on my role as the insider-researcher, and where an underlying level of 'mis-trust' existed leading to participants being restrictive in what personal knowledge and experiences they would share (Coghlan, 2001, Corbin, et al., 2018).

In order to address these issues, I drew on my organisational positioning as a professional practitioner and my long-standing experiences of running and facilitating focus groups. I clearly outlined to the participants that although the study had organisational 'buy-in', they themselves were central to the provision of the in-depth subjective experiences that was needed to answer the research questions with the view of making an important contribution to knowledge and action for change. Building the trust with the participants ensured that discussions were maximised, allowed everyone to 'have their say' and that the study was shaped and guided by the social process of the subjective discourse.

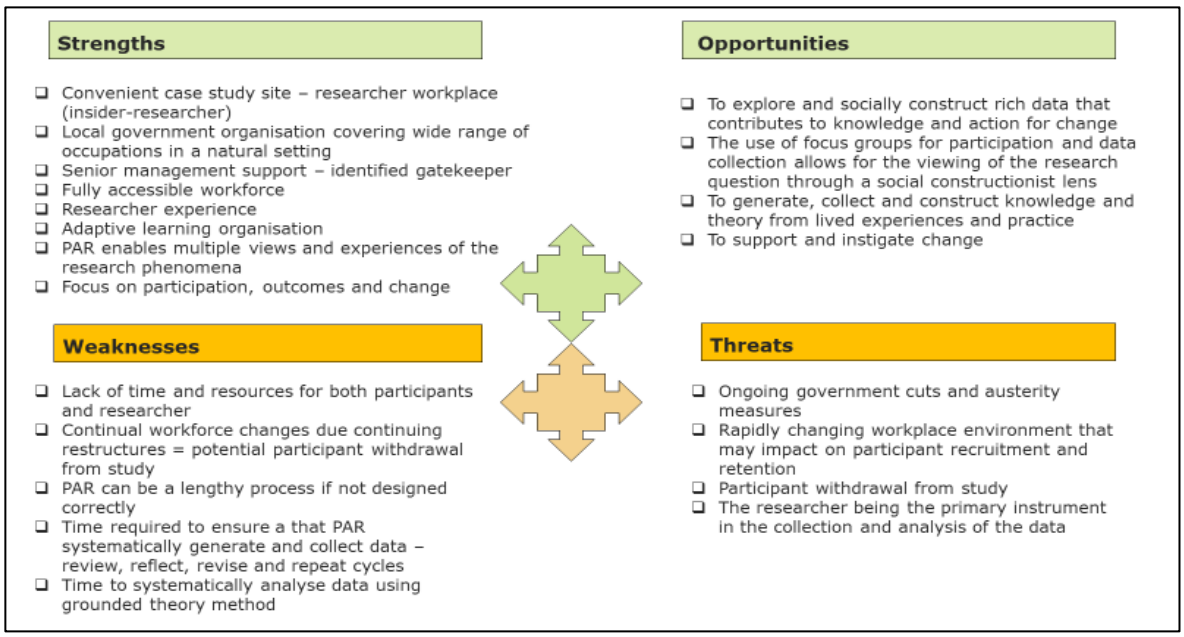
A further challenge that I faced had been timelines, deadlines, and pressures on the time required for undertaking the cyclical process of PAR alongside full time employment so therefore included managing my own work/life balance. In addition, I had also engaged with fellow colleagues, who, on one hand, were fully supportive appreciating the potential benefits of the study and eager to be involved wherever required. However, on the other they had raised similar challenges as those of senior managers.

Therefore, being faced with the 'so what' and 'how will you?' questions prompted me to identify and plan for any potential risks including the potential impacts on time and capacity for both the participants and myself (Zuber-Skerritt &

Fletcher, 2007). In order to identify and mitigate risks that could derail the study, I decided to draw on my past experiences of managing research and work projects, which consequently led to undertaking an analysis of the organisational strengths, weaknesses, opportunities and threats (SWOT - Figure: 6). However, having accepted that a SWOT analysis tends to focus on designing and formulating strategies, I felt it was necessary to focus on identifying internal and external factors that could either influence, enhance or negatively impact/hinder the progression of the study (Helms, et al., 2010).

Moreover, when presenting this back to the organisation, the outcome of the analysis revealed that the strengths of study outweighed the weaknesses and threats, thus allayed any fears and concerns that had been raised by the stakeholders, whilst at the same time the SWOT outlined the value and opportunities that the study would provide. In turn, this further persuaded the organisation that the research was warranted, particularly as the stakeholders would be beneficiaries to any emerging theory with the view to actioning change. The SWOT and the study plan with clear timelines was then presented back to the stakeholders who acknowledged the potential benefits of the study and agreed that risks had been mitigated along with an acceptable and achievable timeline, thus enabling effective organisational and individual efficiencies throughout the course of the study.

Figure 3- PAR SWOT Analysis



A key strength was the commitment from the organisation which in turn provided me with some major advantages. As discussed in the previous chapter (5), the organisational study site itself being public sector and my place of work, thus acted as a convenient case study site. Furthermore, the organisation being a social structure and characterised by external and internal politics and power differentials, had over several years been forced to adapt to a range of challenges both locally and nationally, enacted though continual cycles of change. However, despite the continual shifts and changes, my belief had been that this presented a further advantage as the organisation had embraced change by operating as a dynamic and continual learning organisation (Roper & Pettitt, 2002). Moreover, this meant that the PAR design was suitable for this study as it facilitated collaborative thinking from across the organisation rather than fractional parts of it. The organisation, therefore, was not at odds with the design as it mirrored previous approaches that had been adopted to manage change thus provided organisational buy in (Senge, 1990, Agyris, 1993, Easterby-Smith, 1997, Roper & Pettitt, 2002).

Nonetheless, I was continually mindful that whilst accessing the workforce, further opportunities, threats and constraints could present themselves, thus contingencies and risk mitigations were factored into the research project timeline as it evolved which enabled me to address weaknesses and safeguard against any failures of the intended research objectives (Helms, et al., 2010).

7.6 Planning and Actioning PAR

Having obtained access approval, the study started to gather pace thus leading to the planning and development of the focus group activity, participant recruitment and developing the sampling strategy as discussed in the previous chapter.

A fundamental step in the planning process was the engagement and recruitment of focus group participants from a range of diverse stakeholder occupations. For the first cycle of PAR, I decided to design and plan an organisational mental health week roadshow, not only to recruit employee participants, but to promote good mental health, organisational support

mechanisms available, and provided a range of takeaway resources, and where I assumed the overall responsibility for its management and delivery [Appendix 1].

In tandem, I began to plan manager recruitment as I was fully aware that because of time constraints and work commitments a similar approach to the employees recruitment would not be feasible. Whilst paying attention to the hierarchal positions situated within the study site, the aim was to ensure the groups had the characteristics and sufficient diversity to stimulate discussions thus facilitating comparison between the groups (Barbour, 2005). This led me to work with organisational stakeholders to develop a manager recruitment strategy [Appendix 2]. I discuss the recruitment and sampling processes in more detail later in this chapter.

7.7 Study Site Demographics - Focus Group Participants

Recognising that for the research to be relevant, credible, and rigorous would be dependent on the participants I therefore took steps to ensure that the focus groups were representative of the organisation and the occupational groups within it. In order to utilise the in-depth discussions that focus groups provide, I undertook an analysis of the total organisational hierarchical structures across all occupational areas including headcount. However, being driven by the aims and objectives, further compounded the need for me to be acutely aware that the approach adopted would need to reflect the rich and diverse field of study (Willig & Stainton-Rogers, 2010). In tandem, I drilled further into the organisational employee data to identify the distribution of job roles, teams, and their localities which had also enabled me to identify any logistical issues that could arise.

The groups in the table below were those groups that were included in the selection process, the exclusions were those that were not under the direct employment or share the same governance arrangements of the organisation for example, schools. The occupational groups that took part in the focus groups is presented later in this chapter.

The previous table [Table:4] represented the cross section of participants and occupational service areas that took part in this study.

7.8 Ethics

Throughout all phases of the research process there was an absolute requirement to be sensitive to ethical considerations at all times and particularly important when obtaining access to the workforce. Therefore, as required by both my academic institution and the study site, a risk assessment had been undertaken at the outset in order to identify any potential risks that could arise during and after the data collection process and assessing what control measures would need to be in place to mitigate those risks. No major risks were identified, however, as an employee (Local Government) I had been duty bound to adhere to strict protocols that exist within the study site if any issues or problems arose during the study.

The study did not involve direct contact with participants under 18 or others that may be deemed as vulnerable therefore a data and barring service check (DBS) was not required. Due to the nature of the organisation under study, data protection was not an issue with full security and confidentiality of personal information being guaranteed through ensuring the anonymity of participants, responses scanned and stored in locked digital files and any paper notes destroyed by a confidential shredding process. In addition, my professional status and job role required me to sign the organisation's confidentiality agreement with regards to accessing individual's confidential information.

Moreover, there was a statutory obligation due of my professional work status in regard to the Data Protection Act, the Medical Records Act amongst others that include both the workplace and professional codes of conduct.

I accepted that due to the nature of the study it would be highly likely that personal information would be disclosed within the focus group setting. This in turn led to further consideration of the potential risks of vulnerability and possible distress to participants whilst expressing sensitive experiences and opinions within a group setting, as opposed to expressing them in a one-to-one interview, with the risk potentially being greater where beliefs and attitudes held by some participants could be at odds with the thoughts of other group participants (Wellings, 2000). Further accepting that the group discussion would be highly likely to trigger experiences, memories, thoughts and feelings that

would not normally be obtained from an individual interview or survey (Gill, P. et al., 2008), I fully acknowledged that a 'safe place' would need to be created for the disclosure of sensitive information. Therefore, it was important to be continually mindful of the pitfalls that could rear their heads during the data gathering stage, particularly where the focus groups had not been effectively designed such as ill-prepared timescales or in inaccessible venues.

In addition, whilst keeping my mind's eye on the participants' health, safety and wellbeing, the plan included selecting venues that were accessible to all and ensuring that they were appropriate to protect the anonymity, dignity and wellbeing of all the participants (Barbour, 2005). Furthermore, due to the nature of the study I had acknowledged there was a likelihood that adverse emotions or distress could be triggered. Therefore, in order to mitigate risks the organisation provided the benefit of having direct access to wider support teams if required including 24/7 counselling being available to any participants that exhibited any signs of distress or felt that they needed further support.

At recruitment stage the participants were furnished with all relevant information that enabled them to make an informed decision in terms of taking part, and where informed consent was obtained from all participants prior to taking part and included them agreeing to the focus group discussions being digitally recorded. The research participants, therefore, only took part voluntarily, and were not subjected to any coercion or undue influence, their rights, dignity and autonomy was respected and appropriately protected. In addition, I had made myself available by phone or via a face to face, one-to-one meeting, allowing for prospective participants to discuss the study in more detail if required. I found that instigating the 'open door' approach ensured that those who were wavering on whether to participate or not were fully informed of the purpose, methods, PAR process, time commitment and intended uses of the study data, thus enabling them to make a fully informed decision. Four individuals came forward and following more detailed discussions, three continued into the full study and one decided that they could not afford the time due to work commitments.

As part of this process, my attention turned to the development of the topic guide as previously discussed in section 5.13, this subsequently led to the

development of the letter of invitation, the information sheet, an informed consent protocol, along with a debrief process and qualitative data collection risk assessment [Appendices 3, 4, 5 & 6].

7.9 Power Relations

In order to increase the social validation of the research aims and objectives and outcomes, a broad range of participants were therefore required to explore the phenomena under study (Barbour, 2005). The aim of PAR and focus groups had been to give the 'power of voice' to all those that may otherwise may not have their voices heard within the complexities of the organisational environment. Therefore, the sampling strategy and group composition had been designed to solve this issue and provided a 'safe place' to stimulate interactions and conversations for those who may have previously remained silent within the organisation.

Furthermore, because participants were exploring the complex research problem related to their experiences and relationships within the physical and socio-cultural environment of the workplace, I had identified that some participants could manifest some distinctive risks and ethical implications. For example, to reduce the risk of creating vulnerabilities, whilst selecting participants, I ensured that participants would be empowered, as opposed to others having the 'power over' individuals. Wherever possible, I avoided the selection of group participants that consisted of various levels of occupational superiority or pre-existing groups with knowledge of each other. Furthermore, where power imbalances are in existence there would be a risk that this would raise tensions with the potential that superiority could exert power over others thus oppressing the ability of all participants to express their views (Kitzinger & Barbour, 1999, Barbour, 2005, Hofmayer & Scott, 2007). In addition, the history of the public sector workplace, its contextual issues and organisational norms could have also inhibited open discourse and presenting of experiences and views. Moreover, I fully accepted that as the researcher, I was responsible for ensuring that the risk to harm due to power differentials between participants, over-disclosure, stress, lack of confidentiality were minimised (Kitzinger, 1990, Hofmayer & Scott, 2007).

Therefore, whilst accepting that particular tensions or power imbalances could not be avoided altogether, a detailed description of the PAR process and strict ground rules were developed and communicated to ensure that there were no misunderstandings of how the study would progress from the outset. Furthermore, I decided to recruit an observer in order to assist during the focus group process (Zuber-Skerritt, 2015). To this end, I now turn to the action cycles of PAR that describes the practical steps and subsequent cycles taken throughout the PAR approach for this study. (Bawden, 1991, Zuber-Skerritt & Perry, 2002).

7.10 Focus Group Procedures

Prior to the instigation of the focus groups, the nature of the study had been reiterated with the participants being provided with an informed consent form, thus obtaining their agreement to the anonymised data being used for the benefit of the study thus contributing to any future action and change. The participants had also been made aware that consent could be withdrawn at any point without consequence or prejudice (Vaughn, et al 1996, Mertens, 2018). In addition, all participants had been made aware that the data would be digitally recorded and during analysis, their discussions would be coded and categorised into themes that ensured anonymity with quotes not be identifiable or matched to any particular individual. It had been made clear that participation was purely voluntary with no financial incentives being offered (Mertens, 2018).

Whilst being fully informed of the PAR and focus group processes at the outset, participants were given the opportunity to opt for individual one-to-one interviews if they did not feel comfortable in a focus group environment. Although no requests had been received, I had consequently decided that the approach would not add value to the study, raising the risk of diluting the validity of the data collected from the group scenario and were rejected. Furthermore, the focus groups were designed to provide a 'safe place' for the disclosure of sensitive information and accepting that group discussion could trigger experiences, memories, thoughts and feelings that would not normally be obtained from an individual interviews or survey (Gill, et al., 2008).

7.11 Actioning PAR

This section details the practical steps taken during the two cycles of PAR that were undertaken with two cohorts of focus groups. In total eight focus groups were undertaken and comprised of one cohort of thirty-four employees (cycle one) and the second cohort of thirty-two managers (cycle two). The first cycle of the four employee focus groups was carried out during the mental health week roadshow where the iterative cycles and emergent themes had informed cycle two which included manager groups and are detailed later in this chapter. Furthermore, and in order to provide a true reflection of the overall study site structure, participants for both employee and manager groups had been selected from ten different occupational groups from a total of seventeen organisational service delivery departments across the organisation.

The PAR design being situational and located within the boundaries of the functioning organisation, involved a systematic enquiry of the research problem with those who are affected by the issues (Kagan, 2012). Focus groups had been chosen as a method of data collection because I wanted to gather data from collaborative dialogue as opposed to individual interviews. It was therefore envisaged that the focus groups would lead to the provision of practical theory and knowledge that would be useful to employees and managers in their day-to-day work. Moreover, the application of iteration through the reflective cycles played an integral part of PAR, where the data were analysed, interpreted and presented back to the participants. This was a key step as it allowed for critical thinking and confirmation from the participants as to whether or not I had correctly interpreted and represented the participants subjective thoughts and experiences through the emerging themes presented to them (McIntosh, 2010).

The participatory action cycles therefore commenced with the recruitment of the focus group participants. I facilitated the focus group discussions where I collected, transcribed and analysed the data identifying emerging themes. Furthermore, I had been fully aware that PAR not being linear might not evolve in predefined 'neat' cycles. Notably, I fully understood that flexibility would be needed to work back and forth through iterative cycles of further data collection, analysis and reflection until a collaborative agreement had been reached

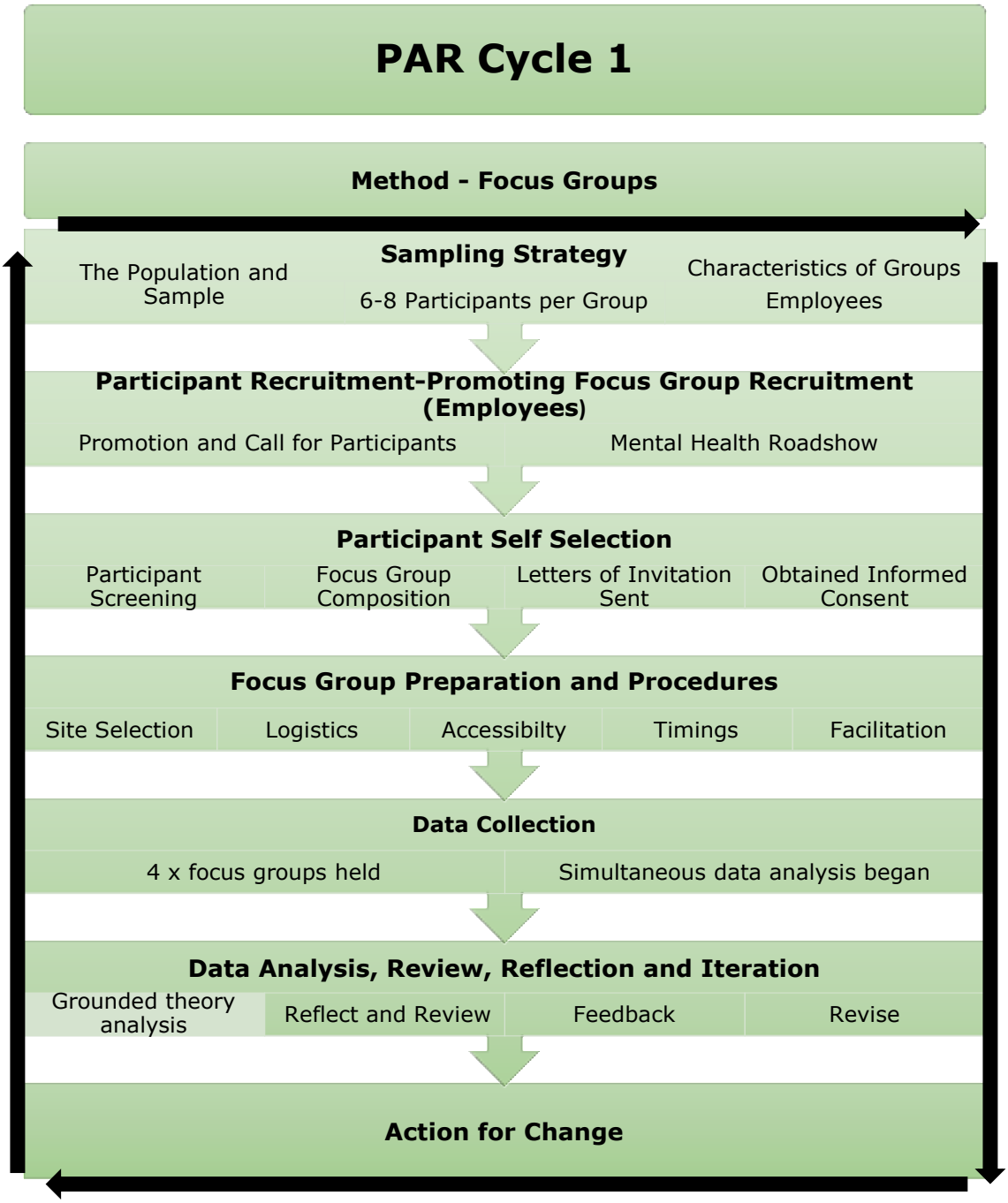
(Walter, 1993). Therefore, the practicalities of the evolving collaborative study and the steps taken are detailed in the following sections.

7.12 PAR - Cycle One

As participation is a core principle of PAR it had been essential to carefully plan and instigate the recruitment and selection of participants (Whyte, 1991, McTaggart, 1997, White et al., 2004). Furthermore, as PAR is reliant on authentic participation, my role as a facilitator ensured that the recruitment, and selection of participant stakeholders allowed for the building of trusting relationships and collaborative involvement in every aspect of the research process (McTaggart, 1991, Kahn & Chovanec, 2010).

The diagrammatic cycles of PAR [Figure: 2] provided the progression of PAR from conceptualisation to the development of the action cycles, ethical considerations, focus group participant recruitment and the enacting of the data collection and analysis activity. This not only became a useful aide memoir, it ensured that the methods employed remained embedded within all cycles of PAR. The flowchart below [Figure:4] outlines the study progression through the practical cycles of PAR, cycle one – employees and cycle two - managers.

Figure 4- PAR Cycle 1 Flowchart (Employees)



[Source: Adapted from Vaughn et al., (1996)]

7.13 Promoting Focus Group Recruitment (Employees)

As outlined previously I decided to run a 'mental health week' roadshow for the recruitment of the first tranche of employee focus group participants. The roadshow was also planned to run in tandem with a national mental health

campaign to promote and maximise interest for prospective participants to take part in the focus groups.

The call for participants to register interest to take part in the focus groups had been instigated at the same time as the promotion of the roadshows [Appendix 1]. In addition, a range of promotional activity was planned to raise awareness of CMHPs in the organisation that in turn resonated with the national mental health promotion in work settings. In line with the national mental health campaign, promotional activity had included workplace posters, corporate newsletters and actively promoted by the volunteer workplace health and wellbeing champions, some of whom became participants of the focus groups.

Furthermore, the benefits of the initial roadshow promotion were three-fold; firstly, they maximised the raising of the awareness of the study and had provided an opportunity for prospective participants to ask questions and obtain more information that allowed them to register their interest in taking part. Secondly, they had attracted interest from over fifty employees, and as noted thirty-two actively took part in the focus groups for the full duration of the study. Thirdly, they allowed for the raising the awareness of mental health through a range of available literature, free resources and the promotion of a range of support services.

The promotional activity alongside the call for study participants took place over a three-week period, where the study and participant recruitment were key features of the roadshows launch. However, due to their locality, time constraints or work patterns and shifts there had been several individuals that were unable to attend or access the roadshows to register their interest in taking part. Therefore, to ensure that the opportunity was accessible to all, I kept the interest register open and extended the timeframe for a further week. In addition, I made myself available through a range of contact methods, such as phone, email or via one-to-one sessions during the extension period, which provided further opportunities for prospective participants to come forward and ask questions in order for them to make an informed decision. Although there was some interest during this period no further participants were recruited.

Owing to the size and complexities of the organisation, the time and effort that was needed for the planning and enacting of the recruitment activity within the defined timelines had not been underestimated. A dynamic action plan assisted with the management of tasks, kept track of the mental health week timelines, focus group venue bookings and logistics, and activity timings. Moreover, without this the PAR cycle could have got unwieldy, overwhelming and unmanageable.

However, I had recruited a colleague who was conveniently part of my wider team and assisted and supported by keeping the action plan and roadshow promotions on track, booked the chosen venues, obtained resources for the roadshows and the managing the workplace media messaging and corporate communications. A dedicated email inbox had also been set up with a secure data base that captured and tracked actions and progress alongside the registers of interest. The data base became the heart of the planning and action cycles of PAR and provided an effective management system for tracking, reviewing, updating and amending the PAR project plan. For confidentiality and ethical reasons, a separate secure folder was only accessible to me and held all confidential information such as invitation letters, participant data, informed consent, demographics etc.

7.14 Participant Self-Selection (Employees)

Having moved from the initial recruitment stage and enacting the participant self-selection techniques thus led to screening prospective participants who had come forward and were willing to provide information by virtue of knowledge and/or experiences (Etikan et al., 2015). The screening process was carried out to make sure that the prospective participants met the inclusion criteria for the study and ensured representation across the organisation. With focus groups being the data collection method, the participant selection was therefore central to the qualitative methodology (Robinson, 2014). To ensure success of the focus groups, the selection techniques focused on individuals who would provide the information rich data by communicating their opinions, expressing their thoughts and reflecting throughout the cycles of PAR, thus contributing to the depth of knowledge and understanding required to answer the research question (Vaughn et al., 1996). On one hand, it was vital that participant selection and

composition of the groups covered a diverse range of employees and managers, but on the other hand, not so diverse that they would not provide the depth of information required. However, the focus groups had been designed to ensure that appropriate representation was drawn from a wide range of employees and managers who, due to their hierarchical positions within the organisational structure can often be under-represented by traditional social and organisational research methods (Tongco, 2007).

Being guided by the research questions and objectives a self-selection sampling technique had been employed to identify and select participants that were highly likely to be knowledgeable about or have had experienced the phenomena under study (Cresswell & Plano Clark, 2011). Furthermore, the focus groups provided the 'natural' context in that they already existed as individuals, work groups or teams in the 'natural' organisational environment thus, empowering them to foster social and organisational change (Kitzinger, 1994a).

Furthermore, in order to manage the expectations of the participants, it had been made very clear to any prospective participants what their participation and commitment to the study would entail and that due to the nature of PAR they had been asked to commit a considerable amount of time to the study. All participants were therefore furnished with detailed information about the study, how the iterative cycles would progress thus enabling participants to enter into the study with an open mind in the belief that they would generate new ideas, contribute to the construction of knowledge with the potential to drive action and change (Vygotsky, 1978). However, owing to the nature of job roles such as being engaged in front line positions and some associated management roles, the time commitment was particularly difficult for some interested parties, leading to fourteen out of a total of eighty respondents withdrawing from the process prior to any data collection.

7.15 Focus Groups Screening (Employees)

Whilst clearly publicising the aims, objectives and PAR framework of the study through the roadshows, and study promotion, it subsequently led to over fifty employees self-selecting to participate. The prospective participants represented a cross section of occupational roles from across the study site and for this

cohort of focus groups, managers, supervisors, and team leaders had been excluded. However, whilst screening the employee participants, it was found that interest had been registered by five individuals who identified as being within the management hierarchy. Therefore, not wishing to dismiss them because of their management role, I contacted the prospective participants and carried out further screening such as checking if there had been changes in their job roles, status etc. which led to them being placed on a 'wait list' for the second cohort of manager focus groups. Outlined in the table below is the selection inclusion and exclusion criterion that was used to screen the self-selecting employee group participants.

Table 5- Employee Focus Group Screening Criterion

Employee Cohort Focus Groups Participant Selection **The sample Population – all those directly employed by the organisation**	
Inclusion Criteria	**Exclusion Criteria**
>18 years of age	**<18 years of age**
An organisational employee not at management grade	Managers/supervisors/team leaders
Preferable that they had presented with, had experience of, and/or been medically diagnosed with a CMHP	School employees because many are no longer local authority maintained and are employers in their own right for example Academy Schools
	An employee of the local authority arm's length companies as they are employers in their own right for example the airport, care providers and highways maintenance
Focus Group Composition	
Cross section of occupational disciplines and any non-managerial employee, who may or may not have experienced common mental health problems. Included a selection of professionals who interact regularly with staff i.e., occupational health clinicians.	

7.16 Data Collection - Focus Groups (Employees)

Being acutely aware that when focus groups are not held in accessible venues there would be a risk of participant 'no shows' or withdrawal. Therefore, the

employee focus group sessions were conducted in a variety of settings across the organisation covering the length and breadth of the county and within easy access for the participants. When asked the lunch period had been the most favourable amongst the majority of participants. I had also recruited a trusted assistant who carried out the 'meet and greet' capturing the names and job titles and occupational service area (Vaughn, et al 1996).

Each of the focus groups consisted of between six and eight participants and the sessions were scheduled for an hour. Whilst I did not wish to move straight into the in-depth discussions, I allowed for fifteen minutes taking into account any late arrivals and for participants to get comfortable and settle down. I ensured that a further thirty minutes be added at the end of each session which allowed for a formal or informal debrief if required. After instigating a casual conversation as an icebreaker, I briefly introduced myself whilst helping participants to relax and allay any anxieties that they may have had about taking part in the focus group.

Surprisingly, casual conversation naturally progressed thus encouraging the participants to introduce themselves to each other as and when they felt ready. Because of this natural conversation a formal introduction was unnecessary, although the opportunity was given for each participant to make their own brief introductions which further enabled an open group communication process. Similarly, this informal process took place at the start of each of the focus group sessions without any instigation or interaction from me, and where the discussions proceeded to flow with ease and surprisingly requiring very few prompts throughout the discussions.

The focus group participants were all under the full understanding that they themselves were fully responsible for providing rich and valuable information that would contribute to the outcomes of the study. It was stressed to them that this could only be achieved by open and constructive communication between them as the participants. The formal process had started with the participants being made fully aware and agreeing that confidentiality and discretion was absolute, and were reminded of the 'Chatham House Rule' meaning that the participants' discussions and activity within the groups would not be revealed or

divulged outside of it, 'what is said in the room stays in the room' and where all participants are required to maintain that confidentiality and discretion throughout (Royal Institute of International Affairs, Chatham House, 1927, 1997, 2002).

As discussed in section 5.8.1 the focus groups discussion topic guide had been developed following my organisational gap analysis review of policy, practice and training provision. Organisational stakeholders had also been consulted during the development process. The focus groups commenced with the focus being on the overarching research question and exploring of "*how early is early*". The detailed discussions centred on how interventions for CMHPs were understood, if and what early interventions were enacted within the workplace going on to explore what barriers were in existence that prevented the instigation of early interventions.

The generation of data had been purely dependant on the participants and their willingness to share a range of sensitive and emotional experiences thus placing their full trust in me as the insider researcher (Karnieli-Miller et al., 2009, Ely, 1991, Reason, 1994). Their collective discussions and viewpoints were captured within and between focus groups which allowed for me to interpret, clarify and confirm the meanings that lay behind the views expressed, thus generating a rich understanding of participants' experiences and beliefs (Carnwell, & Daly, 2001). With the process being iterative this further allowed me to systematically seek and develop theory through the cycle of action and reflection.

A noteworthy point and a surprising development had been that one group built a good level of trust amongst themselves so that they went on to form their own support group. The support group was a spin-off of the PAR process and evolved because of the diversity, social interactions and relationships that developed through their shared norms and experiences (Breen, 2006).

Following another focus group, I received an email from one participant who thanked me for the experience and on reflection had found it to be a very therapeutic experience and where that individual felt that they were "*not on their own*" in their thoughts and experiences of CMHPs (Breen, 2006).

No monetary incentives had been offered or provided to the group participants. However, at the end of each focus group session I arranged for a facilitator to provide a short wind down 'chair' yoga session. Furthermore, I provided an informal debrief session with the participants, providing contact details for further support if required at any stage. Although these were not mandatory all participants took advantage of the sessions. The participants fed back to me that they found that the sessions to be calming and therapeutic, particularly after being engaged in intensive discussion of emotionally charged experiences.

7.17 Initial Data Analysis

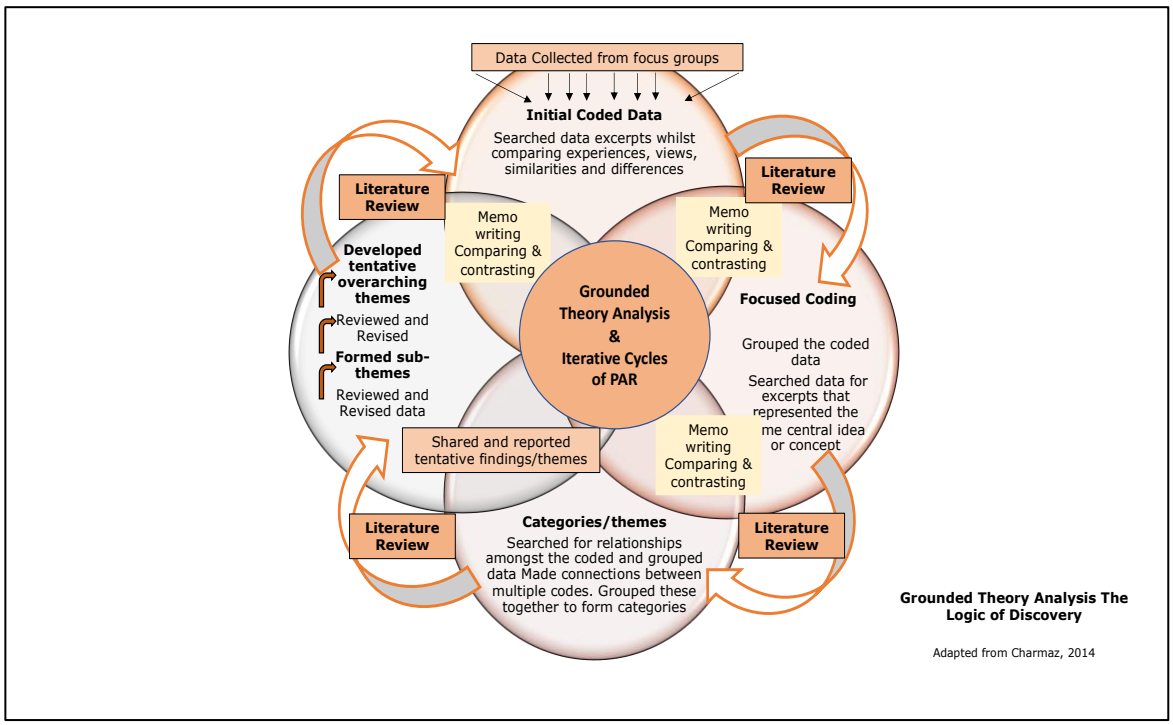
As discussed in the previous chapter (5) grounded theory was employed to analyse the data obtained from the focus groups. The data analysis had set out to make discoveries of how participants experienced CMHPs and interventions in the workplace (Charmaz, 2014). An integral element had been to simultaneously collect and analyse the data that aimed to view the participants world from 'the inside out' whilst adding pieces to the research puzzle as the data was gathered (Charmaz, 2014). Therefore, the method of analysis sought to socially construct participants experiences, views, meanings and actions which provided a more in-depth understanding of their social realities (Flick, et al 2004).

The four employee focus groups discussions had been digitally recorded, secured and then uploaded and transcribed verbatim utilising NVivo 11 & 12 software (QSR International, V:12, 2018). Once transcribed, the reading and re-reading of the transcripts and narratives allowed for me to work directly with the data where I commenced the first stage of exploring and coding the data [Figure: 5]. A line-by-line initial data coding process began, moving in to focused coding where I had identified the most significant and frequent codes from the initial coding and comparing data to data from across the four employee focus groups which allowed further refinement of the codes. From this I had been able to group focused codes into categories which became subsumed into common patterns and themes and through the inductive process became the sub-themes. In addition, I made a comparative study of incidents that helped me to discover patterns and contrasts of participants experiences of CMHPs. For example, I made comparisons and contrasts of positive and negative experiences of early

interventions for CMHPs. A detailed description of the data analysis procedure is provided later in this chapter.

Following the data collection from the employee focus groups I began the process of analysis from the raw data captured in the transcriptions. The figure [5] below depicts the path of the initial data analysis and the subsequent cycles of analysis.

Figure 5- Data Analysis Cycle



I did not assume that theory would simply emerge from the data, instead realities, sub-themes and the wider and overarching themes were constructed by continual interaction with the data and the participants, who through the cycles of PAR had shaped the outcomes (Charmaz, 2006). Moreover, the method provided a series of lenses to view the data, firstly taking a broad look of what was happening amongst the data. As the codes and sub-themes developed these then provided the focal points that brought the key emergent themes closer into view (Wasserman & Clair, 2010, Charmaz, 2014). The method of analysis did not provide a magic wand but allowed for mutual construction of the social realities between me as the researcher and the participants who provided 'thick descriptions' of their subjective experiences and views.

I presented the initial tentative findings to the participants with a view to evoke further insights into meanings and interpretation. Owing to time constraints and work pressures, ongoing organisational restructures and geographical spread of participants, it proved difficult to get all the participants, 'around the table' for further iterative discussions. Driven by the participants themselves the consensus was to continue the iterative collaboration digitally through secure group email discussions which culminated in over twenty-five secure email exchanges over a period of three weeks. I worked flexibly with the four groups where the emerging themes and theory remained provisional and open to modification as the discussions progressed (Charmaz, 2006). Furthermore, the method supported the assumption that the role of social discourse, in the social context of the workplace provided the knowledge and theory in a process of social interchange and iteration between me and the participants (Flick, 2004).

7.18 Review, Reflection and Iteration (Employees)

As discussed above, following the initial data analysis, an important step of PAR was the iterative cycles that allowed for the participants to review and reflect on the preliminary constructs from within the data. The goal was to strive for intersubjective agreement as to the accuracy of the initial analysis and allowing time for the participants to review, reflect, confirm or dispute the themes and theory that emerged from within the data. Whilst presenting the preliminary constructs I reminded the participants that they were the 'knowers and owners' and the data, in other words, their collective biography. The participants fully acknowledged that empowering them to construct knowledge from their experiences and perspectives would more likely be transformative for others as well as themselves.

The initial cycle had started out with 5 constructed themes, which I discussed with the participants giving them the opportunity to confirm or dispute the constructs. I asked them to review and reflect on the themes and categories, and whether they were an accurate reflection of their experiences, their thoughts and views. As described in the section above, following the four face to face employee focus groups I carried out a cycle of email discussions and feedback of the initial themes. Surprisingly, the iterative email discussions, were as lively as the face-to-face focus groups and proved to be a quick method of

reflection and iteration and enabled discussions to remain fluid continued over a period of six weeks. Despite email exchanges being in the range of forty, no new data, themes or categories were forthcoming, essentially, the data had reached saturation point. Effectively, I had provided the participants with a digital platform to review, reflect, challenge and revise the constructed themes and concepts presented. I also asked whether the themes represented the collective experiences of the participants to establish a shared and agreed understanding of the meanings of the data and importantly whether maybe due to unconscious biases any voices had gone unheard?

7.19 Action for Change

Following this first cycle of focus groups some participants questioned if the organisation would indeed challenge the constructed themes in addition to having suspicions that 'nothing would change'. However, this issue had in part been mitigated by my monthly updates to the gatekeeper which had progressed without major challenge. In turn, this led to some innovative thinking by the gatekeeper about how the emergent themes could feed into a programme of organisational change that included leadership development.

Furthermore, believing that the iterative cycles of PAR had enhanced the credibility of the data collected from the first cycle of focus groups, I seized the opportunity to design and develop a mental health awareness e-learning training module based on one of the constructed themes and was an action that I took upon myself to deliver. To enable this, I recruited additional stakeholders from within the organisation who provided the support that enabled the build of the module. Furthermore, the organisational learning and development team stakeholders confirmed that it was a module that had been needed for some time. This led to the formation of a small collaborative stakeholder project group for which I took the lead being the researcher with access to the data.

A pilot e-Learning module was designed and built where a cross section of participants were invited to review and reflect on the content to ensure that it reflected the themes that had emerged from their discussions. This then led to them providing their comments and views with the content being adjusted accordingly. Once a collective agreement had been reached the module was then

further piloted with wider human resources professionals to capture their thoughts and views and was subsequently launched across the whole organisation. In essence the participants had socially constructed the training module through the collaborative process and taking ownership of the content.

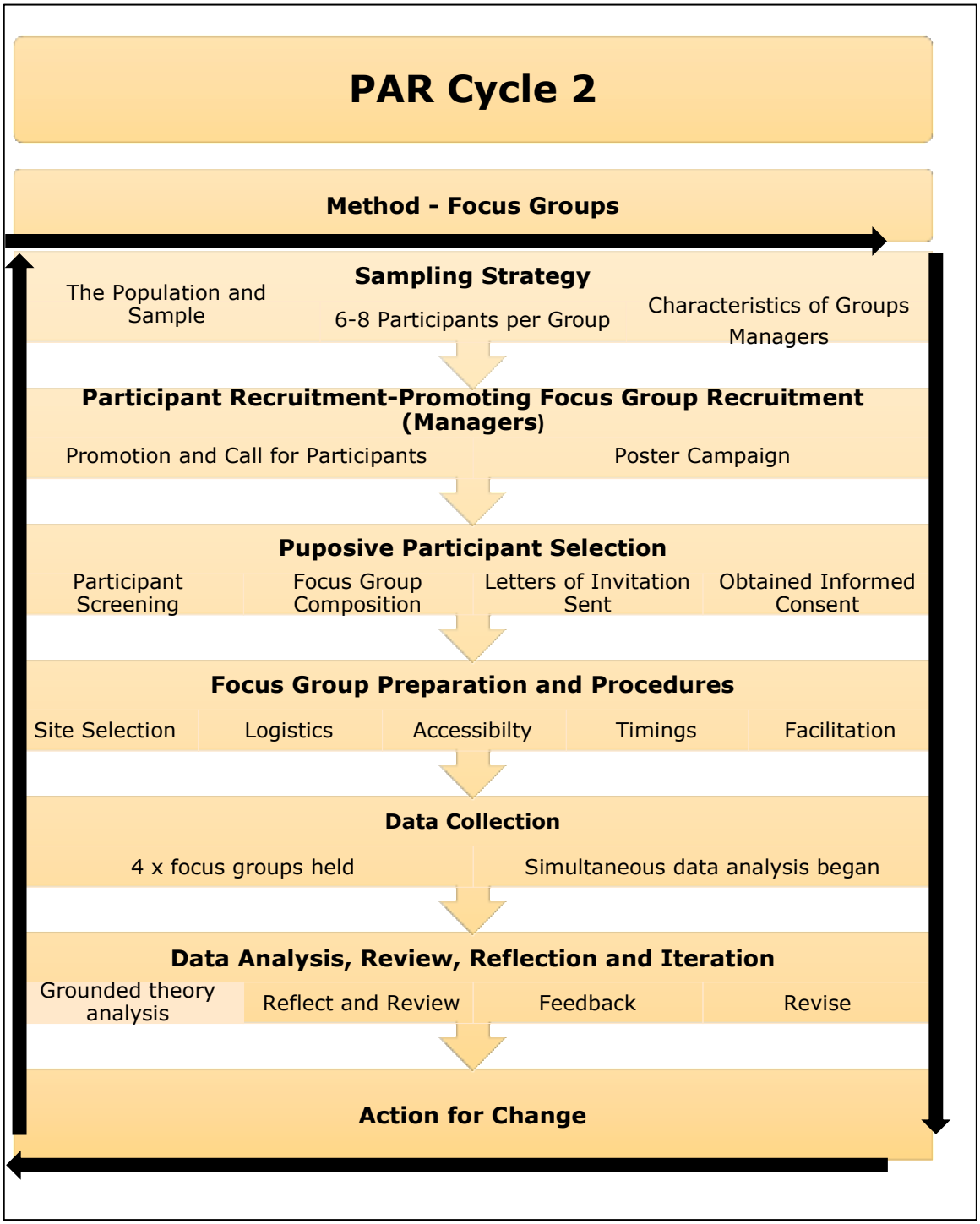
Additionally, it had provided an organisational change, albeit a minor one, where organisational learners could complete the module in their own time through a digital platform thus not being constrained to taking time out of the workplace to attend traditional face to face training. Whilst completing this action and change I had started to instigate the plans for the next cohort of focus groups that would engage managers, thus commenced the second cycle of PAR activity which I now turn to.

7.20 PAR Cycle Two

A fundamental element of PAR was to collaboratively explore the subjective experiences of the participants 'looking from the inside' to identify any potential gaps between theory and management practice of CMHPs within the workplace itself (Kemmis & McTaggart, 2007). Therefore, to increase the likelihood of generating and collecting rich data, a critical aspect was to obtain the perspectives and needs of both employees and managers (Baum, 2006).

The figure:[6] below depicts cycle two of PAR and where a further set of 4 focus groups were instigated that engaged with 32 managers from across the organisation.

Figure 6- PAR Cycle 2 Flowchart (Managers)



[Source: Adapted from Vaughn et al., (1996)]

7.21 Promoting Focus Group Participation (Managers)

Unlike cycle one, the call for recruitment to the manager focus groups was achieved through a poster campaign, displayed in the corporate buildings.

In addition, and aligned with the employee recruitment programme, the organisational health and wellbeing champions assisted by promoting the call for manager participants through a range of mechanisms that included service and team newsletters, email groups and meetings.

I accepted that due to the variants across the organisational management hierarchy the recruitment of managers would not be as straightforward as the employee groups, although I had an added advantage because of my professional position within the organisation. My job role had offered me the opportunity to further promote and recruit participants through a range of management contacts and teams, who in turn further promoted the opportunity to take part within their own management teams and hierarchies. The promotion activities proved to be fruitful with forty-six managers from across all levels within the organisation coming forward and registering interest, thirty-two out of the forty-six took an active part in the focus groups.

7.22 Purposive Participant Selection (Managers)

For this study the manager participants were purposively selected from the same management tier across different occupational groups in order to represent the occupational diversity (Kreuger 1994, Ritchie and Lewis, 2003, Morgan, 1997). This involved selecting participants from 3 grouped management grades that spanned across at least ten out of seventeen different occupational groups. Whilst I accepted that heterogeneous groups could produce interesting discussions for effective management discussions to take place, I purposely selected managers who did not typically work together to optimise cross-organisational discussions of the topic under study. In addition, the participants in the manager groups were at the same tier of management within the hierarchy, mixed occupational job roles and geographically spread across a large county. In addition, this provided an opportunity to create a community of management practices that would contribute to organisational change.

Furthermore, the selection process aimed for the manager groups to span all departments across the organisation and where the participants offered the possibility of facilitating organisational change that would not have necessarily

occurred if sampling were limited to one occupational group or if a different sampling were to be used i.e., a survey.

Table 6- Manager Focus Group Screening Criterion

<table>
<tr><td colspan="2">Manager Cohort Focus Groups Participant Selection

The sample Population – all those directly employed by the organisation</td></tr>
<tr><td>Inclusion Criteria</td><td>Exclusion Criteria</td></tr>
<tr><td>>18 years of age</td><td><18 years of age</td></tr>
<tr><td>An organisational manager at tier 2,3,4,5 or 6</td><td rowspan="2">School managers were not included because many are no longer local authority maintained and are employers in their own right for example, Academy or Independent Schools</td></tr>
<tr><td rowspan="2">Preferable that they had:

▪ experience of managing those with a CMHP and/or
▪ they had personally been medically diagnosed with a CMHP</td></tr>
<tr><td>Managers from the local authority owned arms-length companies were excluded as they are employers in their own right for example functions such as the airport, care providers and highways maintenance</td></tr>
<tr><td colspan="2">Management Focus Group Composition

The managers were grouped together into 3 overall levels of management (strategic, transformation and transactional) that were representative of the span of management influence across and within the organisation.

This promoted the horizontal (transformational) and vertical (transactional) influences of organisational change.</td></tr>
<tr><td colspan="2">▪ Tier 2/3 Managers represented a more strategic level who were essential in driving forward organisational policy and change in relation to common mental health problems in the workplace.
▪ Tier 4 – (transformational) Middle managers that influenced others in order to achieve organisational change
▪ Tier 5/6 (transactional) supervisors and team leaders managers who were closer to the research problem through day-to-day interaction with staff, providing of views at a practical level, their understandings and exploring what barriers that they face.</td></tr>
</table>

7.23 Data Collection – Managers Focus Groups

Following the manager participant recruitment and selection, the second cycle of PAR [Figure:5] proceeded to engage with a further four focus groups that consisted of thirty-two managers, supervisors and team leaders, who were operationally defined as employees that have a supervisory or management role for other employees and/or teams. The participants had been purposively selected from across a range of organisational departments and were crucial in providing the data in relation to the relationship dynamics between employee-manager and manager-employee. Furthermore, this allowed for systematic engagement with each group to explore the research questions in depth (Vaughn, et al 1996, Barbour, 2005).

Based on their job role and being constantly mindful of managers' time constraints, I replicated the procedures employed in the employee groups with six to eight participants within each group and lasting one hour. In addition, the manager focus groups were held at a range of familiar, easily accessible and where possible, neutral venues with minimal commuting distance. However, a slight difference between these and the employee groups was that the manager groups were held over a longer period with sessions being held over the course of four weeks. This catered for the wide variety of management roles and a range of dates and times were offered which attracted a good level of participation. Furthermore, the selection process had been more challenging than the employee groups, were managers being situated within three hierarchical management groups across the organisation I needed to ensure that each participant had commonalities in that they were operating at the same tier as other group members. Therefore, the groups were not a mix of hierarchies but purposely sampled and selected due to their operational, middle or strategic manager status. Moreover, this approach allowed for common understandings, and they were able to relate to each other as they were 'talking the same language' and in a safe environment.

To overcome potential obstacles, in terms of availability and time pressures, I provided first and second choice dates and times which allowed me to effectively enact the purposive sampling. However, being the insider researcher proved to be of critical benefit, particularly where my in-depth experience and knowledge

of the management structures allowed for the selection of managers from across the organisation that ensured similarities amongst the participants to facilitate open, honest and trustworthy discussions to take place and avoiding conflict. As discussed earlier in the previous chapter (5) one of the challenges that I faced with the manager groups was the potential for 'power struggles' to emerge during the discussions. However, it became clear that this issue did not cause a problem and due to their similarities within the management hierarchy thus resulted in lively and honest discussions amongst the participants within each of the groups.

It was clear from the discussions that the managers at all levels felt that their voices were not always heard, particularly when managing individuals with CMHPs. At times the discussions had started to veer off track prompting me as the researcher to interact to keep focus and avoid complete diversion from the subject under discussion. It was surprising how enthusiastic that the manager groups were, which resulted in deep and detailed discussion of the research problem in addition to highlighted an issue that some managers felt that their views were often under-represented within the workplace hierarchy.

Notably, the manager group discussions had begun to contemporaneously assess problems that they had faced not only with employees that they managed but reframing their own personal lived experiences. Being akin to Schon's (1983) model of reflection-in-action, this had triggered an unexpected opportunity for them discuss and learn from their experiences, thus making a shift from their fixed views which provided the potential for the development of new approaches (Raelin & Coghlan, 2008).

Furthermore, the manager focus group forum allowed for them to engage in open and honest exchanges in terms of their experiences of CMHPs and early interventions. Moreover, the manager groups had progressed more smoothly than I had initially anticipated, where the participants had naturally developed relationships with others with whom they had not previously associated with.

As noted in cycle one, data analysis commenced simultaneously to the data collection.

7.24 Data Analysis

The data analysis for the manager focus groups followed the same process as previously outlined in cycle one [Figure:5]. The detailed description of the data analysis is provided in section [6.10] below.

7.25 Reflection, Review and Iteration (Managers)

As previously noted, owing to ongoing restructures and time constraints it had again proved difficult to convene further face to face meetings particularly with managers. However, they had agreed to utilise the digital method of confidential email discussions as employed in cycle one, although unlike the employee groups the manager discussions spanned just two weeks, were more succinct and totalled over twenty email exchanges. I then set out to capitalise on the iterative cycles of PAR and presented the initial constructs from the data to the manager participants in order for them to review and reflect on the initial themes and categories. The participants were asked if they agreed or disagreed with the themes and categories presented and if they provided an authentic representation of their experiences and practice, whilst identifying if the data required reframing and reconstructing. Furthermore, the data analysis unmasked some interesting categories and themes that were not too dissimilar to those that emerged from the employee focus groups. As previously noted, the employee focus groups had identified five themes. However, following the reflection and review cycles of PAR it had become clear that the constructed themes had overlapped and become interconnected and were consequently reduced to three. In turn this provided the basis for the potential for transformation, change and improvement to management practice thus further contributing to the research question of '*how early is early'?*.

The diversity of the occupational functions across the focus groups had provided multiple realities and sensemaking from a wide range of management situations (Schwandt, 2005). Surprisingly, whilst moving through the PAR cycles the participants from across a variety of professional teams had become cohesive and committed workgroups that brought together the generation of rich data, review and reflection into action (Kemmis & McTaggart, 2007, Koshy et al., 2010). Many of the manager participants had shown their passion for being

given the opportunity to help drive action for change. Although, not all participants shared that passion, as some showed some scepticism and others had been more questioning, however, the different points of view allowed for the debate to naturally evolve into further detailed discussion which in turn provided useful rich data (Kitzinger, 2005, Barbour, 2005, Cornwall & Jewkes, 1995). An interesting development was where one group that consisted of senior managers concluded that they would like to continue to meet in a similar group following the study. They felt that this would allow them to discuss and exchange general management experiences and ideas in addition to helping them to learn from one another in a safe space and within the social context of the workplace.

7.26 Grounded Theory Analysis (GT)

As previously discussed, the GT approach that I took for this study was not designed to be an exemplar of the method. My rationale for applying the principals of GT was to ensure that there was an open, transparent, iterative and systematic approach to the data analysis. Furthermore, GT combined with PAR allowed for a process of simultaneous data collection, analysis and reflection. The iterative principles of GT allowed for checks to be made by the participants on the emergent themes and concepts thus contributing to its originality, by offering new insights and a fresh conceptualisation of the recognised problem of early workplace interventions for CMHPs. In addition, the application of GT principles linked with PAR, contributed to and informed an action for change process in terms of workplace policy and practice (Charmaz, 2020).

Being a qualitative researcher, my interest had been rooted in social discourse amongst the focus group participants that provided 'thick' descriptions of the phenomena under study theory (Gibbs, 2007, Flick, 2007). One of the defining characteristics of applying the GT principles of analysis was that through inductive analysis, it focused on the creation of categories, themes, sub-themes thus resulted in the development of the theoretical model (Charmaz, 2006, Charmaz, 2014). Moreover, the principles of GT analysis offered a method that explored participants social constructions of '*how early is early'* when instigating 'early' workplace interventions for CMHPs which employed the principles of the social constructionist GT approach of Charmaz (2006, 2008, 2014). Firstly, the approach sat comfortably alongside the iterative cycles of PAR and my

philosophical positioning. Secondly, my belief was that theory is constructed by the participants and myself as the researcher, as opposed to being discovered.

Being in contrast to other methods such as Glaser (2002) or the Straussian (1998) approach that tends to be structured and employing a set of prescriptive or methodological rules, the method employed a set of flexible guidelines, principles and practices. This allowed for me to be reflexive and responsive to any emerging questions, insights or information in relation to the phenomena under study. Moreover, as the researcher and being part of the subjective situation afforded me the ability to see the world from the participants viewpoints and to understand how the participants construct their worldviews (Charmaz, 2008, pg.403).

Although there are multiple approaches to GT, for this study I implemented the basic GT principles and guidelines such as coding, memo-writing, and used comparative methods (Charmaz, 2006). A systematic approach of thematic analysis in the context of GT was employed, additionally, being an exploratory study, the analysis had been content driven where the codes, themes and sub-themes were derived from within the data and were not pre-determined.

I fully acknowledged the frequent criticisms of qualitative data analysis techniques and the risk of inherent researcher bias and prejudice; the iterative cycles of PAR therefore became critical to the data analysis. My belief was that through participant validation throughout, the iterative action and reflection cycles of PAR thus strengthened the emergent themes. In addition, the combination of PAR, and the grounded theory approach thus identified how the patterns connected and related to each other and consequently resulted in the development of the themes and sub-themes. Furthermore, to ensure quality in the data analysis the systematic process of grounded theory coding had been applied and where the themes that emerged from the coded data led to the construction of the resultant theoretical model.

7.27 The Interface between PAR & GT

The combination of PAR and GT provided a strong interface and methodological overlap that in turn complemented each other. The combination provided the ability for the data collection and data analysis to be applied in a flexible and

responsive way where each provided valuable contributions to the findings of this study. Notably, the repeating cycles of PAR – planning, action and reflection were deemed to be in parallel with the constant comparison method of GT thus enhancing one another (Dick, 2007, Manuell & Graham, 2017, Azulai, 2021, Williams et al., 2022). Furthermore, recent literature suggests that the combination of PAR and GT has greater crossover with the more recent iterations of GT as opposed to its traditional predecessors (Azulai, 2021).

Additionally, both PAR and GT were committed to the development of theoretical understandings that are grounded in practice-based evidence, with each having been focused on the contextual conditions of the social phenomena under study (Charmaz, 2006, Dick, 2007). Moreover, an important principal had been that both PAR and GT empowered the participants to share their life experiences, where they were the owners of the socially constructed the data, and the three overarching emergent themes, and the resultant theoretical model (Charmaz, 2005).

The table below illustrates the interface between PAR and GT and how the two enhanced each other.

Table 7: The Interface between PAR & GT

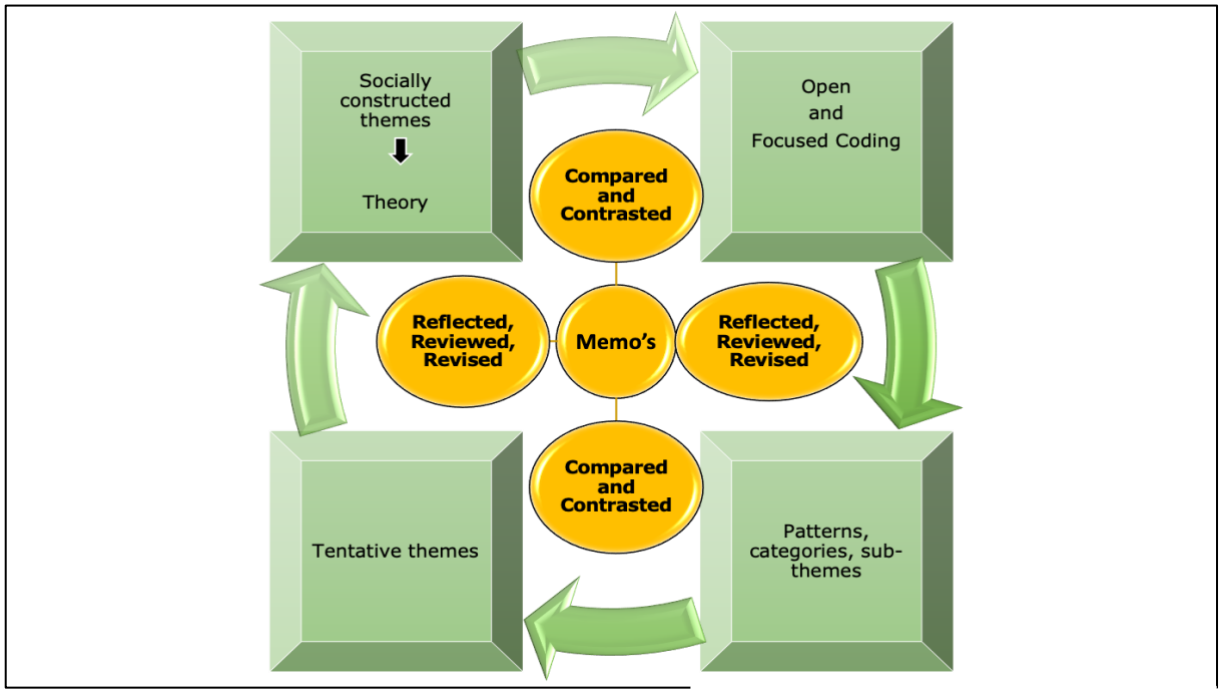
Participatory Action Research (PAR)	**Principals of Grounded Theory (GT)** ***Applying the principles of Charmaz (2005)***
▪ PAR aimed explore the research problem with a view to action change	▪ GT aimed to develop theory grounded from within the data in order to inform the change identified in the PAR process
▪ Researcher, participant and stakeholder interest in exploring and understanding social phenomena with a view to action change	▪ The research question led to the exploration of the social phenomena under study
▪ PAR lent itself to a wide ranges of methods – focus groups were the chosen method of data collection	▪ GT allowed for the use of focus groups ▪ Allowed for knowledge to be socially constructed and analysed alongside literature review
▪ Cyclical and iterative process	▪ Repeated cycles
▪ Data collection	▪ Data analysis
⇒ Inductive data collection and analysis ⇒ Codes, categories and themes drew on GT principals of analysis ⇒ Participants contributed data and checked researcher's interpretations	
▪ Qualitative experiential data informed the data analysis, themes and resultant theory. Informed action for organisational change.	▪ Themes were generated from the data which linked together to provide the wheel and spoke theory. ▪ The findings explained the 'how early is early' research question and informed the action for change within the organisation
Review of literature during data collection and analysis helped develop more accurate understanding of the research topic	
Builds on previous academic literature	
Table adapted from Bradbury (2015) and Creswell (2013)	

7.28 Implementing the Principles of Grounded Theory Analysis

As previously discussed, I had not intended the analyses to present an exemplar of GT. Although, there are multiple approaches to GT, for this study I used the basic grounded theory principles and guidelines such as coding, memo-writing, used comparative methods alongside of reviewing the literature (Charmaz, 2006). The steps taken in the analysis had been a systematic approach of thematic analysis in the context of GT. The focus group data having been fully transcribed, I familiarised myself with, organised and coded, combined and grouped the data which became the building blocks to development of the themes and sub-themes. The cycles of analyses thus led to the construction of the theoretical model whilst I continued to compare and contrast against existing and new data.

Depicted below is an outline of the four phases that I took for the data analysis [Figure: 7]. In the following sections I present the practical process of the data analysis whilst employing the principles of grounded theory that blended with the cycles of PAR. A point note is that although the review of the literature had commenced at the start of the study and reviewing what had been done before, the literature review had been reviewed and revised and continued throughout the cycles of PAR and the data analysis.

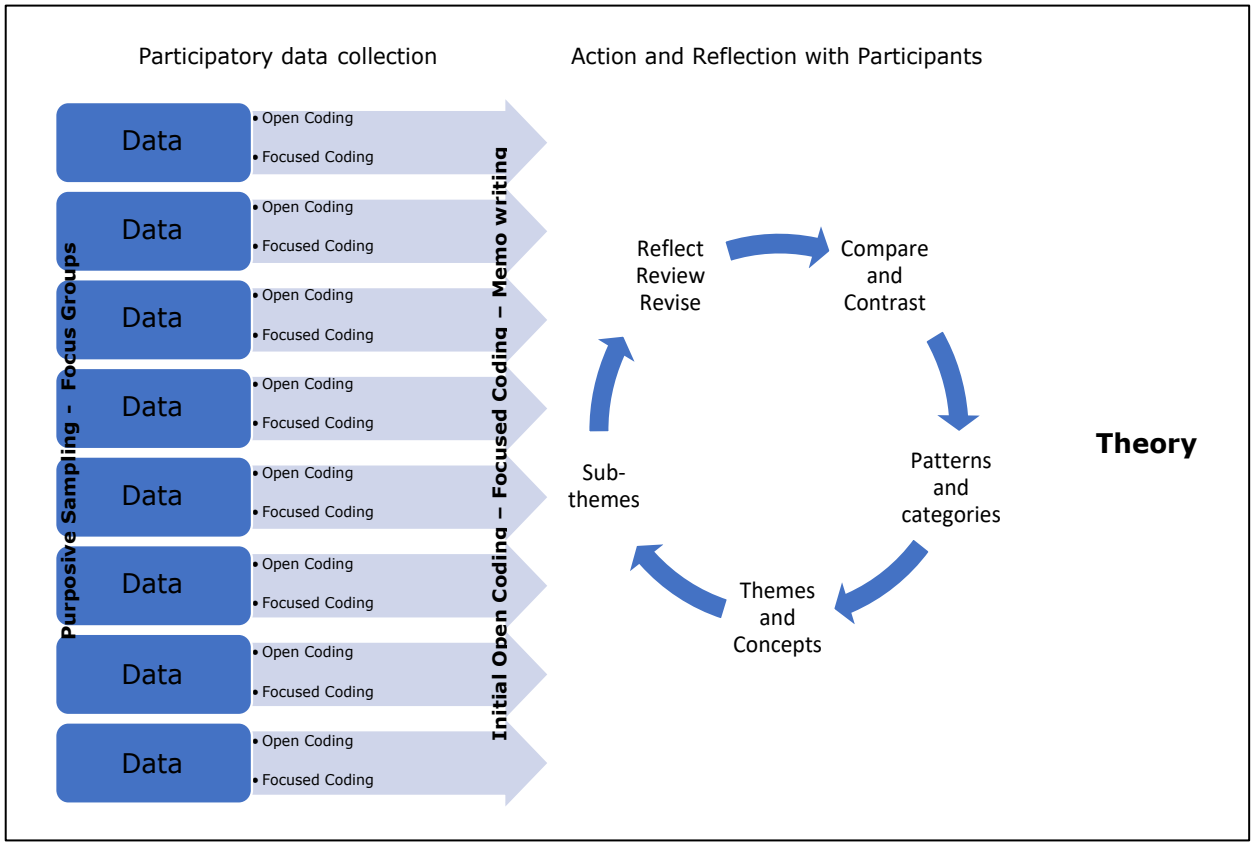
Figure 7- Four Phases of Grounded Theory Analysis



[Source: Adapted from Charmaz, 2006]

As previously noted, the discussions of the eight focus groups (four employees and four managers) had been digitally recorded, secured, uploaded and transcribed verbatim utilising NVivo 11 & 12 software (QSR International, V:12, 2018). Once transcribed, I read and re-read the transcripts and narratives and commenced the first stage of exploring and coding the data as shown in [Figure: 5]. I began the initial coding process and developed the code book from the large amount of raw data and where I logged and kept track of the coverage and the density of the coded references as shown in [Appendices 7 & 8]. As the process of analysis continued, the constructed codes, categories, themes and sub-themes were linked back to the research questions. Following this the iterative process of review and reflection of the emerging themes and sub-themes with the participants took place which subsequently aided the construction of the resultant theory [Figure: 8]. Moreover, my priority was to ask analytical questions of the data that I had gathered. Not only did this develop my understanding of the shared views and experiences of the participants but had also been the driver for the identification of gaps, nuances or anomalies in the data that facilitated subsequent data collection where necessary (Charmaz, 2006).

Figure 8- Practical Stages of the Data Analysis



[Source: Adapted from Charmaz, 2006]

The following sections describe in more detail the steps taken during the data analysis.

7.29 Initial Open Coding

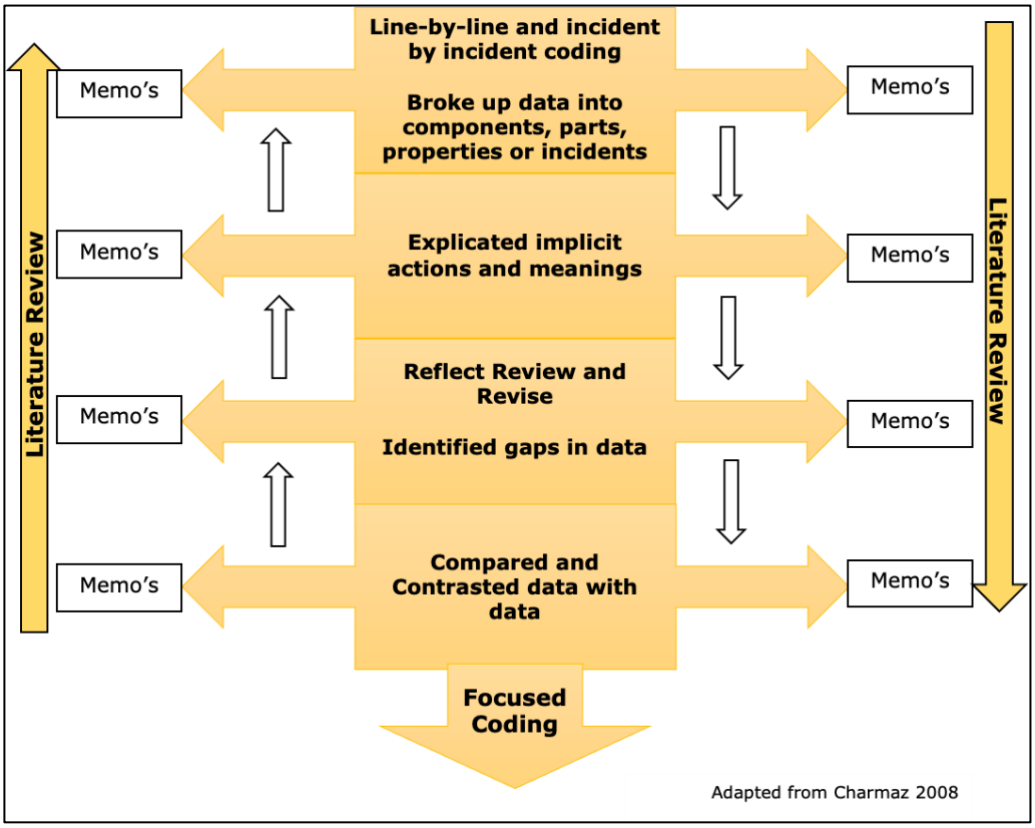
Being a pivotal link between the data collection and developing an emergent theory from the data, the coding of the data was the first analytic step that provided the building blocks for me to make analytical interpretations of the data collected (Charmaz, 2006). I enacted the sorting and the breaking down of the data into discrete parts and where a process of concise coding took place, I started with open coding the data in a line-by-line, sentence-by-sentence and incident-by incident procedure (incidents in this study means identification of negative and positive situations or experiences). I moved swiftly through the initial analysis and focused on words, actions and gerunds which led me to construct precise, short and simple codes. The focus had been on what was jumping out at me, what grabbed my attention and what warranted further

exploration in order to link and relate the codes to meaning (Strauss & Corbin, 1990, Miles & Huberman, 1994, Charmaz, 2006, Gibbs, 2007, Saldana, 2009, Miles, Huberman & Saldana, 2014, Glaser, 2014, Charmaz, 2015). However, amongst the data not all of the coding was obvious which is where deeper exploration and the re-reading of the transcripts proved fruitful. For example, comparing incidents and coding gerunds helped me with obtaining the sense of 'action(s)' and 'processes' from within the data as did the comparison of incidents (Glaser, 1978, Charmaz, 2006).

Remaining open minded I stayed close to the data and where the initial open coding had been grounded in the data transcripts and data interpretation. I had also compared incident-by-incident in order to look for patterns, similarities and differences in participants experiences, whilst asking questions of the data such as 'what is happening here?' and 'what is the data telling me?' (Holton, 2007, Bryant & Charmaz, 2007, Glaser, 2014, Charmaz, 2015).

As the analysis continued to develop, I started comparing data with data in order to focus my analytical thinking on to constructing codes that reflected the participants experiences and not my theoretical presuppositions. I continued the cycle of asking questions of the data such as 'what are the participants 'stories' telling me?' and 'what are the main concerns of the participants?' (Glaser, 1998). In addition, I also found that the writing of memos and descriptions helped generate further codes to ensure that nothing was missed or left out. Furthermore, I had acknowledged that some of the initial codes had become active and replicated across various topics within the data (Glaser, 1978, Charmaz, 2006). The initial data coding separated and developed the data which provided the analytical direction, reduced the codes down and in turn instigated the second stage focused coding process (Glaser, 1978, Charmaz, 2006).

Figure 9 – Open Coding Process



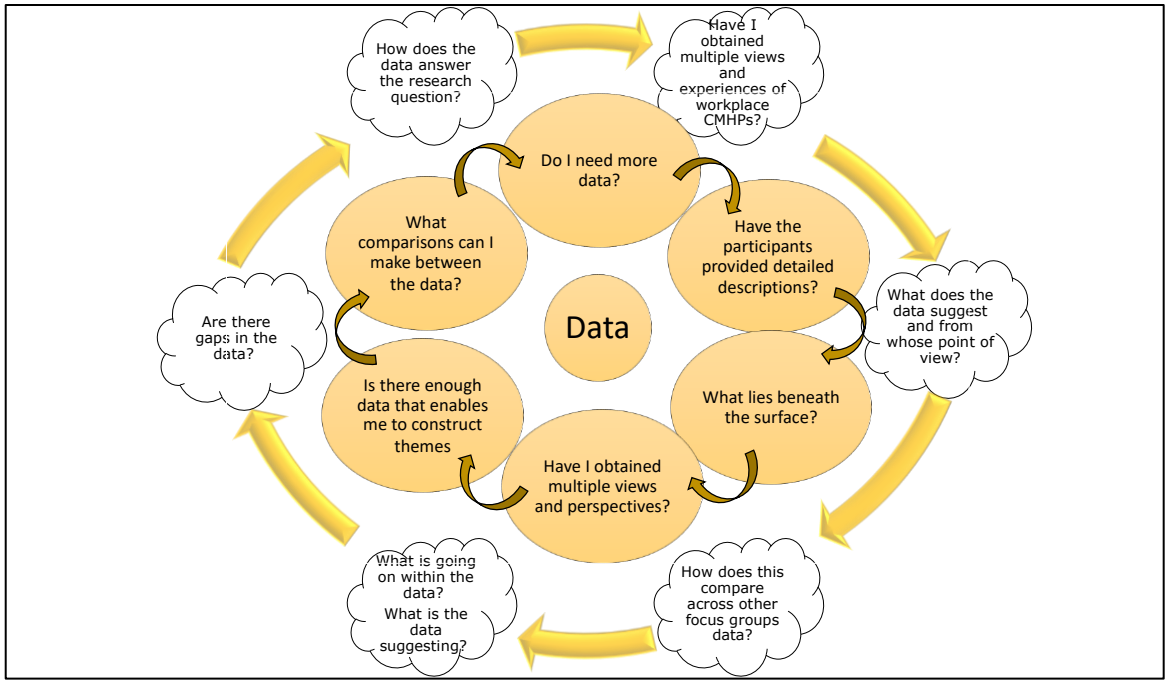
Before moving on to describing the focused coding process, it is important to discuss memos and how these had woven together the codes in order to clarify and understand what was happening within the data that allowed for the review, reflection and revision (Charmaz, 2006).

7.30 Memos

I proceeded with memo writing in tandem to the data analysis. This was a pivotal and intermediate step between the data collection and writing up the findings (Charmaz, 2006, Glaser, 1998) that prompted a process of reflection on the initial open and focused coding and how the emerging patterns, themes and sub-themes were being shaped thus fitting the pieces of the puzzle together in order to complete the full picture. The coding and analytical memos had not been a standalone process but were part of the concurrent analysis activities and where there was a '*reciprocal relationship between the coding and the understanding of a phenomenon'* (Weston et al., 2001, pg.397, Salanda, 2009). The analytic memo writing had been a useful tool that triggered critical and deeper thinking, thus enabling the asking of further questions of the data,

comparing and contrasting, connecting data with data and identifying gaps (Salanda, 2009). Memo writing provided an additional advantage and being a non-linear transitional process continued to further prompt new ideas throughout the cycles of PAR as shown in [Figure:10] below.

Figure 10- Memo writing Process

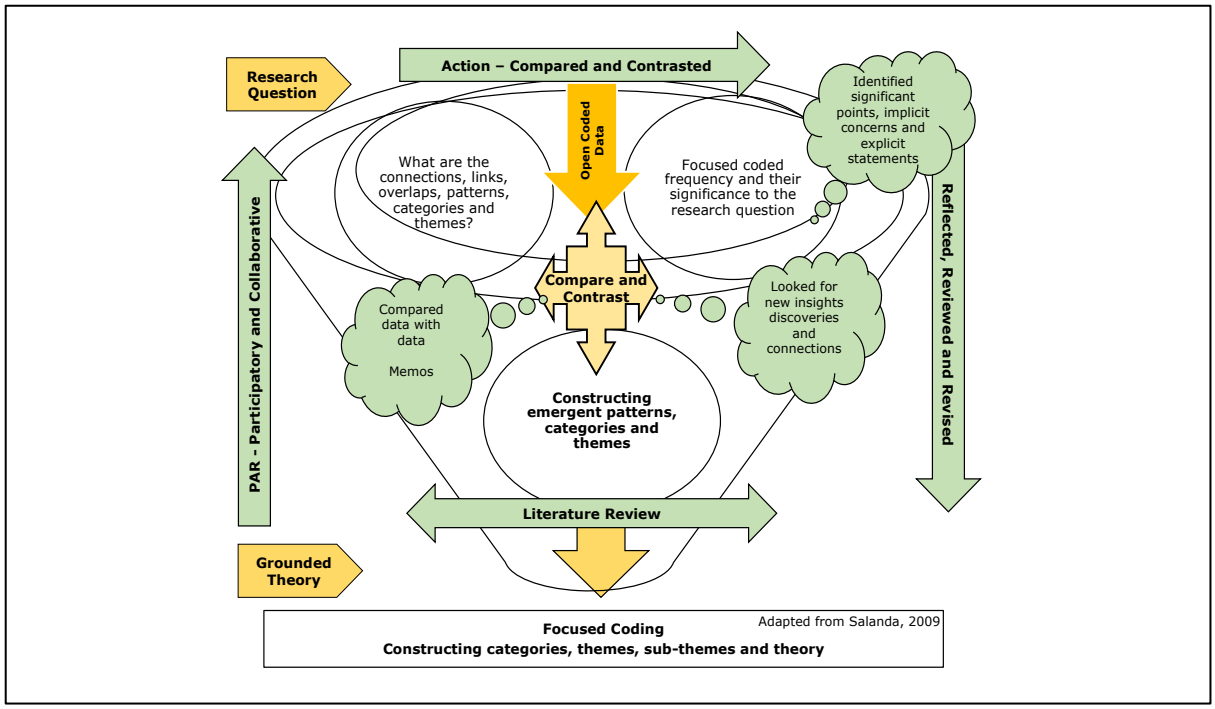


Memo writing focused on specific events, acts and behaviours (positive and negative), workplace practices, and tactics, and included workplace relationships and constraints which led to the emergence of the themes from within the data. These were then refined and revised through two iterative cycles with the focus group participants which in turn formed a fundamental element of the data analysis and PAR (Gibbs, 2007). Presenting the initial tentative findings to the participants enabled them to review and reflect and sought to identify any variations, gaps, agreements or disagreements within the emerging themes and concepts. In addition, the iterative process provided encouragement and reassurance that the analysis had not deviated and gave a true representation of the participants experiences and meanings that were grounded in the data.

7.31 Focused Coding

Focused coding being the second major phase in grounded theory analysis required a more direct and selective approach than open coding. Figure [11] below depicts the focus coding process and outlines how this progressed.

Figure 11- Focused Coding Process



During the inductive focused coding stage, I sifted through the most frequent and significant codes from the initial coding combining them to develop focused codes. Defining their properties and dimensions I continued with the constant comparison process, compared data with data to identify gaps and moved on to developing tentative preliminary categories, themes and sub-themes (Charmaz, 2006, Salanda, 2009, Holton, 2007).

However, this was not a linear process where I found that some participants views and experiences became clearer when I revisited and explored the transcripts in-depth. Undertaking this procedure thus led to the identification and crystallisation of significant points based on thematic similarities and the discovery of implicit concerns and explicit statements (Charmaz, 2006). Furthermore, to assist with the intensive and immersive reading I focused my analytical thinking through the application of further memos and applied the basic questions of "*what is going on*?" "*what is being said*?" "*what do these*

actions and statements take for granted?" and "*how does the context serve to support, maintain, impede or change them*?" (Charmaz, 2003, pp.94-95, Gibbs, 2007). The memos, comments and questions had enabled further development of the focused codes which further constructed and substantiated the emerging categories, themes and sub-themes (Gibbs, 2007). At this stage, I was then able to link and connect back to the research question and the overall aims and objectives (Gibbs, 2007, Holton, 2007).

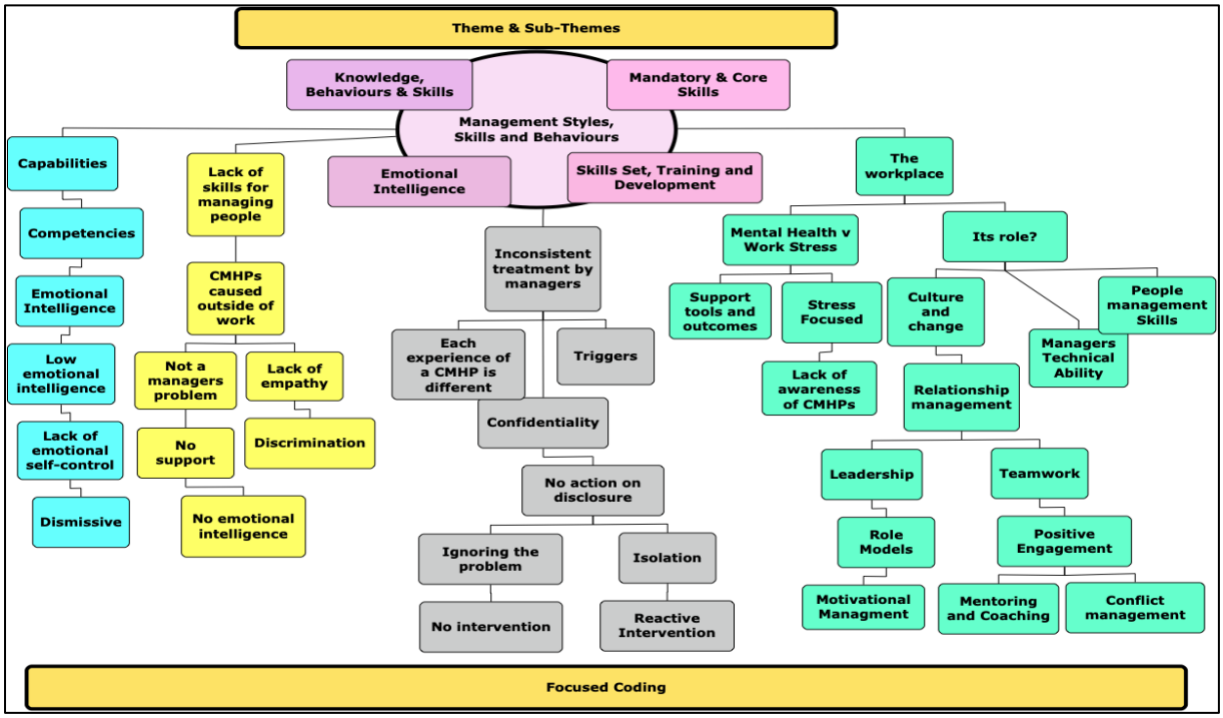
The blending of PAR and grounded theory had been advantageous where the research had drawn on focus group participants to construct in-depth versions of their views and experiences in a social context. Secondly, my decision to code the full focus group transcriptions as opposed to simply coding from focus group notes provided me with an in-depth understanding of participants experiences, views and realities in terms of CMHPs and early interventions.

In addition, PAR and grounded theory had facilitated the iterative, reflective and clarification process which allowed for participants to review, reflect, confirm or challenge the emerging themes and concepts. In order to enable transparency and ensuring that my analysis had accurately reflected their described experiences, narratives of their own words were used when presenting back to the participants in order to explain their subjective views and experiences alongside the developing themes and theoretical constructs.

As previously noted, NVivo 11 & 12 software (QSR International, V:12, 2018) had been utilised to assist with the data transcriptions and the analysis. An example of the focus code mapping for the theme and sub-themes which became management styles, skills and behaviours is illustrated below. The data from the initial coding had been searched for excerpts for frequency, connections, links, overlaps, patterns and their significance to the research questions. I had kept my mind open to 'expect the unexpected' that allowed for me to discover new insights and connections that emerged from the data. These inductive cycles continued alongside the PAR cycle where the focused codes had started to develop the themes and related sub-themes, an example of this is shown below [Figure:12]. The more detailed coding charts and examples of

NVivo 12 hierarchal coding charts that had been developed during the data analysis can be found in appendices [7 & 8].

Figure 12: Example of Focused Coding Mapping



As the focused coding further developed alongside the iterative reflection and constant comparison process it became clear that no further information or data was forthcoming, thus confirming theoretical completeness otherwise described as 'theoretical saturation' (Glaser, 2001, Holton, 2007).

7.32 Contrasting and Comparing with Organisational Data

In social sciences, triangulation is generally used to collect data from multiple sources in order to firmly compare and contrast the themes emerging from within the data (Melrose, 2001). Triangulation was not employed in this study because data analysis verification had been carried out throughout the iterative cycles with the focus group participants themselves.

No quantitative data had been used for comparison, but in tandem with the focus group data gathering I continued to review organisational policy and procedures and qualitative data from the study site and reviewed as a secondary data source in order to promote rigour, acceptability and integrity of emerging

themes from the focus groups (Carnwell & Daley, 2001). As part of my job role, I was also given access to other organisational surveys that had touched on mental health and wellbeing of the workforce. The emerging themes from the focus groups were used as a framework to re-review findings from the survey data that had been made accessible to me. This included reviewing qualitative data from a health, safety and wellbeing climate survey (*n=130*), an employee relations case study report and an all-workforce survey (*n=3,864*) and where I found data that supported the emergent themes within this study.

It was interesting to note that the study organisation had also compared the workforce survey data with a similar 2018 cross public service survey that spanned across one hundred and two government departments and functions with (*n=302* respondents). The critical reflection accords with the process of PAR and allowed for a deeper understanding of the approach to mental health and wellbeing from both the focus group participants and from those within the wider organisation. For confidentiality and data protection reasons, I am unable to publish the data in this study. However, the approach facilitated collaboration with the organisational 'data owners' who became an accessible group of professional officers who offered me a sounding board with whom to reflect on the categories and themes emerging from the study data but more importantly checked authenticity and relevance of them.

When combined across manager and employees, the qualitative data sets provided a rich understanding of the research problem which reduced potential weaknesses that may have arisen from using a single study site (Babbie & Mouton, 2001). In addition, PAR and grounded theory analysis facilitated the ongoing iteration of emerging themes over the life of the study thus informing the action process of the PAR cycle. Furthermore, the implementing of this strategy led to a deeper understanding of the problem and allowed for a point of comparison to ensure greater data validity and justification of knowledge (Denzin & Lincoln 1994a: 5).

Summary

As both cycles of PAR progressed it became clear that the categories and themes from within the data had begun to entwine and overlap. As noted initially, five

themes emerged, however these were revised following the manager focus groups in cycle two. The revised themes were presented back to both cohorts of focus group participants where a general agreement had been obtained as to the themes and sub-themes. Furthermore, when revising and refining the themes and sub-themes they had become an interconnected wheel which I discuss in the following chapters (8, 9, & 10). A further development occurred whilst presenting the analysis to the organisational stakeholders and where the constructed themes had caught the attention of the organisations gatekeeper who believed them to be transformational. This led to the gatekeeper agreeing that the themes provided ideas for action, improvement and change to management practices, thus further contributing to the '*how early is early'* question. The actions for organisational change are discussed in chapter 11

Chapter 8

Findings

8.1 Introduction

This chapter presents the findings from the focus group discussions and the qualitative themes that has emerged from the data. The focus groups had collectively constructed versions of their views and experiences, that helped to understand the cultures and behaviours within the organisational environment and how these may contribute to change. As previously noted, during the cyclical process of PAR it had become clear that whilst moving back and forth through data collection and analysis the themes had become intertwined and interdependent on each other. Notably, this led to the socially constructed 'wheel of themes' which is illustrated in [Figure:17] which was then developed further and became 'The Wheel and Spoke' theoretical model and is presented and discussed in chapter (11).

Chapters 9, 10, 11 presents in more detail the conversational discourse from the focus groups that supports the emergent theory.

To put the focus groups representation into context it is important to provide the occupational represents from both the employees and manager groups.

8.2 Occupational Representation of Participants (Employee and Manager Groups)

The occupational groups from across the organisation that took part in the study are presented below. The overarching occupational directorates, age ranges and gender representation is shown, although it should be noted that some participants chose not to disclose [Table:7]. The participants were drawn from a cross section of different employee and management pay grades [Table:8]

Table 8- Participant Representation

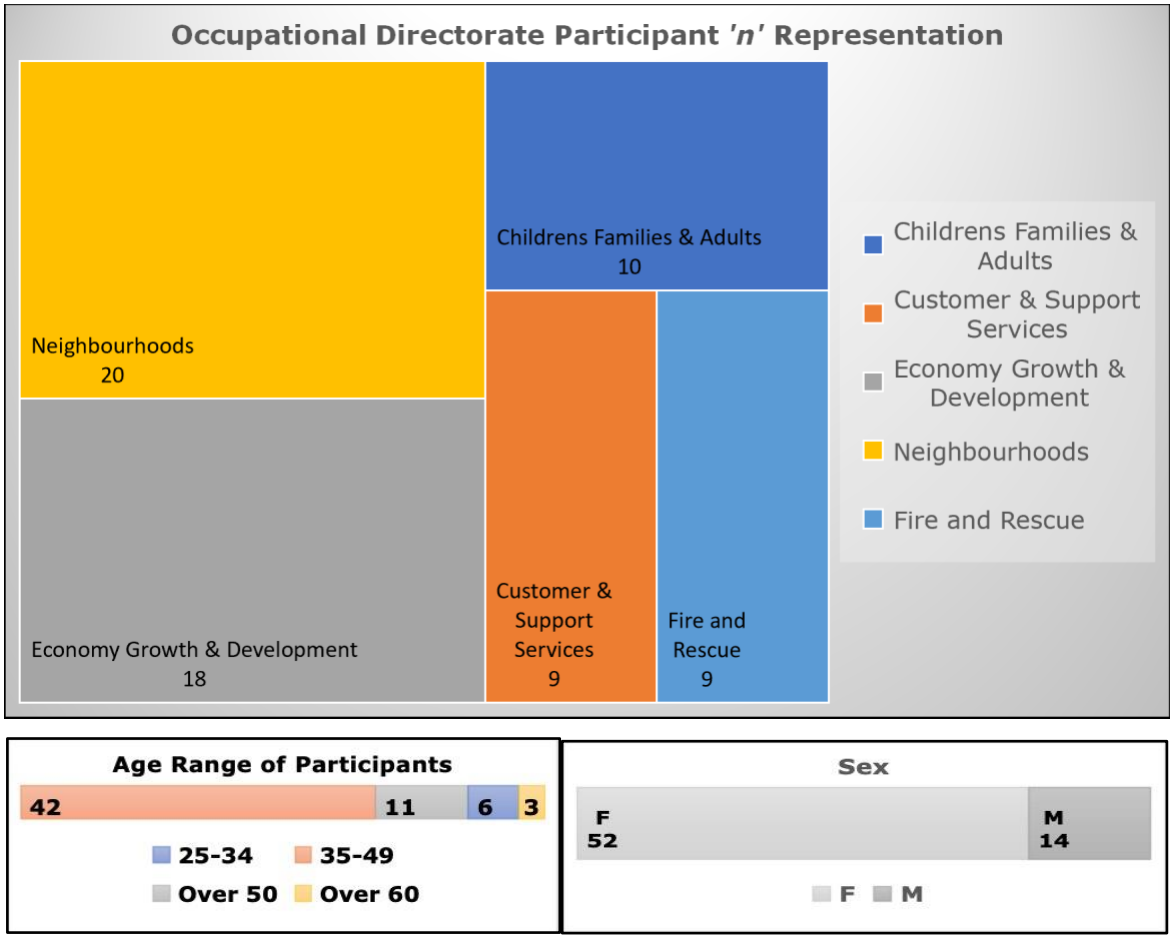


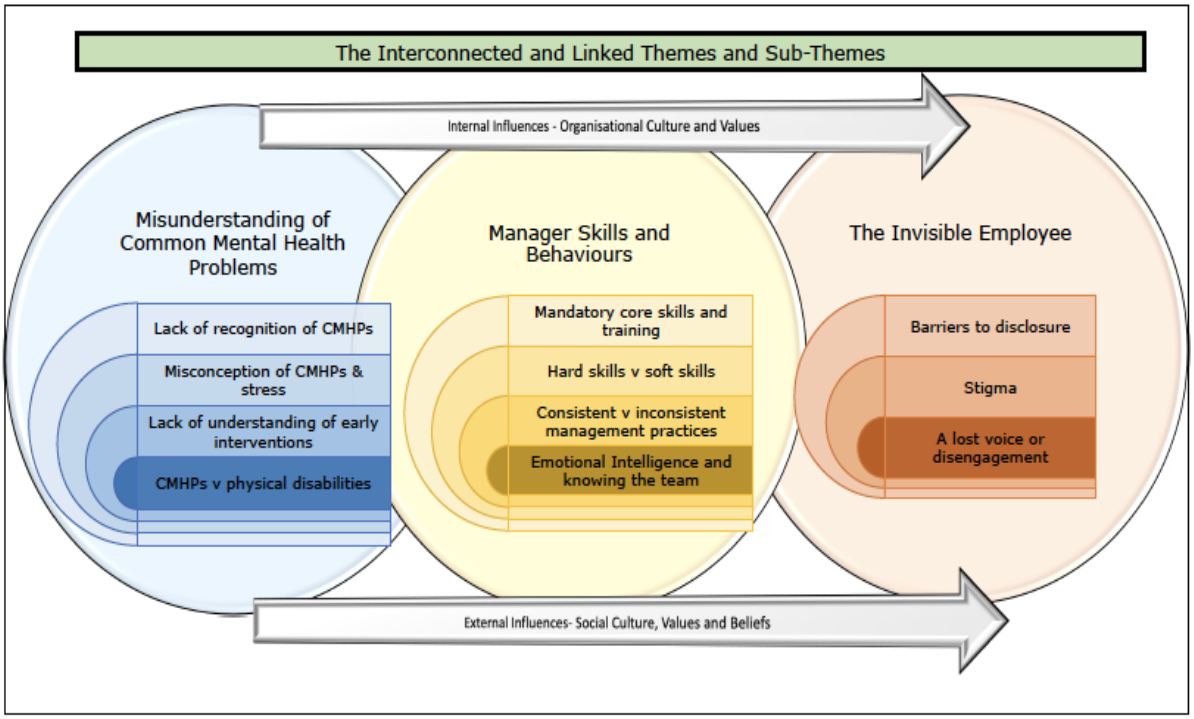
Table 9- Occupational Group Representation

Directorate	**Occupational Groups Represented**
Neighbourhoods	Environmental Health, Civil Enforcement, Environmental services (Parks, gardens, beaches, coastal paths etc.), Business Management.
Economy, Growth & Development	Planning, Housing, Economic Development
Children's, Families and Adults	Social Workers, Support Workers
Customer and Support Services	Business Support, Human Resources,
Fire & Rescue	Firefighters, Business support, Community Safety, Emergency Management

8.3 The socially constructed grounded theory – Interconnected Relationship between Themes

Figure: [13] below illustrates the results of the data analysis and the key emergent themes and sub-themes that were socially constructed within and across the focus groups. From across the eight employee and manager focus groups undertaken (*n=66)*, the data analysis revealed 3 overarching themes with 13 associated sub-themes.

Figure 13- Interconnecting Relationship between Themes



Clear evidence had emerged from across all focus groups that confirmed that barriers to intervening early exist. The three key themes that emerged from the cohorts of focus groups, were cross-cutting, irrespective of the participants hierarchical positioning within the organisation. The 'mis-understanding' of CMHPs, underpinned by poor management skills and behaviours, led to the barriers to disclosure and stigma. Notably, participants from across all groups agreed that the interrelated nature of the themes impacted on the others and invariably led to conscious non-disclosure and self-stigmatisation, thus individuals became invisible to managers.

Moreover, there was an agreement amongst the participants that the impact of these themes had prevented the identification and implementation of early

interventions at the earliest opportunity. On the other hand, there was some evidence, that where there had been a better understanding of CMHPs amongst managers, barriers were broken down at an early stage which culminated in successful outcomes for the employee, manager and the organisation.

In order to construct the theoretical model, common linkages had developed into a series of interconnected themes and sub-themes. The detailed dialogue and descriptions of the experiences and realities of individuals had socially constructed the interlocking themes and sub-themes which turned attention to social values and stigma and the organisational culture.

From the manager groups in particular, organisational culture was seen as a driver for organisational effectiveness and the orchestrating of organisational change. This was not surprising as their views were consistent with their hierarchical position within the organisation and where local government managers have been encouraged to view culture as a powerful tool in terms of the mobilisation, direction and control of organisational effectiveness and change (Sinclair, 1991). Moreover, it became clear that organisational changes were required to enable proactive and targeted early intervention strategies that would benefit the manager, employee and the organisation.

A surprising theme emerged which pertains to 'the invisible employee' and provides an original contribution to knowledge.

8.4 Focus Group and Participant Coding

As previously indicated in the ethics section of this study the ethical practices of confidentiality and anonymity were adhered to. The verbatim conversational data had been presented using codes that identify the focus group and the corresponding participant code. In order to protect the privacy of all those that took part in this study aspects of participant identity were masked and where no identifying characteristics had been used and had included ethnicity, biological sex, job role or geographical area (Allen, 2017). The table [9] below presents the codes and descriptors that were used throughout the qualitative data findings that follow in the following sections.

Table 10- Code descriptors applied in the presented data

Code		Description of code used in presented data analysis	
[EMP-FG]	=	Employee focus group and its corresponding number	1,2,3 or 4 etc
[E-P]	=	Employee participant and their designated number in the group	1,2,3,4,5,6,7,8 etc
[Manager-FG]	=	Manager focus group and its corresponding number	1,2,3 or 4 etc
[M-P]	=	Manager participant and their designated number in the group	1,2,3,4,5,6,7,8 etc
Example: ▪ Focus Group Identifier **[EMP-FG2]** = Employee focus group 2 ▪ Participant Identifier [E-P3] = Employee Participant 3			

8.5 The use of conversational quotes

The use of verbatim quotes from study participants has increasingly become standard practice for qualitative researchers (Corden & Sainsbury, 2006). In addition, there is a general consensus amongst academics that verbatim quotes are key to the data quality and where transcribed and presented appropriately clearly evidence how the findings and conclusions were derived (Spencer et al, 2003, Corden & Sainsbury, 2006).

I had chosen to use direct conversational quotes in order to present transparent and authentic citations of the participants views of the emotive subject under study (Patton, 2002, Politt and Beck 2016). In addition, the quotes provided rich and thick verbatim descriptions from the participants' discussions and in turn supported the findings and strengthened the creditability of the data (Noble and Smith, 2015 p. 35). Furthermore, I believed that the inclusion of the conversational excerpts from the data transcripts helped to demonstrate the strength of the participants' views and experiences and gave them the opportunity to express their feelings and views on policy and practices that had affected them directly. (Spencer et al, 2003, Corden & Sainsbury, 2006).

Corden & Sainsbury, (2006) suggested that little had been known about the expectations of participants and how their discussions would be interpreted and

used. I also acknowledged that qualitative data has often been criticised for having been used selectively by the researcher to support their conclusions thus affecting the creditability and dependability of the data (Guest, et al., 2012). To counteract these criticisms, the iterative cycles of PAR and the principles of GT had allowed for the participants to validate the quotes in addition to clarifying the links between the constructs, conclusions and the resultant theoretical model (Corden and Sainsbury, 2006). Moreover, owing to the complexity of the subject under study, I had used longer in-depth conversational quotes in order to illustrate the richness of the data that further deepened the understanding of the participants experiences (Corden and Sainsbury, 2006, Yin, 2011).

Moreover, the use of the conversational quotes ultimately brought the raw data to life and the voices of the participants were pivotal in the social construction of the findings and the theoretical model.

Chapter 9

Theme 1 - 'The Mis-understanding' of Common Mental Health Problems in the Workplace

9.1 Introduction

When asked what their understanding and perception of CMHPs had meant to them, the focus group participants described in detail their understanding and meanings of the term 'common mental health problem' with the discussions revealing several societal factors that both employees and managers believed led to a failure in the general understanding of CMHPs. This led me to call this theme 'the mis-understanding of CMHPs'. Furthermore, the discussion and debated narratives within the groups revealed that a good level of understanding of CMHPs by managers would be required to enable early identification and provision of support.

Throughout, the discussions captured how both employees and managers believed there were differences of understanding, opinions, perceptions and interpretations of CMHPs not only between themselves, colleagues, and managers throughout the organisational hierarchy but as reflected in society in general.

9.1.1 'Misconception of CMHPs and Stress'

The discussions initially centred on the groups' understanding of what is meant by a CMHP. The majority *[n=60]* concurred that CMHPs are often misconstrued as stress and discussed how they felt the term stress is confusing and often used as a default position by managers when an individual discloses a CMHP. The participants agreed that although stress should not be ignored, it needed to be better understood. Referring to stress masks a 'mis-understanding' of problems such as anxiety and depression as something which they are not, although these CMHPs can in turn lead to stress and vice versa.

[Q] Tell me about what kinds of common mental health problems you have experienced within the workplace as an employee?

[Emp-FG-2]

> *"Stress…colleagues have experienced...mmm...Stress…. yeah, there is a lot of emphasis on managing stress……..." [E-P3]*
>
> *"Yeah ..but I have seen that underlying issues can cause problems, and a CMHP can come from a variety of sources and is not always stress" [Ep-P6]*
>
> *"…. the thing is…. everybody is different and another thing is every single case is completely different" [E-P1]*
>
> *"Yes…. but it seems that people are not being diagnosed……. several people have said that they are not stressed and work but live with a mental health problem and do not see the need to be signed off work" [E-P5]*
>
> *"Stress …. yeah…..but you don't wait for the problem to get worse before doing something - prevention in my mind is key" [E-P7]*

Furthermore, when exploring with the employee groups what their general understanding of what the term common mental health means to them they did not refer to stress as being the most common problem *[n=8]*. Many expressed confusion around the term 'common mental health problem' *[n=20]*. Some participants felt that managers had a misconception of stress, whilst others believed that no clear understanding exists.

[Emp-FG-2]

> *"The thing is…. with mental illness there are so many different levels - stress is one thing but it could mean something different to somebody else" [E-P2]*
>
> *"Yeah….I refer to it as an invisible illness that many people do not understand" [E-P1]*

"….mental illness is not taken as seriously as a physical disability…..I feel that there is a lack of understanding by employers" [E-P2]

"Yes, I agree with that" [E-P3]

"Well…. it is someone who is diagnosed with some form of either depression or other diagnosis that incorporates it…..it can be a range of things…..managers just think it is stress" [E-P6]

The employee groups talked about anxiety and depression and agreed that it can exist in the absence of stress. Moreover, they reported that whilst they may be struggling with anxiety or depression they would not necessarily be 'stressed' by the workplace environment. Some employees went on to suggest that managers do not understand CMHPs and tend to use stress as a default position.

When the same issue was discussed amongst managers the responses from across all four groups were consistent with the employee groups assumptions. The manager groups agreed that there had been a continuing focus on stress with the workplace environment commonly attributed to being the cause of stress. In addition, some suggested that the problems with stress have often been driven by a range of avenues such as government, legislators, academics and organisational practitioners alike. Notably, *[n=27]* of managers had cited stress as being the most common mental health problem as evidenced by the groups excerpts below:

[Manager-FG1]

"The pressure of working I suppose and in terms of common problems for me, is stress overload and then how that might lead on to depression" [M-P4]

"Yes, I agree because people are feeling that overwhelming pressure. For me I think common problems that stand out to me would be stress and depression" [M-P1]

"Yes……but it's also how those people are also feeling on the day. You know, one day they might be able to cope with it and another day they might not" [M-P6]

"Mmmmm….some people can cope……but stress overload and how that might lead to depression and then isolation??…….mmm" [M-P1]

"Yes, that is a good point as those things affect people in different ways…." [M-P3]

The debate continued where managers linked CMHPs to stress and where there appeared to be little understanding that stress, anxiety and depression can exist independently of one another and where stress can aggravate a long standing CMHP.

[Manager-FG2]

"Umm….mental health, we don't really know what the term means, what the implications are, we don't know how to identify it, how to treat it, it just sometimes becomes a bit of an issue, whether it's labelled as stress or something else isn't it?" [M-P3]

"yeah…. we've got a chap who's had a lot of leave, its stress that he's signed off with, but I think it's severe anxiety, I think they are linked anyway aren't they?" [M-P6]

"Yes, and if you are stressed you are going to show heightened anxiety anyway" [M-P1]

"I think there is depression and anxiety that is underlying it all …….and the doctor just puts stress on a sick note…. the thing is as a manager you might be missing those underlying other causes" [M-P2]

[Manager-FG3]

"Most people would call it stress I imagine" [M-P1]

"Yeah, I agree and think that that stress is the most common thing that we, as managers, identify with, but whether or not that is the most common problem, I am not sure" [Man-P5]

"…….it is stress isn't it?" [M-P3]

[Q] "Is that a general consensus in the room?"……..YES!

The discussions had proved insightful where managers tended to identify CMHPs with stress. Managers confirmed that although they interacted with employees on a regular basis and were familiar with the job roles of their employees, there continued to be a lack of knowledge and understanding of the concepts of stress, anxiety and depression and how to differentiate between them. Managers highlighted that the terms stress, anxiety and depression were often used interchangeably which led to further confusion. Furthermore, managers highlighted concerns that general practitioners often signed individuals off work sick citing 'stress'. However, some managers questioned whether 'stress' could indeed be masking an underlying issue and could they as managers do more to support individuals. It had also been clear from the group discussions that confusion remained in terms of defining a CMHP despite decades of national and international legislation and guideline development, widespread mental health campaigns and a growing academic knowledgebase.

However, whilst comparing the data across the manager groups, some understanding of CMHPs emerged, where some had outlined examples of where they had instigated a variety of 'early' interventions by making a series of workplace adjustments in order to support a team member through a period of mental ill health. Standing out amongst the data was a positive experience shared by a manager, who described how he had recruited a team member who had had a break in their work history due to a workplace stress incident. During the recruitment process an open and honest discussion had been instigated whilst discussing the gap in employment, and the comment below illustrates this:

[Manager-FG4]

> *"It was clear from somebody's CV that there had been a gap and I wanted to know what this was about, and they did talk about it, they had a work based stress related incident and a period of time off and what that incident lead to…… Because we recognised the good candidate that they were, we just ensured that they had a support process in the role, and they proved to be a huge asset to the team" [M-P3]*

Not only had this enabled the manager to employ the right candidate for the position, but it also instilled trust and confidence within the employee. The discussion in the group concluded that the manager's approach had likely provided reassurance to the employee that disclosing the incident created a mutual understanding of the situation and that support would be in place if and when required. The group fully agreed that this should be deemed as a good example of what an early intervention could look like having been instigated at the earliest stage.

9.1.2 Understanding v Misunderstanding of CMHPs

The initial data from employee focus groups data revealed that *[n=24]* out of the 34 participants had expressed confusion in terms of what constituted a CMHP. Although others suggested anxiety and depression were the most prominent CMHP, *[n=18]* out of those 34 employee participants disclosed that they live with anxiety and depression on a day-to-day basis, and they had not revealed the problem to managers or colleagues. The main reason given for the non-disclosure had been attributed to a lack of confidence in the response they would get from their managers.

Notably, the majority of the participants from the employee groups *[n26]* had been clear in expressing what they believed to be a lack of understanding amongst the workforce in general. It was felt that by disclosing a CMHP to their manager and/or a colleague could have an adverse effect on future job prospects, how they would be treated at work and where they believed that their experiences and feelings would not be understood:

[Emp-FG1]

> *"Understanding? speak to your manager? - I know that there would be no point as he would not understand it I would rather find out about other supportive mechanisms" [E-P3]*

> *"Yeah…. for someone who is diagnosed with some form of depression or where it incorporates other mental health problems …..I feel that there is a lack of understanding by employers" [E-P5]*

"……Mmmm….yeah…..It's the understanding of anxiety and I think that some people think that you bring on yourself and I think that they [managers and colleagues] think that you need to control it more whereas that isn't the case and you don't know when it is going to happen and certain things can trigger it so you are as not in control of it and people just don't understand that do they"?
[E-P6]

Furthermore, the accounts of the employee participants were in turn supported by managers *[n=26]*. Similarly, only *[n=4]* manager participants admitted that they had disclosed a CMHP at some point during their career, attributing the lack of understanding by others for the non-disclosure. In addition, managers agreed *[n=14]* that they would consciously think through and choose who they could and would actually disclose to, revealing that any disclosures were dependant on the nature of the issue causing the problem and the perceived attitude and behaviour of their own manager. A specific example discussed by some of the female participants was the issue of the menopause and how it can impact on an individual's mental health agreeing that they would not want to talk to a male manager:

[Manager-FG4]

"……I think mental health issues that are attached to the menopause are really mis-understood…. mmmm yeah…anxiety, depression, fatigue" [M-4]
"Yeah…I don't know if I would go to my male line manager, probably could, it wouldn't bother him talking about that, but there might be some things linked to my own mental health and wellbeing that maybe I might choose somebody different, and I think that for some other people it is uncomfortable and you can see barriers go up can't you? [M-P7]

Haha….yeah…..you can see like "Oh God! Don't have that difficult conversation with me! I don't want to do it! I will be honest, I would pick and choose who I would go to, but that's just me as a person… [M-P1]

…. and I wouldn't expect them to go [Yawn], but I think if you are looking at a broad spectrum, yes there will be, 'I'll avoid that, and we will talk about everything else but the elephant in the room'. [M-P7]

"Um, yes …but it's like anxiety or depression that comes and goes and are not recognised or recorded as a health issue as such" [M-P3]

"Anxiety, um, depression are the two that are the most common. There are a whole range of mental health problems, but anxiety and depression are the two that I sort of think of as being the most talked about" [M-P1]

In contrast, the male managers' concerns had centred around the perceptions of CMHPs, the 'macho' male stereotypes and how they are often seen as a sign of being 'weak' thus constituting a further misunderstanding:

[Manager-FG4]

"It's perceptions…. I think it is perceptions isn't it? I think nobody wants to be seen as weak. I have picked up on weaknesses…. It's always been instilled in us…… I certainly know that I have had that as a thing growing up. You know…. it's always been the line 'come on! Up you get! Don't cry!" [M-P2]

"I suppose some might pick up on some signs and signals and we have some conversations, but it is mainly banter without knowing personal details……as we don't want to talk about it……I just glide over those conversations" [M-P3]

As noted, a common view had been that participants often and consciously avoided talking about their own CMHPs. Furthermore, some manager participants also had a sense of distrust and confidence in the organisation's support services. Concerns were raised in terms of support services and their lack of understanding of CMHPs, going on to describing some support services as 'blockers' in the system.

[Manager-FG2]

"…Mmm for me It's that trust thing, occupational health do a good job, but they have gone through a period of being, perhaps not as good as they should be, they have actually caused me and our team, more problems, because they have given incorrect advice, and then the employee has gone off on that track…….[M-P4]

"Yeah, the problems and blockers are employment law and other laws and as such causes occupational health and HR to do everything by the book…. a tick box exercise" [M-P6]

"Yes, I am with you XXX on this it is all about policy and procedures, then you do not look at the person with empathy, it's about the process and not the person……. yeah, make sure there are no repercussions on them" [M-P3]

I also think that…. umm… yeah…. it's not only Occ. Health, I think it's the link of Occ. Health and HR that is lacking, from a management point of view of dealing with these issues, it sort of see-saws back again" [M-P7]
"……I found that you can get different advice from different advisors. It's not consistent which is frustrating" [M-P6]

"Occupational Health's advice has not been good, hopefully it will change and also the fact that actually HR or ER advisors in general are not consistent either" [M-P4]

In contrast, the majority of the employees *[n=27]* described what they perceived as a misunderstanding of CMHPs by managers. However, they echoed the views of the male managers, expressing a major barrier for them was being seen as 'weak'. As discussions progressed the themes of barriers to disclosure and stigma were emerging as recurrent and are discussed later in chapter 9.

[Emp-FG4]

"…. Now you see how I keep hold of my job, I don't want anybody to see me weak, I don't want to be defined by my disability or my mental health problems [E-P1]

"…. what about the amount of people who are undiagnosed, you don't know how many are out there and especially for blokes they are not going to go to a GP as it will be seen as a sign of weakness" [E-P4]

Yes, I agree…. you want to be seen as that same person and so I think weak is a very prominent word. I think to not show any weakness has always been instilled in us" [E-P6]

However, echoing those opinions one manager group had described CMHPs as being a 'problem' that is 'mis-understood' by many and too often looked upon as a negative…….

[Manager-FG3]

"I think when we talk about mental health, I think we automatically go to the negative aspects of it and set up camp there so, I don't think we recognise what good mental health looks like" [M-P8]

"…yeah … I think for mental health, depression and anxiety is the attitude of 'pull yourself together' isn't it?" [M-P4]

Furthermore, within this group, a senior manager went on to openly admit that he did not fully understand CMHPs and felt that he needed to obtain more knowledge and understanding quoting:

"There are limits to my understanding and that it will be useful to open my eyes to the wider issues on this" [M-P2]

On the other hand, another group felt that they were getting better with understanding CMHPs. In support, many managers *[n=20]* had confirmed that they had undergone Mental Health First Aid Training which they had found helpful in developing their understanding…..

[Manager-FG4]

"I think understanding is getting better and certainly recently I have been on a Mental Health First Aid Training Course, which is a 2 day course, which is pretty helpful. But I think that peoples understanding of depression is fairly well developed but I am not so sure about anxiety [Man-P6]

"I agree …. everybody has heard of anxiety, but actually when it comes down to it, there are so many different types of anxiety and ways in which it manifests itself, that a lot of people will say "I'm a bit anxious at the

moment", but they are not actually suffering… you know, we all get anxious occasionally, but it's not actually a problem of anxiety being an issue…. there's still a lot of work, I think, to be done to get to that level of understanding…. would be great if training was mandatory" [Man-P3]

Mmmm…it's helpful.…but you have to remember that it is only first aid it is not a solution…. [M-P5]

"I think understanding from managers is really important, but also the point of it being more acceptable to talk about it……. I think that it is really important for early identification because then the support can be put in place before someone is off for weeks and weeks. So, it's a case of what can we actually do earlier to support people" [Man-P1]

A further compounding factor discussed and linked to the 'mis-understanding' of CMHPs was the putting of timelines on recovery despite the fact that a CMHP, in some cases, could be a lifetime condition. This issue had been more prevalent amongst the employee groups, where they argued that a set time scale could not be applied to how long a CMHP would last……

[Emp-FG2]

"……the thing is ….anyone can have a mental health issue and something that you can have for a short period of time and then not have it - they should not be categorised or shamed you can have an issue for a short time but get better, others might have different views on that" [E-P2]

"I just wanted to share that I wasn't comfortable and that there may be times when I may not be able to cope with the situation - there is no length of time to recovery" [E-P4]

"Mmmm well…when I first had my problem….out of desperation I asked my manager to refer me to occupational health…..she said no 'give it a few days and you will be ok'" [E-P6]

"Oh god that is awful….I think sometimes people will put a length of time of the problem – I was off for a while following operations etc. and then developed depression my manager started telling me that being off was

going to affect my pay – I wasn't ready to go back but I went back – I did not have a return to work interview or phased return it was straight back into the role again" [EmpFG5]

"Managers need to be able to understand that certain life events can affect people in different ways" [EmpFG1]

Across the employee groups a range of issues had been discussed. However, a prominent and reoccurring theme were the concerns that managers do not have a clear understanding of how CMHPs can affect each individual differently, and that CMHPs may not necessarily be a long-term problem. In addition, it had been suggested that management and colleagues alike do not understand what triggers anxiety and depression including the impacts on an individuals, again noting that there is no defined length to the time to the CMHP.

However, *[n=3 out of the 66]* participants referred to the mental health continuum model and highlighted that there can be shifts on how individuals may feel on any particular day, such as mentally healthy and able to cope on one day or unwell and struggling with daily functions on another.

In one example a participant stated that:

[EmpFG4]

"……. for me it's the negative that exists, I suppose the starting point is to define what normal mental health is and what good mental health is" [E-P1]

…. which led to agreement from another participant

"Yes, but it's also how those people are also feeling on the day. You know, one day they might be able to cope with it and another day they might not" [E-P2]

As more focus groups were conducted there was an emerging consensus from across the employee and manager cohorts that attitudes, beliefs and the 'mis-understandings' of CMHPs were often shaped by a range of factors. Participants expressed that the factors were often driven by ill-informed personal views,

stereotyping, cultural differences and beliefs alongside the misrepresentation in media reporting and various social media platforms.

In addition, whilst describing their lived experiences and realities, the participants were clear that 'the misunderstanding' often stemmed from stereotypical views which were primarily held amongst those who had not experienced a CMHP either in the workplace or personally as illustrated below:

[EmpFG3]

> *"I think it is lack of understanding that people who have perhaps have never experienced it so it is what they stereo typically think is mental health issue and don't recognise in themselves, in fact they have because everybody wakes up and feels like c**p at some point or have a trauma in their life that is particularly upsetting and impacts on your mental health" [E-P3]*

> "yeah……..*what they [managers] may think is a minor issue could actually be fairly big for that person" [E-P1]*

Similarly, a view held amongst the manager participants was that there was not enough discussion either in the workplace or in the wider population in terms of CMHPs thus leading to further 'mis-understandings', confusion and differing perceptions.

[ManagerFG4]

> *"I think it's different for everybody and everybody's perceptions of it are different. I don't think we talk about it enough. Certainly, I don't think we talk about it enough in general as people……but as a workforce I don't think we talk about it" [Man-P6]*

> *"True…. but I think the Council are doing more to support staff in work we have the health champions and the travelling health promotions, so it is a step in the right direction we have safeguarding policies to help managers recognise problems. But I do think this is early days and is an area that is new to lots of people and we as a large organisation needs to recognise" [Man-P1]*

Whilst reflecting on the misunderstanding of CMHPs the groups went on to question that without a good level of understanding, how could a CMHP be recognised in order to intervene at an early stage. Furthermore, both cohorts of focus groups discussed the workplace and the range of awareness and support mechanisms that had been made available across the organisation which can open up avenues for open conversations. Despite these mechanisms being made available, there was a belief that, although some progress had been made within the organisation much more needed to be done. Overall, the data revealed that the majority of the manager group participants *[n=30]* agreed that more needed to be done in terms of awareness and skills for all the workforce, suggesting that this would go some way to providing a greater understanding with the potential for instigating early support for those with CMHPs.

9.1.3 Recognition of CHMPs

Both employees and managers cohorts *[n=49]* attributed the lack of recognition of CMHPs to disjointed and inconsistent management styles. This led to concerns being raised that variable approaches resulted in inconsistent management practice and interventions and support or with no support methods being provided. The participants, across both cohorts, felt that the misunderstanding of CMHPs as discussed thus led to a lack of recognition that personal problems can adversely impact on an individual's mental health including having a 'knock on' effect in the workplace. Moreover, the majority of participants *[n=55]* had agreed that there appeared to be a common assumption across the range of the management hierarchy that CMHPs caused by personal problems are not of interest to a manager as they are not 'work related':

[Emp-FG2]

> *"I think that…… in the council we need more of an understanding of what CMHPs are and what commonly triggers them,……. but also we have got personal things that can trigger certain things even though you try and control them sometimes something could happen at work or at home…….I don't think people understand that do they?.....[E-P1]*

"……but yeah, I think there is a lack of recognition and understanding but there should be training for managers as well" [EmpFG3-P6]

"Yes, the thing is….is felt that private issues should be left at the door when coming into work……. my relapse happened following a relationship breakdown, and I wasn't managing my workload very well, but I did have the comments of 'you should leave your home life behind as soon as you walk through the door'…….it is the same as bereavement you cannot leave that at the door" [E-P2]

As the focus group conversations continued and were enriched by the iterative e-conversations that took place over a further 3-week period and where the groups agreed that the lack of recognition and the 'mis-understanding' of CMHPs were an inherent problem across the organisation.

One manager participant cited that within their own team they felt it had been easier to talk about work and personal pressures commenting that:

[Man-FG2]

"My observation are that at a team level, we are quite a caring team, quite well connected and mindful of how each other is feeling and the pressures we might be under [M-P5]

However, the manager participant went on to present an opposing view where it was felt that empathy for personal problems and CMHPs was often lost in the wider organisation where employees are just seen as a resource to 'get the job done' …….

"……. however, my observation of the establishment, the bigger organisation it is quite the opposite. I feel from the top, that level of understanding that the staff are people doesn't sort of filter down, it's become very much that you're a resource, you're doing a process, so I think that's where a problem lies…..but within the team you can turn to your line manager or colleague and say I'm feeling the pressure at the moment and have empathy with each other,…… but going beyond that I think that's where it gets lost" [M-P5]

On the other hand, positive experiences had been shared, highlighting instances where proactive support had been provided using a variety of mechanisms. One employee described a process, whereby a buddy system had been put in place in order to support a colleague who was returning to work following a personal tragedy:

[Emp-FG3]

> *"We have got someone coming back to work in the near future that has been through a terrible time and a personal tragedy, and he is still very shaken up and he's is my team, so he is under my manager……. I am going to be one of his mentors and my manager is also, and another 2 manager levels up …….so he has always got somebody at work every day that he can go to if it all gets too much……. like a bit of a buddy system – he feels he is ready to come back to work but when he does come back, he is going to need that support and it will be difficult because he is still hurting"*
> *[E-P2]*

> *"Mmm yeah …that is really good……My manager has been really supportive helping me through the grief of losing my mother whilst I was off arranging a funeral and sorting out stuff" [E-P5]*

Furthermore, this participant went on to describe a complete contrast where a colleague had suffered a bereavement of her father. Her colleague had a different manager, and the problem was simply ignored because it was a personal issue. The participant described how the manager did not know how to manage the situation which consequently led to her colleague experiencing a reactive stress reaction with negative outcomes:

> *…….one of my colleagues works in a different team and has a different manager, lost her father but she is now signed off with stress and other things have happened since but she has had a terrible time……. but a lot of the problem has been because her manager has not known how to manage it and has therefore tried to ignore it" [E-P5]*

The contrasting experiences described, goes some way to confirming that early intervention and the provision of support provided is reported as beneficial to the individual, manager and consequently the organisation. However, early interventions were considered to be patchy and how or if they were implemented was purely dependant on the competency and capability of the manager.

Participants also felt that due to the perceived complexities of CMHPs, managers and colleagues could often be dismissive of the problem. In terms of anxiety in particular, some managers had reportedly asked for a reason and explanation for the problem, despite the individual not being able to explain and not having a full understanding of it themselves. Moreover, because of the dismissive approach to the problem this caused further anxiety for individuals and setbacks in their condition:

[Emp-FG1]

> *"I didn't disclose my anxiety until I needed to and when I told her she said oh…… I was struggling with a part of my job which was taking minutes and I nearly had a panic attack when I told my manager she said ……it is part of your job but what is it that causes the problem?..... I said I don't know I couldn't explain……..but she couldn't understand why I couldn't give her a reason for it" [E-P5]*
>
> *"Yeah …. thinking about that……I wonder if other individuals would find it daunting to speak to their line manager then" [E-P4]*
>
> *"…the thing is …. I couldn't give her a reason for it and I was trying to explain a bit more but she just laughed and said I don't know how you get out of bed in the morning" [E-P5]*
>
> *" Mmmm yeah…. other people have said that not being able to explain was horrendous and it worsened their condition because of no support ….. so it doesn't seem very consistent across the board [E-P2]*

In their accounts of the lack of recognition coupled with 'mis-understandings', employee group participants felt that it would inevitably lead to managers not

being able to instigate early interventions. The outcome of this being that individuals' problems would be exacerbated with the potential for the person to fall into sickness absence with unknown consequences for the individual, manager and the organisation.

9.1.4 'Early' Interventions

As previously outlined, some good understanding had been revealed, particularly where good management skills, empathetic behaviours and good practice came to the fore which led to an agreement of what early interventions could look like. Many managers *[n=24]* had described the benefits of having the ability to provide support at the 'earliest' stage when being presented with an opportunity that enables an 'open' conversation with an individual who may be experiencing or diagnosed with a CMHP. Managers described an early intervention as being as '*early as practicable'* and '*at the earliest opportunity'* for example, immediately following an individual disclosing a CMHP. The discussion led to managers agreeing that they were in the best position to intervene early and to provide appropriate workplace support.

One participant commented:

[Manager-FG3]

> *"I interviewed somebody, and they are clearly the best candidate for the job…. but they had a very high sickness record on their application, so actually it was about me having a conversation……. I had recognised this and discussed any support or assistance they needed……. they were quite open and said that they had suffered from severe anxiety in the past and explained how they dealt with it. This meant that we could put support mechanisms in place at the outset [M-P3]*
>
> *"I agree……if you are a good manager you should be able to have that discussion…. I have probably noticed it more than I have ever before. That mental health it is something that is much more on the agenda and is acceptable to have that discussion" [M-P6]*
>
> *Well……. you are maintaining the skills and expertise that you need for that role aren't you, plus you are supporting an individual to stay in the*

workplace, and actually the feedback from that individual was firstly, 'well that was unexpected'…….'This is amazing, I am being able to continue in the work with the support I need'……..that person has now not had any sickness absence [M-P3].

A similar experience was described by another manager and where employees had trust and confidence in their manager to disclose a CMHP at an early stage:

"Actually yes…. a similar thing worked for me because I have had members of staff that actually on day one had been honest,… they had got the job, sat down and said 'I'm going to be completely honest with you now, thank you so much for giving me the job, but I don't want to lie to you, but I am OK, but I have got a CMHP and support mechanisms in place. So, I know from day one what support that person has had previously and what they need, so you are kind of aware and you are not discriminating against them" [M-P5].

"Yes. Well even before they have been offered the job, but that's great that they felt comfortable to do that" [M-P6]

"That's fine for somebody that has a history, but for first time sufferers it's more difficult" [M-P1]

"….but that's our role as an organisation to make sure that we are showing that we are an inclusive organisation" [M-P3]

In another manager group it had been described that making positive adjustments to support an employee returning to work following a sudden bereavement had also proved beneficial to both parties:

[Manager-FG1]

"I am currently dealing with a staff member…….instigated a longer phased return to ensure that the person gets well over a period of time following a sudden bereavement…… I think that just having her back part time is much better than pushing it and having her see-sawing between being well and ill so it is better to do it slowly to allow for recovery. She is happy

with my approach I am not pressuring her back ……and I will get the benefit from when she is well again" [Man-P1]

Describing a tragedy experienced by an employee, a manager had the foresight to recognise that owing to the nature of the tragedy she would need to consider support for the wider team as well as the individual. The manager was conscious of possible difficulties and adverse reactions from within the team and was therefore prepared to manage those reactions, this consequently led to the team bonding and supporting each other. The manager described a situation that had been similar to a previous discussion and where similar actions had been taken:

[Manager-FG2]

"I think that managers need to be not just conscious of the individual but also those around them…… I was a manager and a team member had a child killed in a RTA, we needed to support the team members as well as there was a knock on effect when she returned as it was how the team would react……. for example, one member just couldn't talk to her as she did not know what to say.....but there was more than one person to keep an eye on but it is down to just managing those people and knowing the team and how they are likely to react in some circumstances. Fortunately, we were all together and bonded as a result and we could then move forward……. but other managers were concerned about how their teams should deal with the situation - so there are different levels - the individual - the team and the wider teams and as a manager it was very difficult" [M-P8]

The opinions from some employees however, differed from those of the managers, where they indicated that it would depend on a variety of factors before managers could make an early intervention…..

[Emp-FG4]

"Intervention? ….. mmmm… yeah…. but that would depend on your relationship with the manager whether they have good supervision, so if you have a good relationship with your manager, they are more likely to

pick up if there is a change or the individual is comfortable enough to say that I am struggling at the moment" [E-P5]

"…most people, or most managers, the majority perhaps, would not know what to spot or what to do" [E-P1]

"Mmmm…… I suppose that there are some saying that they work with a mild to moderate CMHP every day and it is seen as a negative…. so, they are not going to ask for manager support" [E-P4]

As the focus group discussions progressed, the participants consistently referred to how the differences between how CMHPs and physical problems are perceived by others. The narratives revealed that there is a major disparity between the understanding of CMHPs, mental illness and physical illness with many participants describing an unequal status between them. CMHPs not being visual can therefore often be disregarded as it 'cannot be seen'.

9.1.5 CMHP v Physical Disabilities

Because a CMHP is not visual unlike a physical disability, it was felt that it is invariably seen as a problem or unimportant, pointing to a further factor of 'mis-understanding':

[Emp-FG3]

"I see mental health as no different to physical health …. it is a thing that goes wrong sometimes, and you need to do something about it to make it better or manage it if you can and I find it very frustrating that it is seen as a negative [E-P1]

Yes……it is like if you broke your leg you get 'I am really sorry to hear that is there any help you need …. how are you'……you mention that you have depression…..and it's like….Oooh OK….. and everyone starts fidgeting in their seats" [E-P3]

"…….. if I was in a wheelchair you would move the chair and make space for me but what happens when I walk in with a MHP as you can't see it…..no one would notice?" [E-P5]

"As a CMHP is not visual, or until someone has experienced it themselves or have known somebody who has experienced it, then they will never understand it" [EmpFG1]

The views expressed from within both employee and manger cohorts were not too dissimilar.

[Manager-FG1]

…..for me the mind is the mysterious bit. You can understand physical ailments but there is no knowing about mental health…….at what point and what triggers indicate that a team member has a problem, so you have to be vigilant……it's very hard to know [Man-P4]

"You come into the office with a broken leg, everybody will come up to you 'how did you get the broken leg?' 'what's the prognosis of when you get out of plaster' and if you've declared a mental health issue… People probably won't ask you" [M-P3]

Summary

The presented narratives revealed a lack of knowledge and understanding of CMHPs and a lack of understanding that each person is different, situations are different, and reactions are different.

Across all groups it was generally felt that not only in the workplace, but across society in general, there are too many variables in the terms used to characterise CMHPs with the terms used being predominantly negative. Participants felt that 'emotional and functional wellbeing' is a term that indicates being mentally healthy and takes a positive stance. On the other hand, it was felt that where an individual may not be fully functioning, it could simply be a mild reaction to a minor 'trigger', such as being restless, lacking sleep or generally fatigued. However, even though a mild reaction may be a short-term problem for a few days, it was suggested that by offering interventions at this point such an approach could negate a build-up of the problem thus avoiding the development of more serious symptoms associated with anxiety or depression.

Although, it was acknowledged that the organisation has many mechanisms in place to support those with both short-term and long-term CMHPs, for example, short-term being classed as less than 28 days and long-term being time unlimited, the discussions centred on the lack of understanding and recognition of CMHPs and how in reality these are experienced by individuals. As noted in the discussions, criticisms had been levelled at not only managers but other support services where participants felt that support consisted of a range of 'tick box' exercises.

However, the discussions revealed that the issues go much deeper where the 'mis-understandings' and inconsistencies amongst support services acted as barriers for enabling a manager to intervene early or indeed offering any early interventions to support an individual whilst in work. Moreover, the emergent theme of 'mis-understandings' was also a factor that had led individuals to not disclosing a CMHP. Furthermore, the inconsistent approaches could further impact on an individual's performance and social relationships within the workplace, thus further reducing resilience and underpinning a case for remaining in work whilst ill and with no support (presenteeism).

In terms of those individuals that have spoken out and disclosed that they are living with, or experiencing a CMHP, it was agreed that there needs to be a clear understanding of CMHPs from colleagues who interact with that person on a daily basis in order to foster effective and open relationships. It was evident from some of the narratives that there have been pockets of 'good practice' and 'support' provided by those managers who interacted and intervened early. What was particularly noteworthy was that making those early interventions provided positive outcomes and goes some way to providing an answer to the research question of '*how early is early'*.

To this end, I now turn to the next chapter which presents the focus groups narratives of theme 2 – management skills and behaviours.

Chapter 10:

Theme 2 - Management Skills and Behaviours

10.1 Introduction

This emergent theme is intrinsically linked to the previous theme of the misunderstanding of common mental health problems. There was recognition across all the groups that management styles, attitudes, behaviours and skills vary from manager to manager with a lack of experience, compassion and emotional intelligence being common features across many levels within the organisation. Moreover, the focus groups highlighted that they believed that the disjointed systems in the organisation could prevent the intervening and/or supporting of employees that have disclosed a CMHP at the earliest opportunity.

10.2 Mandatory core skills and training

Despite a range of training available to managers across the organisation over half of the employee and manager groups *[n=36 out of 66]* expressed an agreement that not all managers possess the skill sets to understand or support an employee with a CMHP. The general consensus across all groups was that some managers had been and continue to be promoted because of their technical ability and knowledge base, thus ignoring the lack of people management skills which should go hand in hand with management responsibilities. Participants believed this to be a failure of the organisation in not ensuring that managers have the ability to effectively manage individuals and teams and the array of people issues that comes with management.

[Emp-FG2]

> *"The thing is the organisation runs courses, but they don't necessarily make sure that people have the right skills to manage people……. so, you end up with senior specialist managers who want to advance their careers which is understandable, but they just cannot manage people …. [E-P6*
>
> *"Hahaha …. yeah, but what you get with progression is that you will need to manage staff and you might not necessarily want to do that or have the*

skills to do it so a lot of managers will then avoid doing that management job" [E-P4]

"They give them ILM qualifications which don't really fit the skill set that they need" [E-P3]

"Yes, the lack of people skills - the problem with local government is that people tend to get promoted because of longevity of service or that they are a specialist in an area they are not necessarily properly trained managers" [E-P7]

Furthermore, although it was acknowledged that public sector organisations, have been going through continual changes, managers questioned if they had been given the opportunity to develop new management skills in line with the changing landscape of the workplace and if bad habits had been allowed to develop and continue. There was a sense of openness and reflection amongst the manager participants who questioned if they themselves had been provided with an opportunity to develop skills and competencies for managing people….

[Manager-FG2]

"…….. So many people in the public sectors have borne the pressures of organisational change more than once and clearly brings these sort of issues to the fore……Mmmm yeah I think we need to be better equipped to manage people….don't we?" [M-P5]

"Yes, we do need to be better equipped to recognise the impact of mental health problems and actually adapt the way in which we manage people and look after and the pastoral care of the people whom we are responsible for…… You know, there is a need for it to be a core skill in my eyes". [M-P2]

"From my experience …. across the organisation people skills is the biggest deficiency" [M-P4]

However, some manager participants confirmed that, aside from technical or professional qualifications there had been a requirement to obtain an appropriate level of management qualification, such as a level 5 in management,

although it was acknowledged that, it is good in theory but questioned if it worked in practice and did not necessarily address 'soft' people skills, commenting…….

[Manager-FG3]

> *"….. You could probably look across the council, and if you've been around for a while and see the key managers that are struggling…… they need training, but they probably think 'no I'm at this level, I don't need to know how to look after someone who has got depression……. It's not my problem!" [M-P1]*
>
> *"Yeah but ……Inevitably I think there is going to be good and bad practice in that regard and that is just from my own experience" [M-P4]*
>
> *"But there is no real framework for management that we are aware of is there?..... There is a lot of stuff out there if you are minded to do all that management training and stuff like that isn't there……ILM and stuff but is it relevant?" [M-P5]*
>
> *"No……there is quite a lot of inconsistencies in the application of basic things like …. health and safety, flexible working policy and things like that aren't there? [M-P1]*
>
> *"You are not surprised are you…. if you know what I mean, we know that we have got problems……. there are managers out there are very….uhhh very…..command and control ……..[M-P3]*
>
> *Yes …. but there are others that have a good insight of those that work for them……mmmm…. but it doesn't always emanate from the top though" [M-P4]*

The discussions naturally transitioned to discussions where manager participants drew attention to the hard and soft skills that are needed for managing the job and people. Notably, the manager groups in particular referred to skills such as being trustworthy and being willing to take responsibility. Furthermore, they felt that management needed to possess the right communication skills and

behaviours when dealing with employees and highlighted that these skills complement the hard business-related skills such as technical qualifications.

10.2.1 Hard Skills v Soft Skills

In their accounts of the issues that affects how a manager manages their team, the majority of manager participants *[96%-n30]* agreed that there was a need to possess what is described as 'softer' management skills when managing people. The excerpts below provide the narrative of some of the views expressed ….

[ManagerFG4]

> *"There are people who are in position who you just think are you ever going to bring that person round to being a manager who has got good people skills. They have appalling people skills. How are you possibly going to get them to engage with people and understand mental health issues?" [M-P4]*
>
> *"I don't know if you can be trained to be a people person. I think that you either are, or you're not. You can have a listening ear, you can have empathy, you can give support, but I don't know if you can be trained. Can you be trained to do that?" [M-P1]*
>
> *" I think that a lot of it goes back to recruitment and selection…..[M-P6]*
>
> *"Getting the right people in the job …. but it isn't just about skills to deliver is it?..... It is about behaviours as well" [M-P3]*
>
> *[This received ……a resounding yes response]*

The manager participants argued that there are opportunities for the organisation to use different tools within its recruitment and selection processes:

[Manager-FG2]

> *"We introduced, psychometric testing years and years ago to help with recruitment and people……you know…… particularly external I think is important because they are such an unknown quantity aren't they, coming*

across the door……..they did it with other staff and it is eerie how accurate it is" [M-P4]

"It is not necessarily a magic wand, but it is just another tool to help. You have got different approaches that work with different people" [M-P1]

"Well yes ……. but then why are we surprised ……it is all about psychology and everything else. It's a scientific process in a way, it doesn't always show they are totally 100% and I think you have to be aware to think a lot of people can be dismissive of those things, but it is just another tool" [M-P4]

Across employee and manager cohorts there was a general consensus that many managers did not possess the attributes described in order to understand and support those with CMHPs *[n=49 out of 66]*. Additionally, it was agreed that managers should have the skills and ability to connect and effectively communicate with individuals and their teams. Moreover, it was felt that managers should be able to have that 'difficult conversation', whilst actively listening and displaying empathy and compassion and recognising that each person reacts differently to a CMHP.

Managers went on to having lively discussions in terms of what they felt were the differences between technical skills and people skills……

[Manager-FG2]

"There are people who are incredibly capable of doing a job aren't there and have all the skills and aptitude they need to do and drive that and if all of a sudden that person is managing people, it's two so different things……[M-P1]

Yeah……. It doesn't mean that they are not capable of doing their job but attuning to the needs of others and I would think that as soon as you start to get bigger teams as well, that's where you can miss those people. [M-P7]

"I think the coaching and mentoring program is good isn't it …. but it's matching the right people and skills together really" [M-P4]

"Well…….I have over the years witnessed quite a few managers that are at the top of their game in their career but cannot manage people but the organisation needs to recognise that all specialists are not managers and not force the role upon them - there are those that will never ever be people-people [M-P6]

Echoing the views of managers, the employee groups discussed similar issues commenting that there are issues where managers had displayed bad habits and a poor management culture with no desire to change…….

[Emp-FG4]

"The thing is……managers fall into bad habits… but as things change…cultures change managers need to be coached on up-to-date thinking and the support mechanisms that are there – I think training should be mandatory" [E-P6]

"I don't think that they [managers] have the skill set to manage people and don't want the skill set to do it ……and the organisation does not make sure that they have the skill set either …. it's the culture" [E-P1]

"yeah….it is a fundamental problem right across public sector and in local government I have seen this for nearly 30 years they simply do not have the skills to manage their staff" [E-P7]

Within the initial face to face focus group discussions, managers voiced their opinion regarding why they as managers had opted to take part in the study. However, they questioned that some managers may have been reluctant to take part in the study owing to the risk of potentially exposing themselves to realities that may make them appear to be either vulnerable or incompetent as a manager. In addition, managers queried whether those that did not participate might have felt a reluctance in facing the people issues within their teams thus exposing potential weaknesses in their management skills and within a wider management arena. Furthermore, it was suggested that all managers would

need to possess the skills and confidence needed in order to address any people issues within their teams.

[Manager-FG1]

> "*So, what about the ones [managers] that didn't want to come as they thought that they would be the elephant in the room …. [M-P5]*
>
> "*Mmmm……. because they are the people that actually don't want this 'time-wasting thing' and they have got enough people in their team that have got issues, do they want anymore? [M-1]*
>
> *"Yeah.... they are out there aren't they because they don't want to be in this room having that conversation" [M-P2]*

It was acknowledged that for this study, the recruitment process and purposive sampling strategy had captured a good balance of managers who had and had not experienced a CMHP themselves or have managed individuals that have presented with problem.

Managers in one group felt that some other managers had often been seen as role models within the organisation and possessed both the hard and soft skills. This group suggested that this could provide the potential to develop 'in house' mentoring or coaching programmes that would help managers develop the soft skills required for people management:

[Manager FG-3]

> *"XXX, is a senior manager, who is acutely mindful of who works for him and wants to look after the wellbeing of staff. He has strategic objectives, but also is inclusive of his senior managers and he is not a command of control person…." [M-P2]*
>
> *"Yes, I agree…he is a good role model" [M-P5]*
>
> *"…. He really is…… you could probably look across the council, then look all the way up through the structure to see that it's senior managers and those underneath them that probably need mentoring and coaching" [M-P2]*

"…. You are not surprised are you?..... they need training, but they probably think 'no I'm at this level, I don't need to know how to look after someone who has got depression. It's not my problem!" [M-P4]

"…….XXX is an inclusive person and I think that that is what makes a really good leader and if that is then fed down through the organisation, I think that could be very beneficial as well" [M-P1]

Managers had indicated that those who possess a good range of soft skills were therefore highly likely to be able to instigate early interventions at the earliest opportunity:

[Manager-FG2]

"Maybe if an intervention is at the interview stage of the manager……. When interviewed …. I was asked how I would deal with a person in my team who had a mental health problem. What would I do? How would I tackle it? How would I deal with their performance and that kind of thing……. She clearly had it on her agenda that I had to look after my people." [M-P6]

As described, *[n=37 out of 66]* of all participants agreed the key predictors to enabling a change in attitudes and behaviours in managing those with CMHPs would be having a good level of understanding of CMHPs, being empathetic and possessing good communication skills. Furthermore, it was suggested that such attributes would be more likely to instil a higher level of trust, thus enabling an individual to disclose and discuss their problems more openly with their managers. Additionally, a thread throughout the iterative discussions had been that participants felt there was a need for the provision of ongoing manager/ leader competencies development not only for new managers but those already in the organisation that may be 'stuck in their ways'.

10.1.3 Emotional Intelligence

A further sub-theme emerged which I have characterised as emotional intelligence (EI), because many of the experiences discussed by the participants linked to the core areas of EI which include self-awareness, self-

regulation/management, social awareness, relationship management and social skills (Cherniss & Goleman, 2001). In general, the core competencies of EI include several facets such as empathy and social skills. However, there is no guarantee that individuals who have experienced or been exposed to CMHPs would allow them to demonstrate EI competency and behaviours (Zeidner, 2004). Throughout the group discussions participants felt strongly that there had been a distinct lack of empathy, particularly from managers *[n=49 out of 66]*.

The iterative discussions cited managers' own personal experiences with CMHPs would be more likely to influence their management style, attitudes and behaviours within the workplace. It was also agreed that where lived experiences existed, managers would more likely display positive social skills by being more understanding, empathetic and supportive to individuals with a CMHP, as opposed to a manager that had not had that experience or indeed refuse to acknowledge it.

[Emp-FG4]

> *"My manager went through a really bad time and she became very depressed and came to me and said ah I think I know what depression is now and it has taken me years, as she had always been one of these people that pushed it away" [E-P3]*

> *"My managers are really good…. but my managers have experience of mental health problems in their own lives so they have got that empathy and understanding, so you cannot expect someone who has never experienced a MH problem to understand" [E-P6]*

Directly linked to these comments, managers had also considered it important for individuals to have the confidence in managers and colleagues alike to ensure effective relationships. Additionally, being supportive and consistent was seen as key management behaviours. Notably, it was felt that that these aspects would be crucial to the support process, particularly when an individual experiences a life changing issue that could impact on their mental health within an organisational context……

[Manager-FG4]

"I think that …. If people have got confidence in a manager, then they will share issues with them because often it is just nice to be able to talk about it. I know you can't always, I went through a marriage break up and divorce quite a few years ago now, and for me work and my work colleagues were my lifeline. I would have certainly gone under without it" [M-P5]

"Mmm……yes …. a lot of it is to provide that supportive environment really isn't it?"…..[M-P6]

"It's just intelligence isn't it……. So if you've got that supportive framework, then it goes quite a long way I think……..I think we do that, but there are…. once again… there's the people that need to be you know…. supportive….." [M-P1]

"I think that's the key to it isn't it. It's having that kind of consistency across the managers and creating a supportive framework, and if everybody did that, then there wouldn't be an issue" [M-P6]

These discussions had been primarily focused on managers and the provision of support within the workplace. However, both cohorts of participants suggested that there was a need for everyone to be socially aware of the feelings, concerns and needs of others, as this was seen to be the 'make or break' in an individual's successful recovery from a CMHP. It was further suggested that where a manager acts negatively and defensively this could in turn contribute to a setback in recovery……

[Emp-FG1]

"Within an organisation such as this and even issues in our personal lives, if we trust somebody completely enough…… I would go to the people I know I will get the response and support that I need …." [E-P2]

"So what we are saying is that there is a lot of emphasis on management to determine which way your recovery goes a manager can be the

difference between you returning to work and being well or perhaps ending up worse that you were in the first place? ……[E-P5]

Yes, I think so …. for example, I have an old manager that I still speak to now if I have problems because she has come from a background where she was a MH nurse so she has got the understanding around the issues…. never judges… [E-P1]

Echoing the views of the employees, manager groups commented:

[Manager-FG4]

"Emotional intelligence…. actions and motivation…. it's how you can link those two together so that support also filters into work……. It needs to be part of our culture and organisation" [M-P6]

"…. But how can we do that? Uhhh… I would say that we need to be more emotionally intelligent, and people centred…. build relationships?"

"Mental health is always going to be about supportive relationships…… I think everyone will pick and choose the people they go to…… and it might not be their manager…. and it might depend on what it's linked to" [M-P6].

Overall, a consensus emerged from across the cohorts of focus groups, that to effectively encourage a supportive environment for early interventions for CMHPs, managers would need to possess a level of social competency and emotional intelligence. Furthermore, both in employee and manager cohorts participants identified a need for managers to adapt their behaviours thus enabling them to instigate positive and supportive 'people centred' interactions and communications with others.

10.1.4 Consistent or inconsistant management?

Whilst reflecting on the misunderstandings and lack of recognition of CMHPs, there was a strong belief *[n=52 out of 66]* that misunderstanding and poor recognition skills had contributed to inconsistent treatment from one manager to another.

Participants reported that depending on who the manager was and how they acted would influence what type of intervention or support would or would not be provided and how early would that intervention be made available, if at all……

[Emp-FG1]

> *"I would think that recognition of CMHPs depends on who your line manager is… from my experience and when talking to colleagues I've experienced some people say that I am really lucky that I have got a really supportive manager and I have been off with depression that they have been super supportive……some other people have said that that their experience was horrendous and it worsened their condition because of no support in the workplace so it doesn't seem very consistent across the board" [E-P1]*
>
> *"…….no it isn't consistent ….. also there are those that could use it against you as well or bully you as there are some people that are not very nice …..you have got to be very careful I feel…… that is my opinion" [E-P5]*
>
> *"Some of my previous managers I could speak to but some of my current managers I can't speak to so it all depends on the individual that is around you - you can find some people that you can open up to and others you can't" [E-P3]*

All groups reported *[n=47 out of 66]* that to be effective, intervention strategies would rely on the quality of interactions an individual actually has with their manager, and how supportive that manager is. Both employee and manager focus groups further reported that they felt that there were inconsistencies of applications across a range of management functions. It was interesting to note that while discussing the lack of regular one-to-ones with their manager, participants mentioned that this could impact on whether an individual disclosed a CMHP or not and where self-imposed acts of silence (presenteeism) which appeared to be becoming the norm…….

[Manager-FG4]

"Mmmm……then again, there are consistencies in 121's. I went to a managers mental health workshop ……. a lot of people were complaining that they never had 121's at all because of the geographical issues in Cornwall……[M-P7]

"How can that be an excuse …. that is bad management…."the 121 form we use is useful…..starts with how are you? It encourages staff to talk…..but you must follow up and use all the tools that are there……. but how do you get all managers to use them effectively?" [M-P2]

"……interesting.....it is really surprising that people just don't have that level of interaction at all…. so, you there could be all sorts of issues going on there…….and you are not tuned into them" [M-P4]

In addition, employee groups reported that in certain cases they believed that managers had exacerbated the problem by not following policy or providing appropriate proactive or reactive support through the support services such as occupational health, particularly in terms of return to work after a spell of sickness absence……

[Emp-FG1]

"I have never been through a phased return…. I was not referred to occupational health…and I have never had any of that support" [E-P4]

"Back to work interviews is only as good as the person doing it …. I was asked how are you and I went back into working full time…. I have no idea if that was recorded anywhere so I felt that I was just going to have to cope" [E-P2]

"When I first had my MH problem, I contacted OH but they could not speak to me without a referral from my manager and I couldn't speak to my manager…… but in the end, out of desperation I asked my manager to refer me to Occupational Health and she said no ….. she said no give it a few days and you will be ok" [E-P1]

Throughout the discussions, and as previously discussed, a minority of managers had again levelled some criticism towards support services and the inconsistency of advice from human resources and occupational health. Although this was not supported by all managers. It was thought that the continual personnel changes and the use of agency staff had adversely impacted on the support services.

10.1.5 Knowing the team

Further reflection on the discussions described in the mis-understanding theme led managers to suggest that in order to understand CMHPs and to support the provision of effective interventions, there was a clear need for managers, team leaders or supervisors to 'know their teams'. The groups felt that having and utilising soft skills such as emotional intelligence would be the nuts and bolts that hold a functioning team together. The groups discussions revealed that 'early' interventions would rely on a good level of understanding of CMHPs and the 'knowing' what intervention is appropriate for an individual who may be struggling with a CMHP. Referring to the need to 'know the team' managers stated:….

[Manager-FG2]

> *"……You have to know your team……that is a common problem across the organisation that actually managers are not in tune with their staff, or they don't know their teams" [M-P5]*

> *"Well …. I suppose you might pick up on the way that they are acting and stuff like that, because I have had people before that, you know, you can just see the change in them. Character and stuff like that and then you approach them but they still might not tell you the details, the knowing and offering support……. that's the important part" [M-P2]*

> "I think… errrm … *interventions all need start a lot earlier, I have got a big team, I have managed them for a long time, I've known many of them for a long time. You can still be supportive and helpful, but things will happen, or you start to see, actually, they are not in a good place here and you can be supportive or whatever early on, so that hopefully you don't get further problems arising [M-P4]*

"I agree ….there is a lot of that is external to the workplace, I mean, if anybody gets depressed in the workplace, then the managers should be managing that out of the work that they are giving them, that is what we are doing anyway" [M-P5]

The experiences discussed revealed how good trusting employee-manager-colleague relationships and managers 'knowing the team' as being a key factor to enabling early interventions. Whilst describing their experiences one participant then went on to describe an example of good practice…….

[Emp-FG4]

"….We have been together a long time – about 4 years, we all know one another very well we are very trusting of each other so If one of us goes off in our team they will let us know what it is about so we don't have a problem and because of that trust in our team they are happy to share so we all know what is going on in each other's lives so that is good" [E-P2]

The issues of remote and flexible working became a talking point with many outlining the difficulties of knowing your team particularly where there was an ongoing lack of contact with them. The discussions were emotive and led to an agreement that many managers did not work closely with their team. The subject of 'hot-desking' and remote working being highlighted as being a particular issue. Both employees and managers questioned how managers would ever know if there was a problem when they are not connecting with their teams, thus creating barriers and blocking opportunities for early interventions……

[Emp-FG2]

"…. line managers some are isolated from their staff and work in a complete different location……manager completely remote manages staff nearly 80 miles away - so how would the manager know what pressures and issues her staff have?" [E-P1]

"Luckily we have a manager that makes sure that they are based in each team office at least once a week to interact with the team - most of the teamwork in the community…… so she makes sure that when we start in

the morning or finish at night that she is there so if there is anything they need to talk about we can……." [E-P7]

A further issue of isolation was discussed amongst managers, with remote working and 'hot-desking' particularly being seen as a problem that could exacerbate symptoms of CMHPs.

[Manager-FG3]

As a line manager, I think the way we are working is a barrier because you don't just see things as soon as you would do…… We hot desk and I think it's a nightmare…… Anybody can sit anywhere, but actually for the people in the team who are anxious, they don't know where their desk is going to be and they can come in and the place is full, Wednesdays are notorious, they have nowhere to sit" [M-P5]

"*….. isolation is a big thing and interestingly I have recently lost a member of staff …. it was that isolation having a team that was hot desking….. I know I couldn't keep that member of staff because I wasn't supported" [M-P3]*

"……Was mental health even one of the considerations even when assessing for the hot desking and was this the right thing to do because, certainly from my own perspective, walking into a floor of grey desks and not knowing whether you are going to sit down is not the most welcoming arrival for anybody". [M-P4]

Summary

Whilst there had been an agreement that management skills needed to be improved in a variety of ways, the discussions revealed that an 'all size fits all' approach is not appropriate or effective. There was agreement that soft skills in managing people should be part of the process when recruiting and promoting individuals to management positions and through ongoing development. There was a strong feeling across all the groups that by implementing such a system this would alleviate most of the issues discussed including instigating early interventions for CMHPs. In addition to facilitating proactive actions in terms of the workplace environmental factors and stress.

The discussions highlighted a 'need' for managers to have core people skills and a degree of emotional intelligence when managing people, as technical skills alone do not allow them to 'know their teams'. In addition, all participants felt that the provision of manager development training for the key skills could potentially instil trust and confidence in them. Furthermore, it had been agreed that the mindsets and behaviours of managers can have a powerful effect on shaping culture and working practices throughout the organisation. In addition, it was felt that managers at all levels should understand the impacts of their attitudes, behaviours and actions have on others. It was further suggested that this could help facilitate 'a safe space' for employees to disclose a CMHP and not becoming isolated from the manager.

Notably, whilst discussing the issues of hot-desking and remote working the concerns that isolation could have an adverse effect on the ability to identify and intervene early for those with CMHPs were neither challenged nor disputed amongst the groups. However, the discussions raised further questions such as, does modern working cause or create isolation from the manager and if so how can a manager instigate an early intervention at the earliest opportunity? Do employees become invisible to the manager? Whilst exploring these questions further the narratives from the groups then led to the theme of 'the invisible employee' which I turn to in the next chapter (11).

Chapter 11

Theme 3 - The Invisible Employee

11.1 Introduction

The themes presented throughout the findings chapters outline a complex array of circumstances that when combined are likely to render an individual with a CMHP silent about their experience. I have referred in this chapter to 'the invisible employee' reflecting the lack of disclosures from those with CMHPs. Non-disclosure in itself presents a barrier to intervening early for the organisation as a whole. Where invisibility exists, this could inevitably prevent the organisation from creating the climate or opportunities to encourage disclosure. Furthermore, the invisibility in turn prevents the organisation obtaining a heightened knowledge and awareness of CMPHs that informs ongoing interventions and improvements so that all employees thrive in the workplace as well as in wider society.

The discussion revealed that of the employee participants *[n=13 out of 34]* experienced sporadic spells of a CMHP, *[n=7 out of 13]* had not disclosed this to either their manager or colleagues, inevitably rendering them invisible to their managers and in the organisation. A noteworthy point was that *[n=42 out of 66]* of participants suggested that individuals are likely to mask CMHPs in order to protect themselves as it was felt that it was difficult to set the ball rolling admitting to and talking about having a CMHP. Furthermore, *[n=18 out of 32]* manager participants said that whilst they had experienced or had been diagnosed with a CMHP they had consciously chosen not to disclose this to their managers or others within the workplace.

Notably, only *[n=3 out of 13]* stated that they had not personally experienced a diagnosed CMHP, although all said that they had experienced certain life events such as bereavement, that had affected their mental health for brief periods of time, or that they had interacted with family or friends at home and work who have a CMHP.

This theme, therefore, contributes to the misunderstanding of CMHPs. The linkages between the themes revealed that from an employee perspective, participants only disclosed issues related to CMHPs when they felt that they needed to and/or had no other choice. Typically, when they were struggling with their work and there was a likelihood that a formal capability investigation would be instigated or where there might be adverse impacts on the wider team of their non-disclosure.

11.2 Barriers to disclosure

A range of experiences were described across the focus groups, reportedly driven by a lack of trust and confidentiality [*n=55 out of 66]* and thus reinforcing the invisible employee……

> **[Emp-FG2]**
> *"……. I don't think I would ever go to any of the managers that I have worked for……I could not go to them and say that I have a mental health problem as there are issues with managers and then managers to managers who do not have confidential conversations……it is almost gloating in the office" [E-P5]*
>
> *"……No …. I would want to go to them…. to discuss if I have an issue with mental health…. I would not have the trust to go to someone like that…… I just wouldn't go to them" [E-P1]*
>
> *"…surely individuals find it daunting to speak to their line manager …. not knowing whether that line manager would be supportive or whether they feel that they could 100% trust them, because confidentiality I know is a big problem" [E-P2]*
>
> *"……. there is this barrier that as an individual that you could think that you are talking confidentially with somebody…….. there is no 100% certainty that it is not going to go any further and people know that……I think that is the case sometimes, but it is not all the time, but it is definitely does exist" [E-P5]*

"….. I know that there would be no point in disclosure as he would not understand it I would rather find out myself about other supportive mechanisms" [E-P2]

"Why don't we encourage talking about mental health and being more open……. I agree there is a lack of trust with others….sometimes colleagues can be a help" [E-P4]

Despite the prevalence of CMHPs across society in general, it would be highly likely that the majority of managers manage individuals with a CMHP but could be unaware because of the lack of disclosure from the individual. The lack of disclosure thus removes the ability for the manager to instigate an early intervention. However, throughout the discussions it was clear that the decision to disclose a CMHP was described as extremely difficult by employees and managers, regardless of their position within the hierarchy in the organisation. Moreover, amongst the manager groups in particular, it was felt that after weighing up the costs and benefits to them as an individual, the potential for creating barriers to career progression and promotion had been too great thus the decision had been made not to disclose a CMHP.

[Manager-FG1]

I think it's a combination of several issues…. there are people that have had issues and been off and then come back and not had a lasting effect on their career…. but I think, there are a number of people that have been off and never been seen in the same light again…….[M-P6]

"Mmm… for me……to disclose, I would need to have that trust that it would not affect my role as a manager" [M-P7]

"…… yeah, and I think that's why people don't admit to problems, as they are in danger of not being treated the same" [M-P6]

"I think what you were saying…is that there is this worry…. whether it's real or not…. that actually you will be seen as 'he won't be able to cope' or 'she won't be able to cope'…… it's erm…. Yeah …. it's a worry" [M-P1]

The employee participants revealed similar thoughts, citing that disclosing a CMHP could be a barrier to promotion. A noteworthy point was that participants felt that due to austerity measures, restructures and job uncertainty disclosing a CMHP could pose a threat…….

[Emp-FG2]

> *"……perhaps by disclosing a CMHP the individual may feel that it puts barriers in the way of promotion etc…… [E-P6]*
>
> *"I think it would be good if you could get people to speak up [E-P2]*
>
> *"……but it feels like it is a black mark on your record especially if you are in a temporary contract and with constant job insecurity…….jobs under threat" [E-P4]*

Two senior managers went on to discuss the potential issues that managers may face when making a decision to disclose a CMHP to their managers and/or peers. They felt that by disclosing a CMHP this would heighten their anxieties and risk losing their self-confidence and personal resilience, whilst making them feel vulnerable within the management hierarchy……

[Manager-FG4]

> *"I think that …. by disclosing a problem to my line manager would have likely risked them losing confidence in my personal resilience and ability to perform in the role, which would only have added to my anxiety; and would not have produced any benefits in terms of empathy, understanding or practical support" ……. [M-P2]*
>
> *"So …. it's about the barriers and not all about the manager problem, or the person problem, it could be both or it could be one or the other" [M-P1]*
>
> *"……senior leaders often remark that there is a culture of 'you're only as good as your last piece of work'……., whereas in my experience people perform best (and are in their best mental health) when they feel secure and trusted. [M-P2]*

I think it's a big thing. It's a vulnerability……. It's what makes us, us. Isn't it? ……and to share with somebody at work something that you might not have even told your best mate, it's a big thing isn't it?..... giving over some of the most vulnerable things about themselves and as a woman in a professional environment……I don't always want to be seen as over emotional" [M-P1]

"….I think that building a valuing culture and environment is, I believe, conducive to good mental health and to collaboration rather than competition, and in turn significant productivity benefits" [M-P2]

Even though managers and employees had some different reasons for not disclosing a CMHP, there was a collective agreement that being able to speak out without having the fear of having an adverse reaction from others could then lead to an early disclosure and allow for early interventions. Furthermore, it was felt that by encouraging individuals to talk would not only prevent discrimination, but would build trust within teams, and reduce any further anxiety for the individual who has disclosed a problem. On the other hand, it was agreed that managers would need to instil trust and confidence in their teams by exhibiting clear understandings of CMHPs and the reasons why employees chose to conceal a CMHP. Whilst exploring the barriers to disclosure, the iterative discussions had revealed stigma as an additional contributory factor, thus further confirming the 'invisible employee' through non-disclosure.

11.3 Stigma

The fear of social stigma had been alluded to during the focus group discussions both in the workplace and across society in general. The majority of the participants *[65%-n43 out of 66]* believed that, despite the perceived progress across society as a whole in terms of implementing legislation, the vast media coverage, and a variety of organisations who have attempted to develop understandings and change perceptions of CMHPs, stigma still exists. Participants felt that stigma has continued to have social negative connotations, misconceptions, labelling and stereotypes that in turn manifested in individuals internalising the problem due to fear of discrimination. It was therefore understood that individuals had often been reluctant to share with others in the

workplace that they were experiencing a CMHP fearing it could be interpreted in a negative way.

Furthermore, owing to the predominant white British ethnicity of the organisational setting, cultural differences such as race or religion were not raised or discussed. Instead, reference had been made to generational and gender differences in the thinking and understanding in terms of mental health problems per se. Despite more national media coverage one participant felt that more education around the subject was needed with one manager commenting….

[Manager-FG2]

> *"Nationally in the media there has been this huge push amazingly led by Princes William and Harry……. and there has been a huge push that way, so is there stigma….. I think it's just still a lack of education" [M-P3]*

However, others thought that the older generation had opposing views to those of the younger generation. It was felt that some of the older generation were more likely to find it difficult to talk about CMHPs and would be more reluctant to seek help or indeed accept any help and support offered. It was believed that some might become defensive due to perceived stigma around CMHPs. Others talked about "the stiff upper lip" and not being seen as weak. On the other hand, it was felt that there is a lot less stigmatisation around CMHPs in the younger 'millennial' generation who were more accepting of CMHPs.

[Manager-FG1]

> *"Mmm… generationally …. it's the stiff upper lip and whether you accept it or not……. there is growing awareness of mental health but that is only with certain people from older generations [M-P8]*

> *"Yes, but unfortunately, there is the stigma that exists for some people…. …. somebody might get really defensive….. they may be really offended if you tried to intervene...." [M-P6]*

The discussion progressed to the fear of stigmatisation where the employee cohort groups had identified that *[53%-n18 out of 34]* had not made a disclosure when they had experienced a CMHP, thus disconnected and disengaged with their work colleagues and managers thus internalising and masking the problem. Whilst discussing these issues one employee group commented……

[Emp-FG1]

> *"Personally …. I think there are a lot of masking issues…what do you think?" [E-P3]*
>
> *"Agree….no one can recognise what is going on behind the façade - people mask it and not something that everybody can talk about …. [E-P6]*
>
> *"Yeah …. you can be in this dark place….but it is withheld….." [E-P1]*
>
> *"….. errmmm….so …..recognising those signs behind that façade as well which can be quite difficult" [E-P6]*
>
> *"…I am just not comfortable talking about it….it is how we internalise our feeling" [E-P1]*

A manager group further linked misunderstandings of CMHPs to stigma, masking the problem that led to invisibility, suggested that *"throw away comments"* would most likely affect those who had not yet disclosed a problem to others, thus making the decision to remain silent……

[Manager-FG1]

> *"…….. there are some examples and I see the people saying the right words but the actions that go with them are exactly the opposite of the words that they are saying……." [M-P5]*
>
> *"I think it is also the consequences of throw away comments that are made about mental health problems…..and the impact on to people that might not have mentioned to others they've got an issue…..so their position is to keep quiet" [M-P2]*

"Yes, but also, I think for many people it's a fear of showing weakness or embarrassment……. People don't like airing their laundry, they want to keep that side completely separate……..and say nothing" [M-P1]

"yeah but it's the comments…'so you know, come to me my door is open'……. but it's like, bloody hell we'll never go there……. because of the managers ways or manner [M-P5]

There was a consensus that the if, how and when an individual would choose to disclose a CMHP would be influenced and driven by social stigma and the views held by others making them '*invisible*'. It was also felt that the prevalence of anxiety and depression whether medically diagnosed or not have not been fully acknowledged and these conditions tend to be labelled as negative…….

[Emp-FG2]

"I refer to it as an invisible illness with a lot of stigma around, you can be seen out and about looking well…. errm… but there is something going on underneath the surface……because there is stigma around that as mental illness is not taken as seriously as physical health or disability [E-P2]

"I agree……. there is a huge amount that still needs to be done and we need to quash this stigma, but it still exists" [E-P6]

"Mental health….is always seen in the negative and extreme…… why are we not advertising it that it is ok to have a mental health problem?" [E-P4]

"Yes, but I think that some will still be seeing the stigma……. but I agree that it might make people think a bit…..it is not going to go away until we embrace it and view it positively across society is it?" [E-P6]

"It is probably very hard to quantify…… but what amount of people who are undiagnosed…… we don't know how many are out there and especially for blokes they are not going to go to a GP as it will be seen as a sign of weakness and as you say there is a stigma attached so there are probably

quite a few people who have mental health issues and are not diagnosed and are unseen" [E-P3]

In their accounts, some manager participants referred to those individuals who had internalised the negative belief that they would not be taken seriously or perceived themselves as a 'weak link', thus leading to self-stigmatisation and invisibility…….

[Manager-FG3]

"Some of the stigma is self-imposed because people don't want to be seen to be what they perceive to be the weak link" [M-P3]

"Yes it their own perceptions……. I think it is perceptions isn't it?" [M-P1]

The manager group went on to discuss the focus on complying with the law rather than focusing on the person. It was felt that by making it acceptable to talk openly about CMHPs this could remove stigma, therefore allowing a manager to intervene early. However, the interaction between the constructs of fear and lack of knowledge potentially lead to self-stigmatisation and an employee making a decision not to seek help……

"I think the stigma is around, fear, lack of knowledge……. It's all about making the law around it and forgetting about the person….it should be more acceptable to talk about having mental health issues" [M-P7]

"yeah…. there is stigma attached to mental health illness……and I think having a more open environment to discuss it will enable people to address it earlier" [M-P1]

"Well…. on one hand, we as managers are hearing a lot of noise from some….shall we say raising issues about stress……..on the other hand I believe that there are many… many more that remain silent….not wanting to rock the boat any further……I call those people 'the wallpaper people' they just disappear into the background…..no one notices until the cracks appear……Mmmm" [M-P6]

Although it was not known if previous adverse treatment had led individuals to disengage to avoid a repetition of those experiences, however disengagement is likely to arise from the reactions they may receive and the impacts on their CMHP. Their perceptions in terms of discrimination or fear of disclosing and not being treated in a sensitive manner appeared to be an issue. Furthermore, participants felt that there was an element of self-imposition owing to a lack of confidence or feeling uncomfortable in disclosing a CMHP by walking into the unknown and how it would be received, thus adding to vulnerability……

[Manager-FG4]

> *"Even if you do express a problem….it may be well received……. but people don't know that……so it could in effect constrain them and not expose themselves to getting help…. So…. in effect you're self-imposing the pressure on yourself" [M-P1]*

> *"Yes, it's because we are not comfortable to talk about it. [M-P4]*

> *"……yes, but you will get people who will constantly say Oh my God! I'm so stressed! They are probably the healthiest people because they can communicate it and they can talk about it……. I think there is a hidden majority" [M-P2]*

> *"….. but if I am feeling really low one day……. I might not know how to communicate that to somebody……. It's really hard" [M-P6]*

> *"……I still think it's hidden……. We know with families that we work with how much is hidden and covered……so yes, I think the culture of communication around it is an issue……. How do we shift that as an organisation?" [M-P2]*

> *"I think for me…. I would probably over analyse what somebody else might say. I still think it's an uncomfortable subject for a lot of people" [M-P5]*

Despite some having a longstanding CMHP, one employee explained that they did not disclose that they had a CMHP because they had not experienced any symptoms of mental ill health for some considerable time, and therefore did not

consider that the condition affected their ability to do the job. However, by not sharing their experiences with managers at the outset meant that such individuals went unsupported. Furthermore, non-disclosure meant that the onset of early symptoms of a CMHP would go unnoticed thus missing the chance to instigate an '*early*' CMHP intervention at the '*earliest*' stage.

[Emp-FG3]

> *"…at work I did not admit to that I had a MH problem …. as I was well at time and had been for over 10 years and did believe that it would have had an adverse effect on my being employed…….. if I had a physical disability, I probably would have felt that it would have been an advantage" [E-P6]*

As indicated, the reason for the disengagement was that by disclosing there was a fear this would have an adverse effect on their employment. The participant felt that having a physical disability might have been an advantage.

Similarly, a manager commented….

[Manager-FG4]

> *"if it was a physical problem…. we wouldn't treat somebody massively different and so…… I think the culture has to change and the language needs to change" [M-P4]*

It was also evident that with the ongoing process of restructuring within the organisation which resulted in a regular change of managers this had further impacted the lack of disclosure. Employees felt that from their experiences this had not been conducive to being supported with their mental wellbeing, thus compounding the problem further. The problem of continual changes in management had been a consistent thread through both the employee and manager focus groups. It was noted that some employees had a good relationship with a manager and felt supported, however owing to organisational restructures or promotions the support had then been lost…….

[Emp-FG3]

> *"…..when jobs are changing, they have the attitude of dead man's shoes and they won't be long in this organisation and they are not empathetic and that is not the sort of person I would want to go to discuss if I have an issue with mental health and I would not have the trust to go to someone like that and I just wouldn't go to them" [E-P5]*

> "*…Yes…which all goes towards impacting upon people saying that they have got a mental health issue…. such as anxiety/depression early because they don't want to be the burden on the team" [E-P2]*

The reflective and iterative focus group discussions continued to provide strong links with the themes previously described, in particular the ongoing 'mis-understanding' of CMHPs amongst employees, managers and colleagues. Furthermore, there was a strong belief that many people continued to come into work despite the fact they may be experiencing and not disclosing an episode of ill health.

Summary

The interconnected themes and sub-themes have been instrumental in linking back to the theme of the 'mis-understanding' of CMHPs. The constructed and connected themes show that a variety of issues can affect each person differently and that a variety of approaches would need to be instigated to support individuals. However, '*how early'* could these be instigated, and what other barriers exist? Whilst reflecting on the emergent themes, employees and managers participants alike had described a range of underlying problems that facilitate the barriers to disclosure of a CMHP. The discussions revealed that the decision whether or not to disclose a CMHP would be dependent on many factors. However, it was felt that despite the ongoing promotion of CMHPs across a variety of domains many people continue to hold negative attitudes in terms of mental health ill health. It was felt that revealing a CMHP to their manager was not only a daunting experience for an individual to disclose, but there was concern of how it would be received and dealt with. Additionally, there was a sense of mistrust and the added fear that the disclosure would not be kept confidential.

Moreover, the social constructs of the participants' experiences within society and the organisation had therefore shaped the process of disengagement. Directly linking to the previous themes this theme revealed issues that caused individuals to become disengaged from their colleagues, managers, support services and ultimately the organisation. As discussed, throughout the three themes, participants had described a range of reasons why they may choose not to disclose a CMHP. Some felt fear or embarrassment of what they described as 'exposing' their vulnerabilities, how their problems would be understood or mis-understood therefore 'self-imposing' disengagement.

The following (chapter 12) provides the study conclusions and outlines how this study contributes to and expands on the existing knowledge base.

Chapter 12

PAR and the Contribution to Organisational Change

12.1 Introduction

The aim of the participatory action of research (PAR) design for this study was to involve the organisational workplace in a problem-solving process that is action orientated (Zuber-Skerritt, 2001). One of the key objectives had been to explore the research problem with a view to contribute knowledge and theory in order to facilitate organisational change. Therefore PAR, being participatory and holistic employed the proactive and collaborative method of focus group discourse and where the qualitative data converted the knowledge and theory in order to contribute to the organisation's preparedness for action and change (Levin & Greenwood, 2008). Moreover, PAR aimed to proactively address the research problem that enables an effective process of reviewing and developing of internal solutions such as a change in policy or practice.

Furthermore, the PAR design enabled a systematic approach that explored the research problem and ensured that the participants within the focus groups became cohesive and committed workgroups who collaboratively generated the data from multidisciplinary contexts that brought together reflection and action for change (Kemmis & McTaggart, 2007, Koshy et al., 2010). Furthermore, as previously described, the interconnected wheel of themes had been constructed from the data provided through the cyclical process of PAR and by those participants who were immediately concerned with the research problem. Not only did this provide holistic knowledge and theory for potential change and improvement to management practice but provided further contribution to the knowledge in terms of the '*how early is early'* question.

Throughout the study I continued to capitalise on the relationships and mutual trust that had built with the participants and the organisational stakeholders which allowed for an ongoing cycle of communication and for the emergent themes and findings to contribute to change. Furthermore, the views of the emergent themes were also sought from a range of workplace professional stakeholders such as human resources and occupational health practitioners.

The interdependencies that exist within these groups were key and were fundamental to the change process as these groups were best placed to identify potential practical changes that could be made at the operational level of the organisation. Additionally, the manager groups had continued to remain engaged and enthusiastic where they had offered to assist with facilitating and promoting key changes particularly where they 'had the ear' of their peers and senior managers.

12.2 Contribution to Organisational Change

Throughout the full period of the research study, I was required to report progress back to the organisational stakeholders and the gatekeepers, and at times this presented its own challenges particularly where organisational change was concerned. For example, organisational restructures had taken place during the study period and the gatekeeper had changed on three occasions which led to a shift in organisational priorities and operational thinking. However, the successive gatekeeper being the head of human resources and organisational change development (now the head of people, workforce and change) remained fully committed to the study and its subsequent findings. Moreover, as confirmed by the gatekeeper in the next section, the findings contributed to the strategic workforce planning and development process with a view to facilitate continuous improvement during change management. In addition, the findings facilitated a learning process of the operational practicalities and contributed to the promotion and implementation of improvement initiatives aimed at manager and leadership development. A noteworthy point was that the data provided a deeper understanding of the research problem and where gaps and root causes of why early interventions are not always instigated at the '*earliest'* stage were identified.

As previously noted, this research had been carried out prior to the COVID pandemic. However, it is understood that the challenges faced by organisations and workforces during the pandemic have been unprecedented and early reports have shown that mental health amongst employees has worsened as a result (Chartered Institute of Personnel Development (CIPD 2021), although this is an issue for future research studies. Notably the findings have provided a benchmark of a range of organisational issues such as hot-desking, remote

working and potential isolation that were in existence pre-pandemic. Therefore, against the ongoing consequences and changes that have arisen from and post pandemic the findings provide a good grounding that allows for the organisation to learn, improve and change. I therefore now turn to how the employing of PAR and the subsequent findings will contribute to organisational change.

Below are statements provided by key stakeholders who have outlined how they plan to take forward this research within the organisation. In addition, these include actions already being instigated as a result of this study:

Head of People, Workforce and Change

"The findings from this research reveal important information about the role of our managers and their impact on mental health issues. During organisational change 3 key points were identified for development with the focus on culture, behaviours and management tools, furthermore:

- *The focus groups identified that managers wanted support and help, and indeed running the focus groups has been an intervention in itself*
- *The focus groups have shown that employees and managers alike have a vested interest in action and continual improvement which can be capitalised upon.*

In addition, these findings will contribute to the fostering of deeper understandings in relation to the challenges faced by managers and employees particularly when problems arise that may affect the mental health and wellbeing of all employees.

So far the findings have provided an in-depth understanding into the issues and challenges facing the organisation and has brought attention to:

- *The importance of managers' emotional intelligence and provides a valuable insight into their team members behaviours*
- *Highlighted managers own behaviours in creating trust and rapport, so people can open up and share information*

- *Managers knowledge and understanding of the early signs of potential mental health issue and impact to stress, and simple actions they can take that might head things off at the pass*
- *Their role in intervening early to avoid common mental health issues from getting worse and supporting an individual to remain in work*

Short- and long-term actions have and will include:

- *Interim feedback and findings have been reflected in BEST framework* with a focus on engaging leadership and will continue to be developed*
- *It has been identified that as an organisation going through significant change that building resilience, providing manager tools and toolbox talks is of high importance.*
    - *This includes developing team leadership in order to identify common mental health issues in early stage that could lead to creating whole team resilience*
- *Developing a collective impact plan for improving emotional health and resilience across the organisation*
- *The data will also feed into learning from the Covid pandemic – and will be critical for comparative issues in order to instigate change*

*** B**ehavioural - **E**xcellence - **S**kills - **T**echnical competence

- Whilst technical skills and knowledge will continue to be important in the development of a leader and manager, focusing on these alone will not enable the Council to improve its effectiveness. The **BEST** Foundations Programme focuses on the essential skills and behaviours are required for successful performance as a Council Manager.

[Source: Head of People and Workforce, 2021]

Health, Safety & Wellbeing Manager

From an operational and functional change process the organisational Health, Safety and Wellbeing Manager confirmed the following:

"Many thanks for sharing the outcomes of your research study with myself and the wider organisation. Your findings will be crucial in informing a range of interventions and improvement work both at the current time but also as the organisation embarks on an extremely far-reaching organisational transformation programme which I draw attention to the ("Kreffa Warbath" – Stronger Together programme – detail provided below), and your work will be utilised as follows:

- *To inform the content of health safety and wellbeing training and interventions made available to managers and employees*
- *To support the new project initiated by the People and Workforce Board looking at how the council supports Mental Health in the workplace*
- *To inform the priorities and content of a new Health Safety and Wellbeing Improvement Plan for the council which will be developed by the Corporate Health Safety and Wellbeing Steering Group*
- *To ensure that the potential impacts and challenges in relation to mental health posed by the organisational change, remote working and management by outcomes are recognised by the organisation and embedded with the organisational change programme.*

This is a great piece of work and I look forward to working with you to use your knowledge and findings in these important work programmes"

[Source: Health, Safety & Wellbeing Manager, 2021]

To put the above into context the '*Kreffa Warbarth'* transformation programme had provided a blueprint for the future state the organisation wants to achieve and the programmes which will help achieve it. The transformation narrative evolved from visioning work and sharing stories from across the organisation. A snapshot of the strategic transformation programme is broadly outlined below and where there are several layers sitting beneath this and where the findings of this research will inform organisational change as confirmed above:

Strategies – Vision of the future organisation:

People and Workforce	To work in a positive culture built around shared values, where everyone has a voice, and has the courage to improve, innovate and learn.

	Organisational values are embedded in people practices and employment lifecycle, with HR services digitally enabled and efficient.
	To be highly motivated & engaged and grow skills and are well led by inspirational and supportive leaders

[Source: Southwest Council, 2021]

Occupational Health and Wellbeing Manager

"Many thanks for sharing the outcomes of your research. It is hoped that your findings will be used as part of the organisational wellbeing plan/strategy. Given the current organisational changes and impacts from new ways of working, Covid, covid response and current sickness/occupational health referrals we are planning on organising a new health and wellbeing steering group. The steering group will be made up of Heads of service and/or Directors within tiers 1-4 of the organisational structure. The aim of the group will be to review both pre-pandemic information and results of the recent employee survey to help inform a range of mechanisms and interventions.

A key focus will be on understanding mental health within Southwest Council, normalising the discussions and ultimately bridging the gap between understanding of physical and mental health in the workplace.

Specifically, your research will be used for comparison of (but not limited to)

- *Employee perceptions of management behaviour and culture towards mental health illness*
- *Understanding of current interventions/impacts and effectiveness*
- *Comparison to employee focus groups and 1:1 undertaken mid and post pandemic*
- *To support the new project initiated by the People and Workforce board looking at how the council supports Mental Health in the workplace*
- *To inform the priorities and content of a new Health Safety and Wellbeing (HSW) Improvement Plan*

Further to the above I will also be undertaking a research project for South West Council with reference to the current home worker situation under the "Any space any place project" (ASAP) and impacts on social engagement, management support and organisational demand and mental health. This will be referenced against the recent Faculty of Occupational Medicine (FOM) and Chartered Institute of Personnel Development (CIPD 2021) report into health and home working. Your research will provide a valuable insight and record of pre-pandemic feedback and help us understand what our culture has looked like at an organisational, service, team and individual level.

The internal evidence base contains:

- *PhD research findings (Dawn Bailey)*
- *Employee Check in survey June 2020*
- *Employee check in Survey Apr 2021*
- *Directorate specific culture and engagement focus groups*
- *HSW steering group documentation*
- *Health Champion feedback sessions*
- *Sickness absence data Apr 2020-June 2021*
- *OH referral data 2020-June 2021*

It is hoped that from these two work elements (health and wellbeing steering group and research document) we will be able to provide Southwest Council with a blueprint of how we should create an "employee first" strategy for the next 3-5 years and beyond. The plan is to have additional work groups and I would be really keen for you to be an active part of this so that you can see at first-hand how we have or hope to utilise the information that you have provided.

Once again many thanks for the information you have provided and its value to Southwest Council shaping its future principles around mental health".

[Source: Occupational Health and Wellbeing Manager, Southwest Council, 2021]

In addition to the above, this study has also contributed to:

- The development and launch of an e-Learning module named 'mental health in the workplace awareness'

- Informed a presentation and report to the people and workforce board as part of a management review into sickness absence from stress, anxiety and depression.
- Further informed a cycle of focus group activity undertaken by the occupational health team in order to understand issues arising from the pandemic in relation to stress, anxiety, depression and musculoskeletal problems.

Summary

As previously discussed, for this study PAR was deemed suitable for the in-depth exploration of the complex issue of CMHPs and early interventions within the organisation. Rooted in the direct participation, action and reflection with those that were seen as the problem owners, and who, through collaborative discourse, provided their unique perspectives on the root causes, gaps and issues within the organisation in terms of CMHPs and early interventions (McNiff, 1988, Dick, 2002, Molineux, 2018). Moreover, PAR provided a systematic and dynamic process through the active participation and collaboration of key stakeholders within the organisation who generated and socially constructed the knowledge, themes and subsequent findings, which in turn contributed to a programme of change and improvement within the social context of the workplace (Zuber-Skerritt, 2012, Molineux, 2018). To this end, for this study the PAR design has proven its suitability for occupational management and practice-based research that has consequently brought together the generation of theory and knowledge and going some way to solving the problem of '*how early is early'* when instigating early interventions for CMHPs in the workplace.

I now turn to the next chapter (13) that provides a discussion of the theoretical model that has developed from the study, the findings and the relationship to current literature.

Chapter 13

Discussion

13.1 Introduction

The aim of this study was to explore through social discourse, early workplace interventions for common mental health problems (CMHPs) within a large UK local government setting. The premise of the study was to yield an original contribution to knowledge by addressing two key questions:

- When instigating early interventions for common mental health problems in the workplace – *"how early is early?"* and
- Does *"early"* differ in terms of what employees would find beneficial and what management currently provide.

Previous evidence had remained inconclusive in terms of the definitions of '*early*' and '*very early interventions'* (Vargas-Prada, 2016). Therefore, for this study the key objectives were to:

- Understand whether barriers to intervening were in existence within the workplace and if so, what actions might assist with breaking down those barriers
- Explore the lived experiences of a range of different stakeholders drawn from across the workplace in order to understand awareness, knowledge and management practices existed. In addition, exploring what targeted strategies could be implemented to enable proactive interventions.
- Explore what organisational changes might need to be made to facilitate the implementation of early interventions.

Despite the prevalence of and increasing awareness of common mental health problems in the workplace a range of negative psychological experiences associated with CMHPs continue to be in existence (National Institute for Health and Care Excellence, (NICE), 2019). Notably, this study has identified that issues with the non-instigation of '*early*' interventions are not limited to one single factor but are often multi-faceted and span across a range of organisational and societal factors. In order for interventions to be instigated at

the '*earliest*' opportunity, an effective multidisciplinary approach would be needed and framed within a wider management framework to ensure that the workplace is a psychologically safe place. These findings sit in parallel to the published studies of LaMontagne, (2014), Joyce, (2016), Martin, (2016), Memish et al., (2017) who identified that proactive, positive and multi-faceted intervention are not commonplace in organisations.

As presented in the preceding chapters, three primary themes, namely the misunderstanding of CMHPs in the workplace, manager skills and behaviours and the invisible employee emerged from the grounded theory method of data analysis. Intrinsically linked to these are the broader themes of social and organisational culture and values. These broader themes are particularly pertinent in this study as poor social and organisational culture and values can give rise to a set of beliefs or core assumptions that in turn negatively impacts those with a CMHP (Willcoxson & Millett, 2000).

13.2 The Wheel and Spoke Theoretical Model

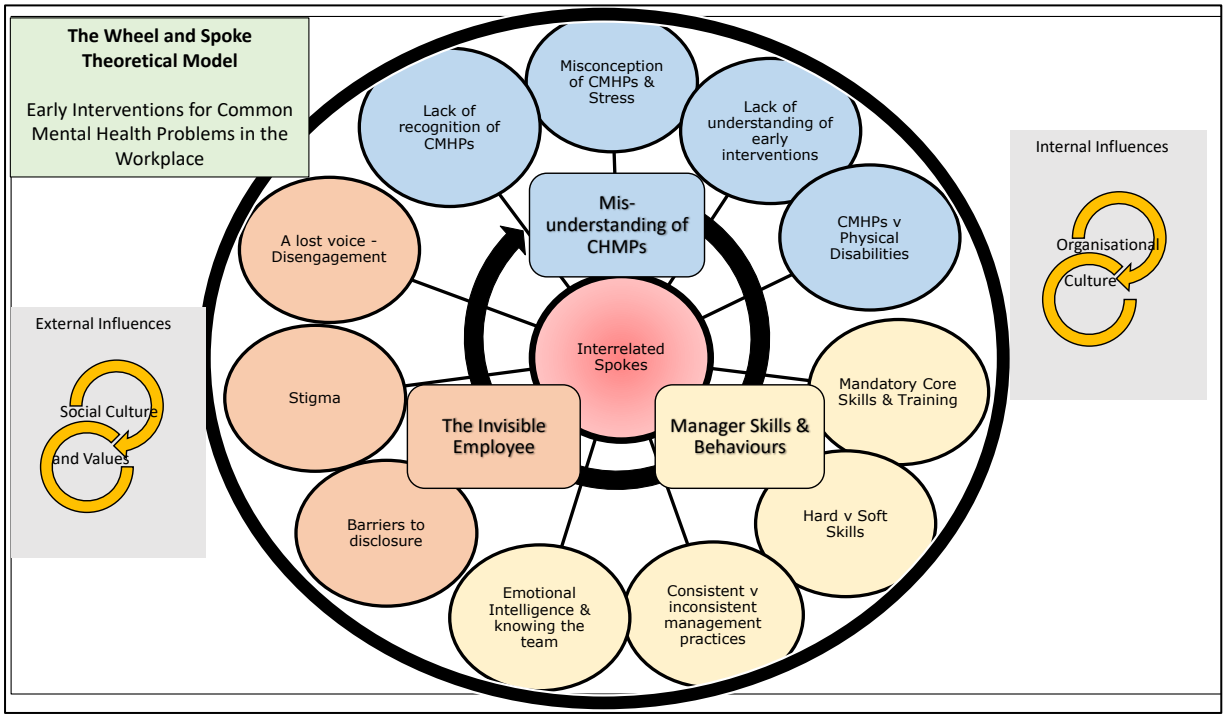
As previously described, the emergent themes and sub-themes together formed a systematic and broad-based series of socially constructed interrelated and interconnected concepts. Based on the research question, '*how early is early?'* in terms of early interventions for CMHPs in the workplace, I further reviewed the socially constructed themes. Whilst reviewing the themes I found that they formed a continuum that brought together the interrelated concepts that explain and predict events or situations and specify relations among the variables (Glanz, 2008, p. 114). I therefore named this the 'wheel and spoke' theoretical mode [Figure:14].

Previous studies had identified a tendency for interventions to be single-focused and where studies have rarely considered multi-level approaches to interventions for CMHPs, therefore the theory in this study builds on this (Martin, 2014, LaMontagne, 2014). Furthermore, I believe that the theory differs from other '*early*' workplace CMHP intervention research studies where the theory and its interrelated concepts supports evidence in the literature where it focuses on the wider, holistic and integrated 'early' intervention approach (LaMontagne, 2014, Joyce et al., 2016, Martin, (2016), Memish et al., 2017).

Additionally, the resultant theory goes some way in closing the gap in current literature and has been developed through utilising the sound principles of PAR, the social construction of knowledge in a workplace setting, with a focus group method of social discourse that acknowledged the views of organisational stakeholders (Baum, 2006, RCPsyc, 2010, WHO, 2010, LaMontagne, 2014, Feltner, 2016, Joyce, 2016, Memish, 2017, Nicholson, 2018).

I believe that the theoretical model that has emerged from within this study presents an innovative, multi-faceted and interrelated approach that provides an explanation as to why early interventions are not implemented at the earliest possible stage. Therefore, the theory supports the development of a system that promotes a workplace culture that allows for positive disclosure, early detection, prompt management, leading to supporting individuals whilst in the workplace thus preventing sickness absence (Fenton, 2014, Karanika-Murray, 2015, NICE, 2016). This in turn could then support the individual, support managers and support the organisation, in addition to improving communications between the manager and the individual that would go some way to building a sense of openness and trust (Pomaki et al., 2012).

Figure 14- The Wheel and Spoke Theoretical Model

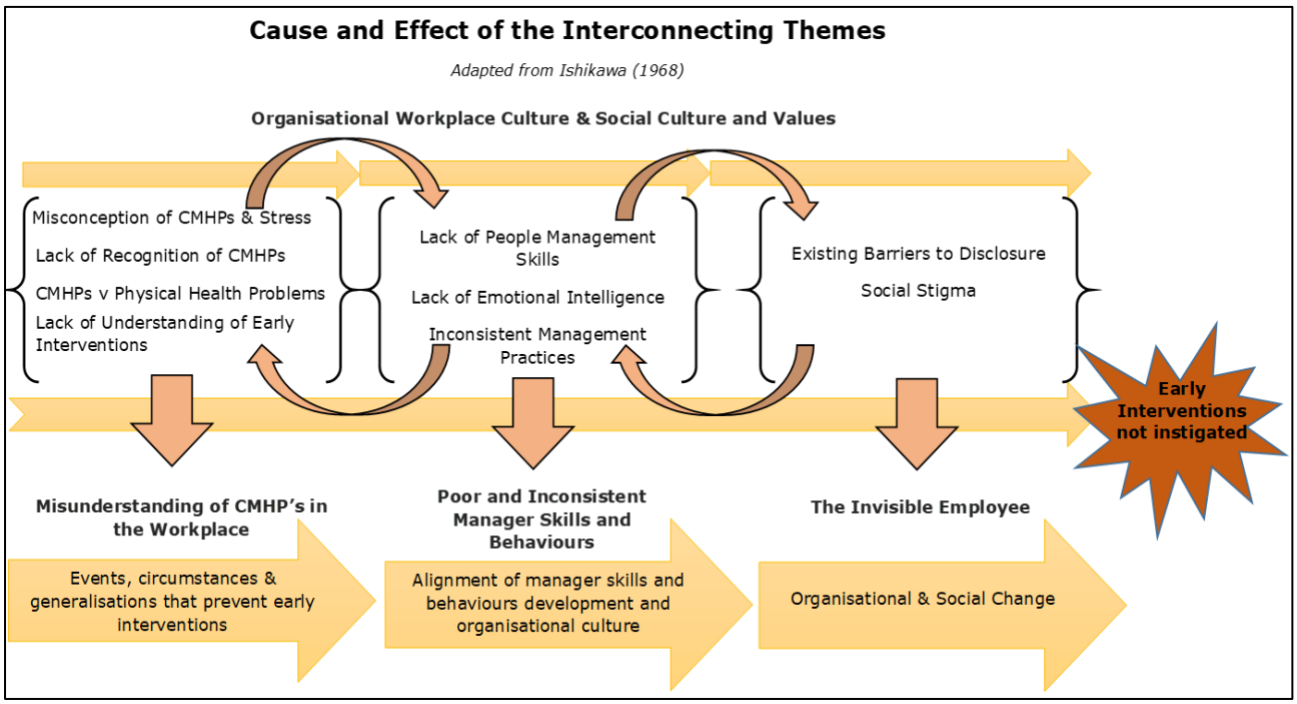


The Wheel and Spoke theoretical model as depicted above represents the three overarching themes where each wheel is a functional part that interacts and depends on the other in order to function efficiently. The underlying sub-themes being the spokes and are a critical set of operational parts that allow for the functional parts to freely gain momentum, thus enabling the potential for '*early*', interventions to be instigated at the '*earliest'* opportunity. For example, '*early*' being immediately following a diagnosis or when an individual is beginning to experience a decline in mental health. Essentially, the sub-themes (spokes) are the operational factors that underpin the three themes, and where one sub-theme (spoke) fails, the wheel is likely to continue allowing for other factors to be instigated, however, where multiple sub-themes (spokes) fail, the momentum stops leading to a collapse in the process.

Furthermore, the themes and sub-themes will be influenced by the organisational and social culture and values, and without organisational change the operational factors are likely to fail, proactive '*early*' interventions will not be made for those with CMHPs at the earliest opportunity and the organisational culture will maintain the status quo. The theoretical model expands on previous primary intervention theories that aim to reduce the incident of CMHPs by modifying the environmental conditions of the workplace (Bhui et al., 2016, Memish, 2017). Although the environmental conditions of the workplace cannot be ignored, the theoretical model arising from this study goes a step further and aims to build on previous theory by putting the focus on social, organisational and cultural development and change that provides an environment that instigates early interventions at the earliest stage.

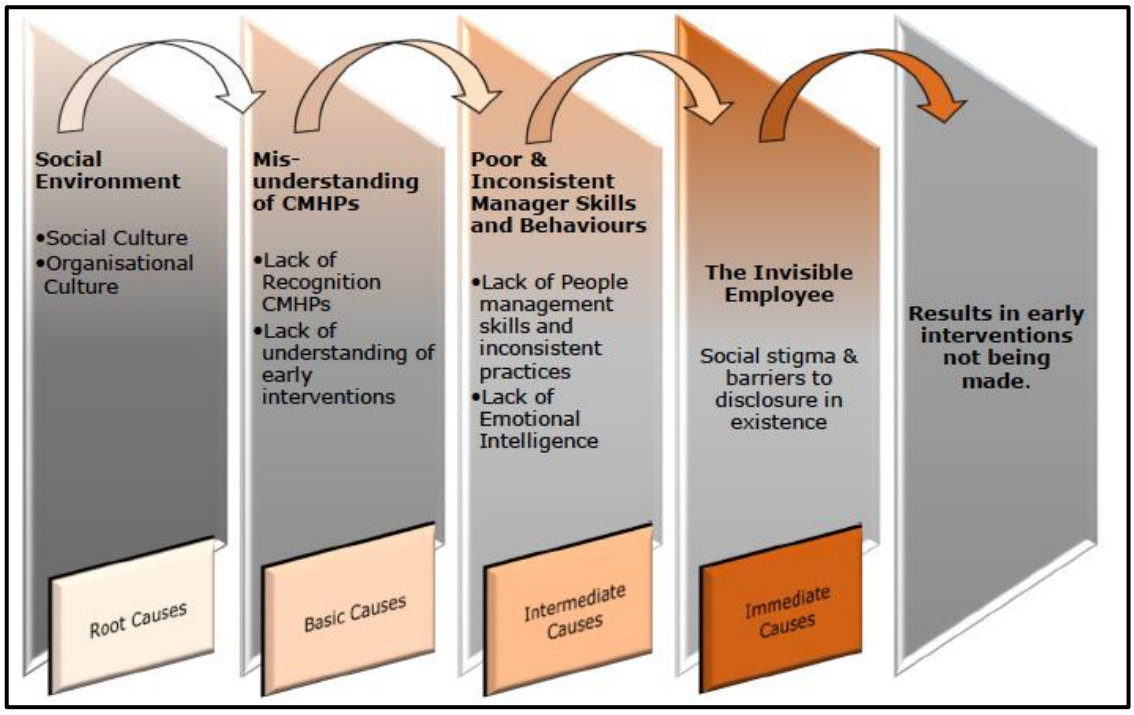
To put this into context, I firstly present the resultant theory in a cause-and-effect diagram as adapted from Ishikawa, (1968) [Figure:15]. The diagram depicts the interlinking themes, provides the primary and secondary causes and the influences and impacts that further theorises why early interventions are not always made at the '*earliest*' opportunity. As discussed above, the theoretical model identifies the core interdependencies and interrelationships that underpin the factors that can result in a chain reaction, where one link fails it is likely that the subsequent links fail thus not supporting the instigation of early interventions at the earliest opportunity.

Figure 15- Cause and Effect of Interconnecting Themes



To expand on and substantiate the emergent theoretical model further, I have adapted the framework of Heinrich's (1931) Domino Theory. Heinrich's (1931) theory presented a set of theorems known as 'the axioms of health and safety' and over many decades the theory has primarily been used as a workplace accident or incident investigative tool. This model blends together multiple causation theory with the concepts of societal and organisational culture and values, and management influences and behaviours [Figure:16]. The multi-factorial and often complicated sequence of factors show that they are complex in nature, are interactive, and where one factor fails this then instigated a knock-on effect on the next factor until each fails and ultimately results in early interventions for CMHPs not being instigated at the earliest opportunity or indeed not at all (Heinrich, 1931, Bird & Loftus 1976, Peterson, 1978, Reason, 1997, 1998).

Figure 16- The Axioms of CMHPs and Early Interventions



[Adapted from Heinrich, 1931]

Furthermore, the identified root, basic, intermediate and immediate causes when activated would be more likely to result in subsequent sickness absences, presenteeism, loss of productivity, a lack of trust of others and low morale.

I now turn to discussing the emergent themes and theory, highlighting its correlation as well as identifying any discrepancies from within the existing body of literature.

13.3 The Findings of this Study and its Relationship to Existing Literature

Overall, the findings identified that inconsistencies in management practices, behaviours and approaches to CMHPs. It was identified that distinct differences are in existence and how CMHPs are understood amongst employees, their peers and managers, and were the key causal factors of why interventions are often not made at the earliest opportunity.

13.3.1 The Misunderstanding of CMHPs in the Workplace

The first theme and associated sub-themes that emerged was the misunderstanding of CMHPs. This theme builds on the evidence from the

existing literature where Keyes (2005) and Barry (2009) suggested that the exploring of the layperson's view would be more likely to provide a greater insight and deeper understanding into CMHPs with the view to enabling positive interventions, thus the PAR design of this study supports this. Furthermore, it is evident from the findings of this qualitative study that the misunderstandings of CMHPs continue, confirming that there are distinct differences between a theoretical based view and that of a lay person and their lived experiences (Milburn, 1996).

Despite anxiety and depression being the most prevalent CMHPs, the misunderstanding of CMHPs in the workplace theme is in parallel with the studies of Sanderson & Andrews, (2006), Theis et al., (2018), and Meunier et al., (2019) who posited that the lack of understanding diminishes work functioning, absenteeism and increasing presenteeism. In addition, the existing body of literature identified that work-related stress had been included in the theoretical debates of CMHPs with a continuing tendency to attribute CMHPs to stress and the workplace environment, this theme and its sub-themes fully supports this view (Kiman & Jones, 2005, McCormick, 1997, Warr & Payne, 1983).

Notably, the findings of this study corroborates other the qualitative studies of Bhui, et al., 2016, Cooper et al., 2001, Cox, 1993, Kinman & Jones, 1993, Irvine, 2014, who have suggested that considerable variations exist regarding how the concepts of stress and CMHPs are understood and where a variety of terms are used interchangeably thus leads to further confusion.

Moreover, despite many theoretical models conceptualising stress as a reaction to adverse life events, the evidence in this study confirms that stress continues to be a default position for many managers when individuals raise issues in terms of a CMHP (McCormick, (1997), Kiman & Warr & Payne, (1983), Jones, (2005), Sanderson & Andrews, (2006)).

In addition, the findings confirm that the concept of stress and CMHPs remains contested with a lack of clear distinction between stress, poor mental health and significant clinical disorders (Cox, 1993, Kinman & Jones, 1993, Cooper et al., 2001, Irvine, 2014, Bhui, et al., 2016). Notably, the subjective constructs of

this study build on previous theory-based concepts of CMHPs and provides further evidence-based research (Helman, 1985, Kinman & Jones. 2005).

13.3.2 Managers Skills and Behaviours

Given the psychological effects associated with CMHPs, the confusion that surrounds the perceived understandings or misunderstandings of CMHPs have resulted in dismissive attitudes often being experienced by those with a CMHP. As such, the evidence shows that the distinct lack of empathy from managers has primarily been caused by the shortfall in their ability to recognise that a wide range of life circumstances can determine mental well-being or psychological distress of an individual. Moreover, the findings have confirmed that the dismissive interactions, communications and lack of emotional intelligence thus negatively affected individual's mental wellbeing, and primarily driven by the lack of understanding of CMHPs and a lack of empathy towards individuals' problems.

The findings correlate with, and build upon the previous thinking of Bryan et al., (2018), Dimoff & Kelloway, (2018) who found that managers approaches and attitudes to CMHPs would ultimately determine the occupational outcome of those who experience CMHPs, whether they are positive or negative. Moreover, existing literature had identified a dearth of qualitative research that explored what barriers both employees and managers face when managing those with a CMHP (Bryan, et al., 2018), this study therefore had attempted to close the gap.

The lack of people management skills was identified as a sub-theme which supports the studies of Goleman, (2001) and Collins & Cooper (2014) who suggested that often organisations focus on technical competencies whilst overlooking social competencies, emotional intelligence and empathetic awareness of others. Social and management competencies alongside mental health literacy are therefore key elements when managing those with CMHP in the workplace and has been evidenced in the findings of this study.

Furthermore, the findings support recent research and guidelines published by WHO, (2022), who made strong recommendations that managers should be trained to enhance their knowledge, attitudes and behaviours in order to

improve employees help-seeking behaviours. In addition, a key point is that this study aligns and supports the WHO, 2022 study where it is suggested that the provision of appropriate training should help managers to identify and respond to those who need support for CMHPs. Other key areas included ensuring that managers had the confidence to recognise, engage and support employees with a CMHP that could produce the benefit of reduced stigma (WHO, 2022)

13.3.3 The Invisible Employee

The findings confirm the continuing existence of several barriers to disclosure within both society in general and the organisation. Whether or not to disclose a CMHP in a workplace environment is not a black and white decision, particularly where there is a lack of knowledge and understanding from others i.e., managers and peers and as discussed in the previous themes (Corrigan, 2012).

Notwithstanding mental health, ill health and employment being high on social and organisational agendas, prejudice, discrimination and stigma continues to exist, many individuals prefer not to disclose a CMHP (Irvine, 2011, Corrigan, 2012, Grice, 2016, Brouwers, et al., 2019). This theme of 'the invisible employee' thus supports and corroborates with the previous literature where it had been highlighted that many individuals feared being disadvantaged or discriminated against thus approached disclosure of a CMHP with wariness and caution (Czabala et al. 2011, Little et al. 2011 Ahola et al. 2012, Brohan et al. 2012, Mendel, et al., 2013).

The findings of this study have confirmed that the 'fear' of disclosure has continued to exist across varied levels of the organisational hierarchy. Furthermore, the findings reinforce the studies of Brouwers, et al., (2019), Uçok, et al., (2012), Corrigan, et al., (2008) where employees believed that the lack of understanding of CMHPs, coupled with poor attitudes and behaviours of managers created a negativity that is often deep seated and where assumptions are made that CMHPs negatively impact on work performance and sickness absence (Mendel, 2013).

In addition, this study found that managers felt that several factors influence their thoughts and decision making whilst considering the pros and cons of

disclosure. These factors included the wider organisational and management cultures and the impacts on their emotional resilience and career progression (Brunner, 2007a, Henderson, et al. 2012, Corrigan et al 2015b, Waugh, et al., 2017).

The findings of this study confirmed that managers often struggled to understand CMHPs, due to not having been trained in the recognition of CMHPs and how they may affect individuals differently, but also how some attitudes can be perceived as stigmatisation. The interaction of these issues thus created a 'domino' effect that triggered subsequent negative repercussions and where trust and confidence in others had been lost. When combined, these factors consequently created a culture of non-disclosure and where employees became 'invisible' to the managers, the organisation and support provision whereby early interventions could not be made at the earliest opportunity or indeed not at all. The findings also bear witness to the studies of De Lorenzo, (2003), Baldwin, (2004), Dewa et al. (2004), Corrigan et al. (2010) where it was found that large numbers of employees choose to keep CMHPs hidden, internalising CMHPs their voices therefore going unheard, thus equating to a 'lost voice' thus ultimately becoming 'invisible' to the organisation.

Summary

Overall, the findings have identified the interdependent problems that exist within the workplace but also extend beyond the workplace. The interrelated themes in this study include the broader aspects of employees' experiences in terms of early interventions for CMHPs.

Notably, the themes and impacting issues found in this study are highly likely to impact further on the current hybrid and homeworking scenarios that have evolved since the start of the Covid pandemic. This dramatic change in the world of work will undoubtably impact on how managers and organisations manage people whilst working remotely. Moreover, where deep seated issues as identified in this study are not addressed effectively it is likely that this would ultimately lead to psychological safety failure within an organisation with employees becoming further disengaged from both their managers and the organisation. However, this is something that should be considered in future

research studies. The following chapter 14 presents the wheel and spoke theoretical model as an enabling tool and demonstrates where certain conditions are in place, positive improvements and change could be made thus leading to early interventions.

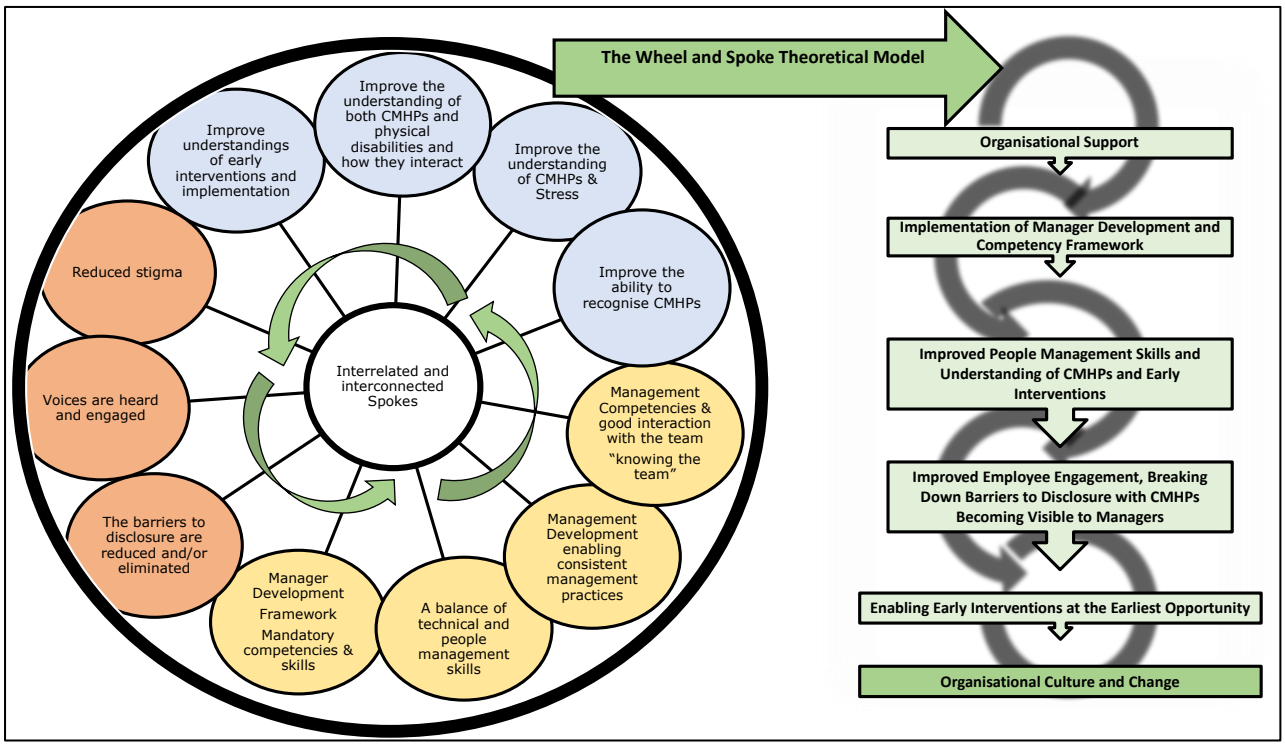
Chapter 14

The Wheel and Spoke Theoretical Model - Enabling '*Early Interventions*' at the '*Earliest Opportunity'*

14.1 Introduction

In order to address the question of "*how early is early*" when instigating early intervention for those with CMHPs would indeed require the creation of a psychologically safe organisational culture. A positive culture would be one that improves understandings of CMHPs, upskills managers to understand the impacts of their attitudes and behaviours on others, provides development of supportive people management skills and competencies whilst addressing other barriers such as stigmatisation. This chapter therefore presents the wheel and spoke theoretical model and the factors that when approached from a positive stance, could contribute to facilitating the implementation of '*early'* interventions at the '*earliest'* opportunity, for example when problems start to arise and/or when diagnosed [Figure 17].

Figure 17: The Wheel and Spoke Theoretical Model



Positive outcomes can include subjective psychological wellbeing, positive mental health management, employee engagement, and positive organisational

attributes such as authentic leadership, supportive workplace culture and workplace social capital (LaMontagne, 2014, Keyes, 2005). Therefore, the functional wheel and spoke model being a critical set of operational and functional parts, can contribute to positive improvement and change, thus supporting the potential for enabling '*early*', interventions at the '*earliest'* opportunity. Furthermore, as an enabling model, its operational factors underpin the three themes that, when implemented in a positive, supportive organisational culture will allow for the flourishing and optimal functioning of employees, managers, groups and the organisation as a whole.

This model thus builds on existing literature and the multi-dimensional concept of 'mental health literacy', that includes the factors of knowledge, beliefs and understandings of positive mental health, interaction, intervention and management of mental health, decreasing stigma and the enhancement of help-seeking efficacy (Jorm et al., 1997, Milliken, et. al., 2003, LaMontagne, et al., 2016, Kutcher, et al., 2016, Moll et al., 2017). Furthermore, the findings bolster the thinking of Martin et al., (2014) and LaMontagne et al., (2014) who suggested that holistic multi-level or integrated intervention approaches that focus on the interplay between individuals, workgroups, organisational and societal factors are rarely implemented in practice. However, implementation and success measures of such a strategy would be something for future research.

As previously presented [Figures: 15 & 16] I have replicated the cause and effect and the axioms diagrams taking into account the primary and secondary influences that could contribute to positive impacts on the early interventions are not always made at the '*earliest*' opportunity.

Figure 18: Facilitating a Process of Early Interventions

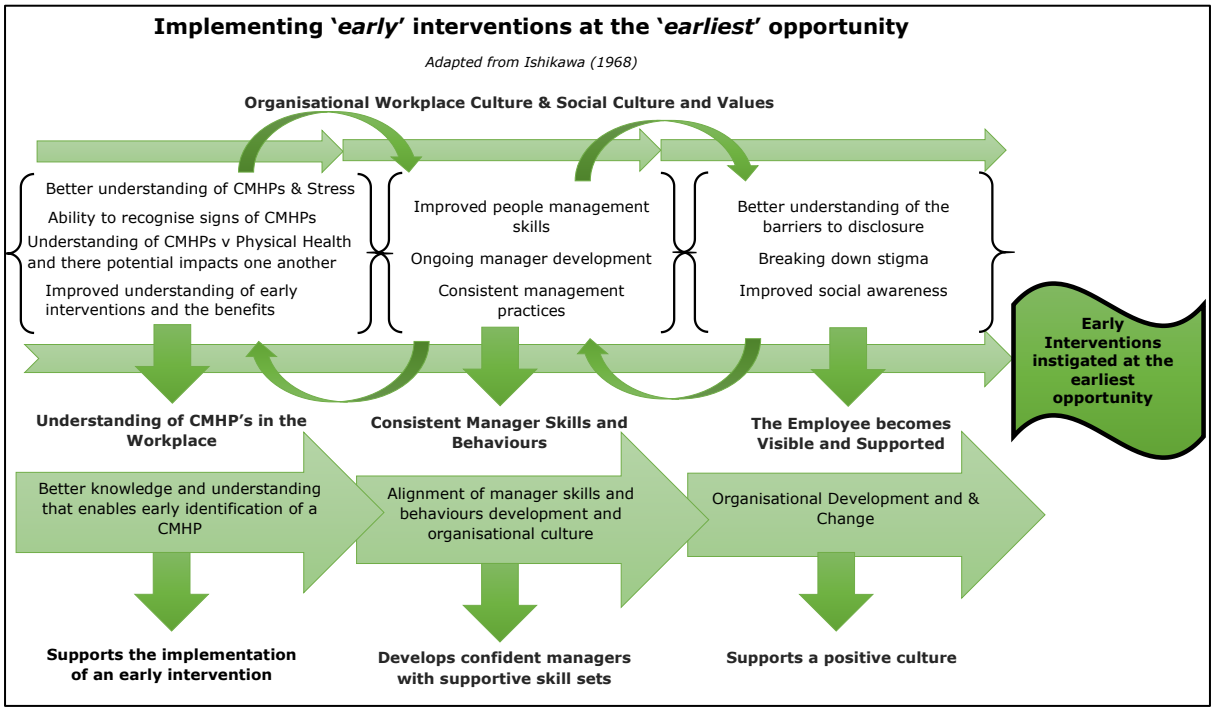
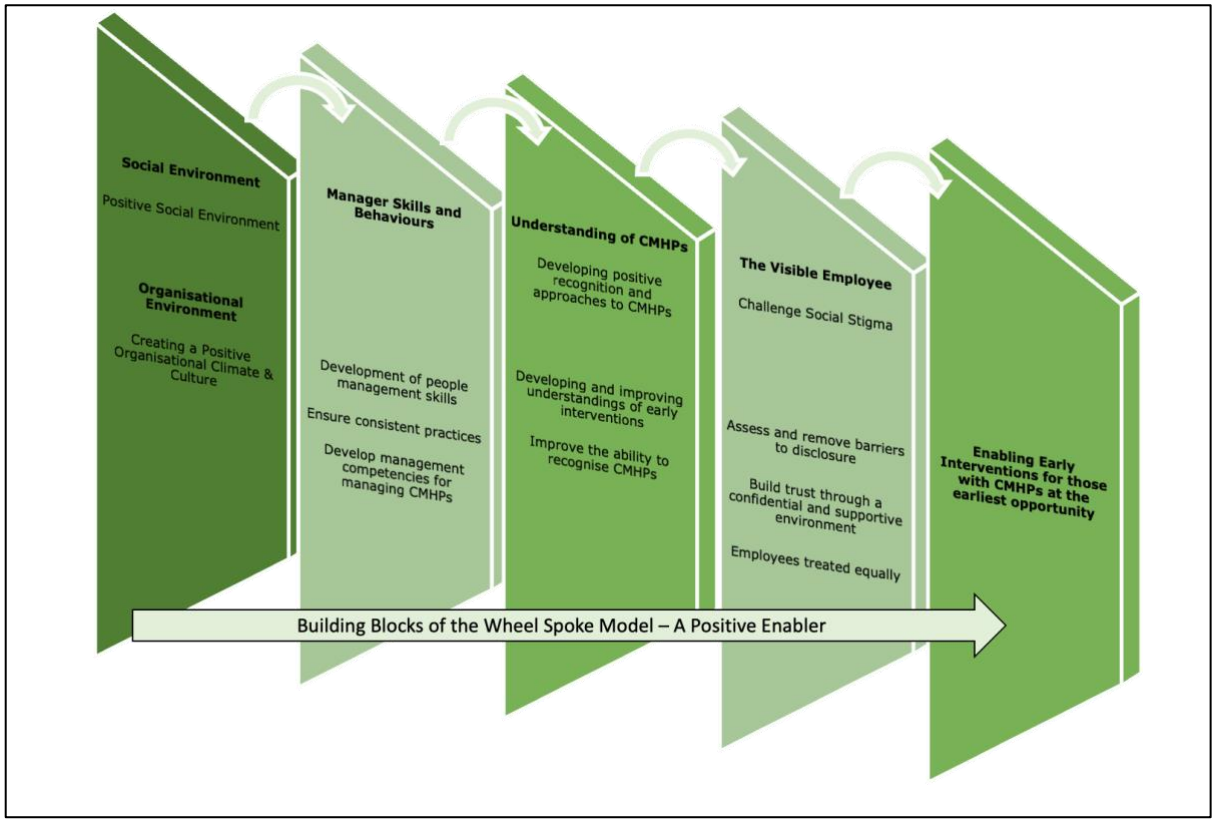


Figure 19: Axioms of Early Interventions



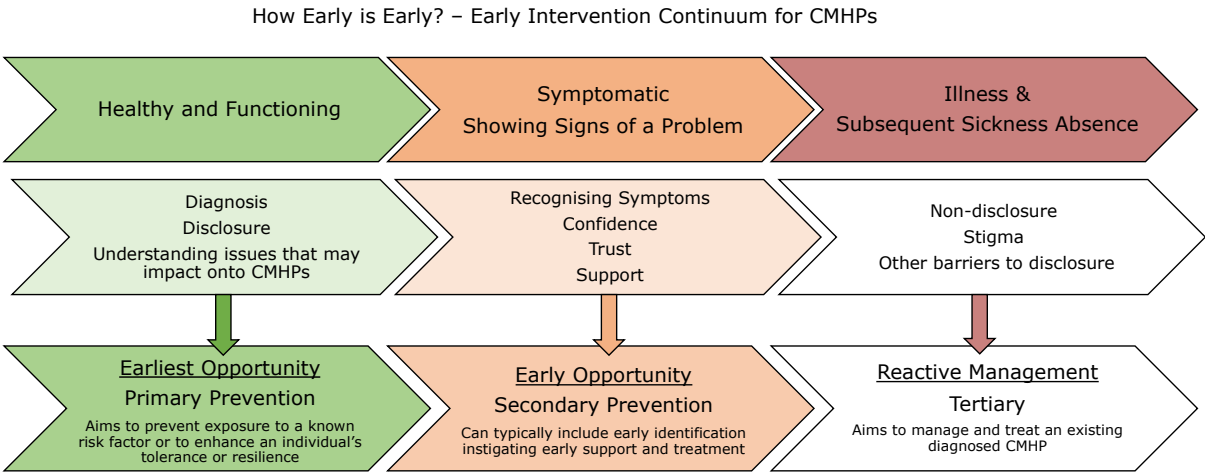
[Adapted from Heinrich, 1931]

14.2 How 'Early is Early?

Based on the literature previously discussed where '*early*' interventions had been broadly classified as primary, secondary or tertiary where they aim to prevent, treat and rehabilitate those diagnosed with CMHPs. The findings of this study challenge the current definition of 'early' when implementing early interventions for CMHPs in the workplace.

As previously discussed, interventions are often made at a later (tertiary stage) when an individual has fallen into a period of sickness absence and where it is often deemed an early intervention when rehabilitating them back into work. It is therefore argued rehabilitation is not an proactive early intervention but a reactive intervention. Furthermore, this study suggests that 'early' is on a continuum similar to the mental health continuum [Figure: 20]. However, in order to negate the need for reactive interventions and activate a positive early intervention several factors and conditions will need to be in place.

Figure 20: How *'Early is Early'* Continuum



Firstly, an individual will need to feel confident before disclosing a CMHP whether it be at a job interview stage or following a diagnosis and secondly, having trust and confidence in their manager to provide a supportive environment. On the other hand, a manager will also need to be confident in either approaching an individual that may be showing signs of a CMHP and knowing how and what procedures to implement, whether it be having a difficult conversation or referring to an employee assistance and onward support, if indeed one exists.

14.3 Instigating Early Interventions at the Earliest Opportunity

The findings from this study reinforces the need for the further development of a broader based holistic framework that promotes early workplace mental health interventions and support. Not only would it go some way to 'normalising' the language used for CMHPs but could also contribute to enabling earlier disclosures and the removal of stigma in terms of anxiety and depression. Furthermore, it would set the standards and expectations of managers to manage CMHPs and ensure that managers obtain a comprehensive understanding of CMHPs. Moreover, this would help managers understand how their behaviours can impact on whether an individual discloses a problem at an early stage, thereby empowering managers to make positive 'early' interventions. In turn, it is suggested that the approach could enable emotional and interpersonal skills thus raising managers confidence, strengthen lines of communication and enabling trust between the manager and employee.

A key point posited by Bryan et al., (2018) suggested that manager confidence was a strong predictor on manager behaviours when faced with an employee presenting with a CMHP. In addition, Bryan's study challenged the provision of general mental health training for managers and as previously discussed it is unclear as to whether this type of training alone would translate into positive changes in manager behaviours towards managing CMHPs and stigma in the workplace.

Furthermore, it was unclear if standard mental health training would provide managers with a high level of confidence to engage with and instigate positive communications with those employees who were suspected or confirmed to have a CMHP (Bryan et al., (2018). Based on the discussions it is clear that EI for example would not necessarily be appropriate in developing managers to actively engage and manage those with CMPs. Instead, the development of a broader based competency framework could assist with the ongoing development of manager competencies in order to build 'soft' skills and confidence. It is believed that the Wheel and Spoke theoretical model would contribute to the building of a broad-based competency framework.

The following chapter discusses how this study contributes to knowledge, outlines those who have been identified as the stakeholders and beneficiaries of this study, the limitations and implications for further research.

Chapter 15

15.1 Introduction

This chapter provides a discussion of the contribution to knowledge that I believe that this study provides. The following sections include an outline of those that have been identified as being stakeholders and beneficiaries of this study, the limitations and implications for further research.

15.2 Contribution to Knowledge

Firstly, the use of a PAR design has provided a deep understanding through a social constructionist lens, stakeholder perspectives of common mental health problems and how *'early is early'* when instigating early support interventions and what barriers prevent these happening. It is believed that the findings of this study have significant implications for understanding when and how an early intervention can be made for an individual presenting with a CMHP.

The findings not only provide a contribution to knowledge but have attempted to close the gap in terms of the lack of qualitative studies that have employed focus groups as a method that target early intervention strategies which aims to collectively benefit the manager, employee and the organisation. Moreover, and as discussed throughout this study, there is a dearth of research of this type within the UK local government arena, it had been identified that more focus was needed on the public sector when undertaking studies for early workplace interventions for CMHPs (Vargas-Prada, 2017). In addition, the literature identified that local government has a crucial part to play in the delivery of the Government's mental health strategy ensuring that action is taken locally to achieve the strategy objectives to improve mental health for all (Farmer & Stevenson, 2017). It is believed that this study will contribute new knowledge to inform and support the government initiative. Furthermore, to date no known research studies have been published that support the initiative.

Secondly, the evidence presented in this study provides a key contribution to and builds on previous theories that have suggested that interventions need to be integrated and multi-faceted and where multi-level approaches facilitate early

interventions for CMHPs in the workplace. Although, in order to do this managers, have a key role to play in determining the effectiveness and outcomes of interventions for CMHPs in the workplace. Building on previous literature this study had implied that managers are a vital ingredient when exploring, developing and instigating interventions (Bryan, et al., 2018).

A key finding of this study further builds on the studies of Johnson, et al., 2015, & Bryan, 2018, and identified that many managers are not effectively equipped with the confidence or skill sets to support those they manage with CMHPs. Effectively, 'managers don't know what they don't know'. Expanding further, this study has confirmed that the attitudes and emotional intelligence of managers from across the organisational hierarchy is a strong indicator of their behavioural response as to whether proactive or reactive interventions are made (Bryan, 2018). Furthermore, whilst it is not expected for managers to become experts in psychology, the findings in this study supports the findings of Schott (1999) who suggested that most management training programmes were inadequate and deficient in the area of CMHPs.

Additionally, the findings add to the rapidly expanding field of CMHPs and work, thus contributing and strengthening the body of knowledge that exists and where it was suggested that a myriad of factors need to be in place and effective in order to instigate early interventions for CMHPs such as those published by LaMontagne, (2014), Joyce, (2016), Martin, (2016), Memish et al., (2017). As discussed above, managers skills, attitudes and emotional intelligence are key when supporting those with CMHPs, although to enable this, it requires trust and a positive attitude from both the employee and manager to ensure a positive outcome. The findings in this study therefore continue to build on those factors that may or may not support early interventions for CMHPs at the earliest opportunity. Moreover, the qualitative nature of this study contributes to the dearth of qualitative studies that explores within the social context of the workplace, the lay perspectives and needs of workplace managers in order to understand what needs to be put in place to better equip them to recognise and instigate an early response to an emerging CMHP (Schultz & Gatchel, 2016, Bültmann & Siegrist, 2020).

Furthermore, the PAR design of this study supports the study of Biron & Karanika-Murray (2013), who suggested that multi-disciplinary and participatory research approaches would be crucial in order to engage with major organisational stakeholders to capitalise on the inside knowledge, individual differences and experiences of psychological interventions. In addition, PAR has supported the suggestion that researchers should work with employers to further strengthen the knowledge on what, who and how early interventions for CMHPs could work to improve workplace mental health (Biron & Karanika-Murray, 2013, Hesketh, 2020).

In addition, this study has further evidenced that managers are pivotal and well positioned to enabling early interventions at the earliest opportunity. Effective relationships with employees, good understandings of CMHPs that enable early support is therefore key with the evidence in this study thus builds on the previous contributions of Munir, (2009), Pomaki, (2001), Simpson, (2015), Wagner, (2016), Nicholson, (2018).

The literature had shown a dearth of research in terms of staff experiences of the social context of the workplace. However, the evidence presented in this study contributes knowledge to previous studies that have shown that in wider society CMHPs are complex, ambiguous and often misunderstood, thus having a bearing on whether an individual will disclose that they have been diagnosed with or are experiencing a problem with their mental health (Corrigan et al 2015b, Waugh, et al., 2017). Finally, the evidence from within this study confirms that stigma continues to exist with mental health problems often sitting in a negative camp which impacts on social inclusion, disability and social stigma, although this study has evidenced that a change agenda has been instigated as a consequence of the PAR design.

15.3 Stakeholders and Beneficiaries of the Research

Through this comprehensive exploratory participatory action research study, a range of stakeholders and beneficiaries were identified and to whom the findings will be of interest to, and includes but not limited to:

- The study organisation and its stakeholders:

- the participants, managers, professional advisors and policy makers. It is believed that the study organisation could benefit in several ways.
- firstly, enabling them to work towards a positive culture, not only for managing CMHPs, but a wider multi-faceted positive and skilled management teams and
- The feeding of the results into wider projects to initiate and facilitate organisational action and change. As previously discussed, some of this work had started during the study and other work is underway (chapter 11)

- The study and the findings could be of benefit to other workplace organisations both public and private sector who could use the results of this study to their advantage. For example, when implementing early interventions for CMHPs or utilising the model to upskill managers, reduce stigma with the aim to develop a positive workplace culture to CMHPs
- Academic organisations, institutions and researchers: It is envisaged that the study and the findings will contribute to researchers' knowledge when they are carrying out similar research and also for those in other disciplines. Furthermore, this research could be developed further or utilised for testing the findings, for example, using the evidence from this study as a starting point to test the model in a workplace setting.
- Academic Articles and Publications, helps to support and develop new knowledge in a range of academic disciplines

Social Communities: the participants, managers and stakeholders are all members of the wider social community. Therefore, the learning from this study could help to spread a wider awareness of CMHPs and help to break down barriers thus reducing social stigma.

15.4 Limitations

This study has presented a conceptual theory based on the research question of "*how early is early*" when instigating early workplace interventions for CMHPs. Whilst the strengths and validity of this study were determined by the PAR design and the selected methods of data collection and analysis, the study was not devoid of limitations which are outlined below.

Due to the geographical location of the study site, there was a lack of ethnic diversity amongst the participants. Therefore, the study was unable to explore if variations, differences and to what level 'early' workplace interventions for CMHPs exist amongst ethnic minority groups. Because of this the study was limited in that it could not explore how misunderstandings of CMHPs are influenced by culture, and whether culture influences whether managers respond to those experiencing CMHPs or not. In addition, the cultural influences could make it more likely for non-disclosures, thus the invisible employee could be further exacerbated when a cultural dimension is added into the mix. This then brings in the issue of social and cultural stigma and discrimination (Corrigan, et al., 2008, Uçok, et al., 2012, Stratton, 2018, Brouwers, et al., 2019).

The ongoing restructures and time constraints limited the ability and availability for some who had shown a strong interest in taking part. From my perspective as the insider researcher, the continual organisational restructures and 'gate keeper' stakeholder changes meant I had to continually justify the purpose, aims and objectives of the study to each of the new gate keepers. My representing of the study each time slowed the study progression down somewhat. On the other hand, the process was critical in order to obtain the ongoing organisational support for the study to continue. Furthermore, there was a risk that the new gatekeepers would not want to support the study going forward, thus added to the already time-consuming process of data collection and analysis.

In terms of the PAR, design a limitation was that it had been extremely time consuming and when coupled with the restructures as discussed above, these issues presented barriers to participation. The time needed for participants to be fully committed to the research had been compromised by the restructures with some either leaving the organisation or changing positions thus negating the ability for them to take part, thus limiting the number of active participants. PAR requires time and has no set time limits and where I found it difficult to balance the expectations of the participants. On one hand, I needed to obtain and retain their trust in the study, but on the other I had to be careful not to raise false hopes which could have led to frustrations where they were not seeing instantaneous actions being taken by the organisation. Furthermore, without fully explaining the process of PAR and that change could not be guaranteed,

participants might have thought that the knowledge they provided would translate into concrete actions being taken by the organisation.

15.5 Implications for further research

This study having been qualitative and exploratory by nature has raised a range of opportunities for future research. The theory has overarching implications for a wide range of organisations and their stakeholders, thus providing opportunities for further concept development and validation through comparative or longitudinal study designs. A comparative study could provide valuable information in terms of comparing the differences that may exist within employment sectors or industries in the management of 'early' workplace interventions for CMHPs. For example, this study was situated in a local government setting, thus an opportunity exists for a comparative research study comparing public and private sector organisations and aims to refine, elaborate, extend and suggest nuances to a deeper extent of the conceptual theory presented.

In addition, qualitative comparison analysis (QCA) could be utilised to test the theory or further investigate the realities of the management of CMHPs in the workplace with a view to develop new theories (Kan et al., 2016). QCA could also take the direction of exploring the relationship between the provision of manager training and development in the understanding of CMHPs and the subsequent outcomes for individuals. Similarly, whilst the theory consists of a set of interrelated themes and sub-themes, they provide an opportunity to generate hypotheses for further empirical testing. For example, undertaking a systematic evaluation of management interventions and training and the subsequent impacts on the management of CMHPs through behavioural change. Or indeed, identifying if there is a statistical correlation between managers knowledge and understanding of CMHPs and 'early' intervention outcomes for individuals with CMHPs.

The findings of this study provides scope for longitudinal studies that describe patterns of change and establish the direction and extent of the change. For example, enabling researchers to track over time employees with CMHPs though the organisation, making repeated observations to identify changes in order to

further refine the concepts with the aim of identifying how you make the invisible employee visible?

As noted in the limitations above, there was an absence of rich qualitative data from ethnic minorities which gives rise for the option to further develop research within and inclusive of those groups.

Finally, further work is needed to examine management behaviours and to what extent can emotional intelligence be improved.

It is anticipated that the evidence will contribute to the wide body of knowledge that is in existence as discussed above. It is further anticipated that the evidence will contribute to informing policymakers and researchers alike to further inform the development of multi-dimensional guidelines and best practice that can be translated into the social context of the workplace environment.

I now turn to the final chapter in this thesis and one which provides my reflective journal as an insider researcher.

Chapter 16

Reflections of the Insider Researcher

This chapter provides my reflective journal of PAR, describing my journey through the cyclical and iterative process and facilitated a retrospective and thoughtful process of questioning and understanding how this study had progressed and how the subsequent findings became constructed (Mortari, 2015), in addition to ensure that the research remained democratic, reflective and empowering to those who participated (Moore, 2004).

16.1 Introduction

Reflection being a cognitive activity that is fundamental to continual learning, to coin a phrase "*It is not sufficient to have an experience in order to learn. Without reflecting on this experience, it may be quickly forgotten, or its learning potential lost*" (Gibbs, 1988, p9). As discussed in previous chapters I had begun to resonate with Schon's (1983) model of reflection before, during and after each cycle of PAR. Reflection on experiences before, during and after the PAR cycles had assisted me to consider any potential opportunities, constraints, achievements and limitations including any implications that may have affected the course of study (Kemmis, McTaggart & Nixon, 2014). Furthermore, my reflective thinking had enabled me to question if the study and working with stakeholders had been moving in the right direction, had it been how I expected, and considered what was working and what was not. Moreover, the reflective practice had provided me with continual learning and development both as a researcher and a professional practitioner and allowed for me to draw upon that learning and experience in order to instigate changes in my practice for this study.

Whilst reflecting on my academic and professional practice I had been fully conscious that fully engaged PAR researchers would need to constantly reflect, act and, where necessary, change the direction of the study in order to fulfil the aims and objectives of the study.

Guiding the PAR design and instigation of the cycles as the insider researcher I had been able to draw on many years of experience and learning through a

variety of roles that I had previously undertaken including previous academic research. In addition to my academic experiences my work roles had included project manager, focus group facilitator, teacher, trainer and advisor within a complex organisational environment. Because of these experiences I had begun to mull over the context of the study, its purpose and the outcomes that I had been aiming for, reflecting on previous learning, building on successes and considering what would I do differently. Furthermore, I had been conscious of the study plan, how it was evolving and identifying any emerging risks, constraints and conflicts that required re-thinking, re-planning and action to be taken (Kemmis, McTaggart & Nixon, 2014). Moreover, as the study progressed, the PAR and grounded theory processes enabled me to reflect on the emergent findings and how these would be beneficial in theoretical and practical terms to both the organisation and the world of academia.

16.2 Reflecting on Previous Experiences

As touched upon above, during this study the reflective process had brought forth my learning from previous experiences and further highlighted the need to evaluate and translate that learning into research and professional practice. I had drawn on previous experiences from within my job role where I had acted as a facilitator for a variety of focus groups, workshops, teaching and training delivery employees and managers from across all hierarchical levels of the organisation. Moreover, the experiences, knowledge and lessons learned from those activities had provided me with good grounding for the utilisation of a PAR research design. Additionally, an integral part in the PAR process had been self-reflection and critical thinking which became an important focus during my research journey and is described throughout this chapter.

On the other hand, I had not been naïve to think that the PAR process would be a smooth ride and where I resonated with the thinking of Zuber-Skerrit & Fletcher (2007) who described action research as a mountain road that has many sidetracks and detours and a description that I found to be true. Having employed a PAR design in my previous research study I had been fully aware of the time that a PAR design would consume and the vast amount of data that social discourse would generate. Reflecting on past experience of focus groups I had been fully aware of the issues of maintaining active participation throughout

the PAR process. The problem that I had found had not been the methods or techniques employed but the continual changes and restructures that the organisation faced. The main concern that I had was navigating around the changes without losing participant interest and the momentum of the active focus groups. However, my insider researcher position had helped with the ongoing stakeholder and participant engagement.

16.3 Insider Researcher

Spanning over 29 years, my professional practitioner and research experience had gained the trust and support from senior managers thus allowing me to access the workforce participants who were critical to the study. Additionally, my professional practitioner role had required me to participate and/or manage a range of both long-term and short-term collaborative project working groups across the study site, thus providing me with a working knowledge of collaborative projects and the stakeholders themselves.

However, from the outset I had acknowledged that it would be highly likely that I would be faced with challenges and potential conflicts whilst acting in dual roles when conducting research within the organisation of whom I am a member. Furthermore, I had recognised that there was a need to plan for the addressing of my positionality and my own biases within the research process (Greene, 2014). This then led me to think about how I would build on being close to the study site, whilst creating distance in order to critically explore the research problem (Coghlan, 2007).

Although the roles of the 'insider' professional and the researcher are distinct, I ensured that my researcher role remained superior over the professional role (Schein, 1973) and planned to maximise the advantages that the duality of professional practitioner and 'insider researcher' had provided me. For example, whilst having a pre-understanding and experience of the organisational politics and dynamics, I had planned to orientate myself within the social environment of the organisational workplace whilst being attentive and responsible in confronting any challenges that may have presented themselves. However, the first step had been to engage and enable effective working relationships with organisational stakeholders.

16.4 Working with Stakeholders

It had been abundantly clear to me that effective engagement with organisational stakeholders would be a non-negotiable component of the research process particularly as I required agreed and open access to the workforce. Despite being an employee, I found that stakeholder engagement had not come without its challenges where I had been required to justify the nature of the access, the timescales of the research and the perceived organisational benefits. However, I had found that despite the challenge I found this to be a thought-provoking experience. The constructive engagement with the stakeholders had not only granted me access to the active focus group participants but motivated the stakeholders themselves to produce some creative and strategic thinking in terms of how the knowledge would be utilised.

During this stage I had also begun to realise that the longevity of my employment within the study site would have both advantages and disadvantages, some of which have already discussed in preceding chapters. Furthermore, drawing on my professional practitioner and research experience within a local government setting thus provided me with additional advantages, particularly when planning the research project. Firstly, my professional and practical experience had enabled me to become fully knowledgeable of the complexities and workings of a local government organisation, particularly when presenting emerging themes, theory and practical outcomes that could contribute to action for change. Secondly, having had operational involvement in a wide range of projects over the years thus further provided me with a clearer overview and understanding of the 'nuts and bolts' of the organisation, how it operated, the continual challenges it faced and how it had learnt from research.

An example was where I had participated in what set out as an action learning group who were tasked to review and revise human resources and health, safety and wellbeing policies and practices. Although I had my own views on how the project could progress, I was not the lead facilitator, however, during a reflective discussion on progress participant representation had been discussed and it had become evident that the group had naturally evolved into a participatory action group. Participants had consisted of a range of organisational stakeholders that included subject experts, practitioners, managers and employees who

collaboratively reviewed and reflected on the existent policies and practices. The discourse amongst the participants had then influenced the development of a new knowledge base, new ideas and instigated a process of action for change.

The experience had further concreted my interest in PAR and where I felt that the approach had been effective with the group took collaborative ownership of the review meaning that the emerging knowledge and ideas were in effect socially constructed. In addition, it had instigated a cycle of improvement and change, alongside a fluid process of review, reflection and continual improvement which to this day has been an ongoing process. Moreover, the approach had been accepted and promoted by managers as an effective way of working and had continued to develop within other projects. A point to note is that the data from this project is unrelated and has not been included in this study, however reflecting on the experiences had proved useful when planning for this PAR study.

16.5 Planning

At the planning stage I had not been surprised to find myself giving deeper consideration to the role I would take from an insider researcher perspective which had included acting in and balancing dual roles within the study site. Furthermore, in the forefront of my mind had been the realisation that the iterative review and reflection would not sit neatly as a final cycle of PAR, but instead had been the golden thread throughout the cycles of PAR (Coghlan, 2007). I therefore retrospectively reflected on my past research and practice, recaptured the experiences and had asked questions of myself - what went right, what went wrong, and what did I learn? I had found that undertaking a deeper look at previous experiences had not only been transformative but provided me with the grounding and opportunity to put my learning into practice (Alsop & Ryan, 1996).

Whilst planning the practical elements of the PAR journey I had drawn on my project management skills and fully utilised the knowledge, skills and experience that I had obtained throughout my professional and researcher career. Putting the skills to use I had planned the practical and operational strategy which led to

the formulation of the series of methodological procedures and clarified what, when and how the action and reflection cycles would proceed.
I found that my reflective thinking had been of immense benefit and led me to consider more deeply the ongoing engagement with senior manager stakeholders and how effective relationships would be maintained, whilst acknowledging that they were critical throughout the research process. The maintaining of positive interactions with the stakeholders had in turn sustained their ongoing commitment. Moreover, I had the full understanding that interaction with all participants needed to be innovative and adaptive to any of the evolving situations within the study site. I had aligned participant and stakeholder engagement with my day-to-day professional practice and the concept of reflection-in-action - "*thinking on your feet - doing something whilst doing it*" (Schon's (1983, pg:54, 1987) and had felt that there was no reason why the practice should not be replicated into my research practice.

During the planning, I had become conscious that a degree of self-reflexivity would need to be considered in terms of the interplay between my experiential knowledge, assumptions and perceptions and maintaining an appropriate emotional distance between myself and the participants. (McGhee, et al., 2008, Greene, 2014). Therefore, during the planning cycle I had planned that the group discourse and narratives would not be influenced or distorted by any biases that I may have held. I had integrated the participation, action and reflection cycles and ensured that the participants were fully engaged in the reviewing, reflecting and verifying of the tentative findings in an iterative and cyclical process (Greene, 2014, Guba, 1981).

Further planning had led to a surprising discovery, where many of the professionals from across the study site had routinely used action learning (AL) and reflective practice as part of their professional development. Notably, having similarities to PAR in that it is collaborative and a cyclical process, the action learning had enabled those professionals to learn from a variety of work experiences and where they had transformed collective learning into improving practical strategies. However, whilst being aware that action learning had tended to traditionally be used in organisational and management development within education, social work and health sectors (Zuber-Skerritt, 2015), I had been

surprised to learn that the utilisation of action learning was much more widespread and cross cutting within the study site than first anticipated.

Although the use of action learning sets had been routinely used by a range of professionals from across social and health services, human resources and organisational development, there was no evidence in existence that PAR had been practised. On one hand, I had viewed prior knowledge of action learning (AL) to be a potential benefit and provided an understanding of the concept of PAR. However, on the other hand, I had concerns that those individuals would not understand that PAR would call for deeper and deliberate questioning of their experiences, perspectives and beliefs. I had also been conscious that conflict could be a risk, where power could be exerted over those who had not previously experienced AL or PAR (Raelin, 1997).

16.6 Action and Reflection

Whilst I had a full understanding that PAR would be dynamic and a process of shifting, twisting and turning as new understandings, knowledge, and meanings emerged from the data, I needed to be prepared for the unexpected.
Whilst entering into the participants world and exploring the emotive subject of CMHPs, I had been reminded of Blumer's (1969) dictum 'respect your subjects and their dignity' and had been particularly relevant when participants had reflected deeply on their experiences. Therefore, during the course of the study I had made a concerted effort to gain a good rapport with the participants which helped me obtain a deeper understanding of 'their world' and 'their experiences' through each of the cycles of PAR. I had found that being an insider researcher provided me with the opportunity to blend into the focus groups whilst building a sense of trust amongst the participants as opposed to 'mis-trust' that can often arise where an outsider researcher is not familiar with the social group or culture under study (Greene, 2014).

Furthermore, the trust that I had built with the focus groups became evident where I encountered two disclosures that had seriously concerned me and where I instigated procedures with each of the participants that included carrying a debrief and signposting to appropriate support mechanisms. After a period of a few days 'watchful waiting', which allowed the individuals to reflect, I followed

up with each one and gave them the opportunity to withdraw. In addition, a referral to occupational health and counselling support had also been offered, both the participants declined the support decided to continue with the study. On reflection, it had been fortunate that I had been trained in mental health and suicide first aid in addition to being trained as a domestic and sexual abuse assessor and where these skills then proved useful. I subsequently received thank you emails from both participants as my intervention had helped them and enabled them to reflect and re-evaluate the issues they had presented with (Bloor, et al., 2001). Furthermore, the disclosure and intervention had been such that one decided to change her job and has since progressed into a new role.

16.7 Data Analysis, Iteration and Reflection

I had been fully aware that the grounded theory (GT) method of analysis would be an iterative and time-consuming process that would interweave the iterative cycles of data collection, analysis, constant comparison, consequently leading to the gradual emergent theory that was 'grounded' in the data.

In addition, I had also been conscious that as an insider researcher my objectivity would be tested where I needed to keep an open mind, and not hold bias from any preconceived ideas or knowledge ensuring that this was distinctly separated from the themes and theory that developed from within the data. Therefore, a critical element of PAR and the grounded theory data analysis had been the iteration cycles that enabled the participants to partake in a deeper reflection of the emergent constructed themes and concepts. That said, the data analysis had not been a standalone phase of the study as PAR and grounded theory called for the analysis to commence at the data collection cycle and continued throughout the cycles. Nevertheless, during these cycles I had at times felt overwhelmed by the volume of data collected, thus leaving me to question whether the data would provide the thick description that I had been seeking. However, despite my concerns and fears during the iterative cycles the participants collaboratively reviewed and reflected on the interpretation of the data presented and confirmed that the emerging themes reflected their views, experiences and perspectives of 'their world' which further crystallised the meanings and themes that I had presented to them (Charmaz, 2006).

Furthermore, as the data analysis, iterative and reflective cycles progressed an interesting and surprising concept of management emotional intelligence had begun to emerge from the data, which gave a new insight into the phenomena under study. Returning to the data corpus I began to compare and contrast the newly constructed concept across all the focus group data whilst considering if further data would be needed to support and reconstruct the emerging concept that may have ultimately led to re-conceptualising and re-assembling the data. However, whilst condensing the data through the iterative discussions with participants, it was found that no further data was required (Strauss & Corbin, 1990, Gibbs, 2007, Charmaz, 2006).

A further point to note is that although the literature review had commenced at the start of the study, it continued throughout the PAR cycles, enabling reflection on the emerging categories and themes and the ongoing review and revision of the literature. However, reflecting on the process it was difficult at times not to get drawn so far into the literature that it impacted on the developing themes and theory.

Summary

In summary, when reflecting on the journey of the study as a whole, it had been at times extremely challenging, particularly when balancing my research project with a busy demanding job role. During the study period I had also faced a wide range of personal challenges and at times tested me to the limit. However, without the continual support from my university supervisors, my workplace managers and of course my family and friends I would not be writing this now. However, the challenges had reaffirmed how my professional practice and experiences were crucial to keeping the study on track and where I had been able to draw on prior experience, knowledge, learning and understandings of the complexities and governance of a local government organisation. This included working with a wide variety of stakeholders from a range of hierarchical positions. In addition, the knowledge and learning I had obtained from carrying out previous participatory research had also proven to be extremely beneficial for a study of this type and where I was delving into a complex and sensitive area of individuals mental health.

Where criticisms have been levelled at PAR and grounded theory (GT), I would agree that the blending of PAR and GT had been time consuming and as previously noted, was at times overwhelming. Furthermore, I had found that as the study progressed, I had to continuously prove the legitimacy of the study both to the organisation and the change of the study 'gate-keepers' following restructure. These changes had therefore raised some uncertainties within my own mind regarding the time-consuming process and the overall direction of the study. I had become concerned that due to the continual restructures within the organisation that the study would become unsustainable in terms of ongoing participation, organisational 'ownership' and commitment to change. Although I had found that revisiting, presenting and justifying of the study to be monotonous during these uncertain times, I found that it had allowed for me to undertake a deeper critical reflection of the PAR and GT process.

However, on the other hand, despite this I had also found it rewarding, where I felt that PAR and GT completely empowered the participants to construct the knowledge that has been presented in the preceding findings chapters. Furthermore, PAR and GT had ensured the high level of collaborative participation that I had been seeking, whereby the participants and myself had actively reflected *on* and *in* action throughout the study (Schon, 1983). This meant that the planning, action and analysis cycles of PAR operated in parallel with a continual reflection process. The cycles included reflection on process that gathered the participants thoughts on organisational practice and procedures, thus led to reflection on underlying perspectives and assumptions that govern attitudes and behaviours, reflecting on sub-cultures and non-conscious consequences and effects and moved on to reflection on the constructed themes and concepts that had emerged from within the data (Mezirow, 1991).

Finally, I believe that my self-awareness and critical reflection stood me in good stead for improving my researcher practice, particularly as an insider researcher. In terms of the wider organisational stakeholder engagement, I fully advocate the need for the positive relationships and support that had been built between myself and the organisational stakeholders. This had been vital and should not be overlooked or seen as unimportant as without this the study may have faltered in its early stages and would have been a certainty during the

organisational restructures. Moreover, the continual engagement and support had led to the organisation taking forward the findings in order to action and implement changes that have arisen from this study and have been evidenced in Chapter 12.

References

Adams, L. Oldfield K Riley, C. Duncan, B. and Downing, C. (2015) Understanding the journeys from work to Employment and Support Allowance (ESA), Department for Work and Pensions. https://www.gov.uk/government/publications/understanding-the-journeys-from-work-to-employment-and-support-allowance

Ahola, K. Pulkki-Råback, L. Kouvonen, A. Rossi, H. Aromaa, A. Lönnqvist, J. (2012): Burnout and Behaviour-Related Health Risk Factors, Journal of Occupational and Environmental Medicine: January 2012 - Volume 54 - Issue 1 - p 17-22 https://journals.lww.com/joem/fulltext/2012/01000/burnout_and_behavior_related_health_risk_factors_.7.aspx

Alexander, J. L., & Campbell, M. A. (2011). Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: A randomized trial. *American Journal of Health Promotion, 25*, 283-284. https://www.scopus.com/sourceid/27620?origin=recordpage

AlGhanem, N., Braganza, A. and Eldabi, T., 2019. Plural leadership during organisational transformation initiatives (Vertical & Horizontal). *KnE Social Sciences*, pp.90-108. https://knepublishing.com/index.php/KnE-Social/article/view/5193

Allen, M (2017) Confidentiality and Anonymity of Participants in Sage Encyclopaedia of Communication Research Methods. (Vols. 1-4). Thousand Oaks, CA: SAGE Publications. doi: https://dx.doi.org/10.4135/9781483381411.n86

Andrews, T. (2012). What is Social Constructionism? The Grounded Theory Review, 11(1), 39-46. http://groundedtheoryreview.com/2012/06/01/what-is-social-constructionism/

Attridge, M. (2019). A global perspective on promoting workplace mental health and the role of employee assistance programs. American Journal of Health Promotion, 34(4), 622-627. https://journals.sagepub.com/doi/full/10.1177/0890117119838101c

Azulai, A., (2021) Are grounded theory and action research compatible? Considerations for methodological triangulation. Canadian Journal of Action Research, 21 (2) (2021), pp. 2-4, DOI: https://doi.org/10.33524/cjar.v21i2.485

Babbie, E. & Mouton, J. (2001). The practice of social research. Cape Town: Oxford University Press.

Bacharach, S. B., & Bamberger, P. A. (2007). 9/11 and New York city firefighters' post hoc unit support and control climates: A context theory of the consequences of involvement in traumatic work- related events. Academy of Management Journal, 50 (4), 849–868. Available at: https://journals.aom.org/doi/abs/10.5465/amj.2007.26279180

Baldwin, M. L. (2004). Persons with mental disorders in the competitive labor market: foundations for a research agenda, in Fisher, W. H., (Ed.) Research on employment for persons with severe mental illness (Research in Community and Mental Health, Emerald Group Publishing Limited. https://www.emerald.com/insight/publication/doi/10.1016/S0192-0812(2004)13

Bandura, A. (1997). Self-efficacy: The exercise of control. W H Freeman/Times Books/ Henry Holt & Co. https://psycnet.apa.org/record/1997-08589-000

Bar-On, R., Handley, R., Fund, S. (2006) The Impact of Emotional Intelligence on Performance in Urch Druskat, V. Mount, G. Sala, F. Linking Emotional Intelligence and Performance at Work https://doi.org/10.4324/9780203763896

Barnes, M., Buck, R., Williams, G., Webb., Aylward, M. (2008) Beliefs about common health problems and work: A qualitative study, Social Science & Medicine, Volume 67, Issue 4, 2008, Pages 657-665, https://doi.org/10.1016/j.socscimed.2008.05.008 https://www.sciencedirect.com/science/article/pii/S0277953608002438

Barry, Margaret M. (2009). Addressing the Determinants of Positive Mental Health: Concepts, Evidence and Practice. International Journal of Mental Health Promotion, 11(3), 4-17. https://doi.org/10.1080/14623730.2009.9721788 Baum, F. MacDougall, Smith, D. (2006), Participatory Action Research. J Epidemiol Community Health. 2006 Oct; 60(10): 854–857. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2566051

Bell, N. Evans, G. Beswick, A. and Moore, A. Health and Safety Executive (HSE) (2018) Summary of the evidence on the effectiveness of Mental Health First Aid (MHFA) training in the workplace. Available at: https://www.hse.gov.uk/research/rrhtm/rr1135.htm

Bellón, J. Conejo-Cerón ,S., Cortés-Abela, C., Pena-Andreu, J. M., García-Rodríguez, A., Moreno-Peral P. (2019) Effectiveness of psychological and educational interventions for the prevention of depression in the workplace: a systematic review and meta-analysis. Scand J Work, Environ Health 2019;45:324–32. https://doi.org/10.5271/sjweh.3791

Berger, P.L. and Luckmann, T. (1966) The Social Construction of Reality: A Treatise in the Sociology of Knowledge. Doubleday & Company, New York.

Bhui, K., Dinos, S., Galant-Miecznikowska, M., De Jongh, B., & Stansfeld, S. (2016). Perceptions of work stress causes and effective interventions in employees working in public, private and non-governmental organisations: A

qualitative study. *BJPsych Bulletin, 40*(6), 318-325. https://doi:10.1192/pb.bp.115.050823

Biron, C., Gatrell, C., & Cooper, C. L. (2010). Autopsy of a failure: Evaluating process and contextual issues in an organizational-level work stress intervention. Interna- tional Journal ofStress Management, 17(2), 135–158. https://psycnet.apa.org/record/2010-08364-003
Biron, C., Karanika-Murray, M., & Cooper, C. L. (2012a). Improving organizational interventions for stress and well-being: Addressing process and con- text. London: Routledge

Biron, C., & Karanika-Murray, M. (2014). Process evaluation for organizational stress and well-being interventions: Implications for theory, method, and practice. International Journal of Stress Management, 21(1), 85–111. https://doi.org/10.1037/a0033227

Biron, C., & Karanika-Murray, M. (2013). Process evaluation for organizational stress and well-being interventions: Implications for theory, method, and practice. International Journal of Stress Management, (Special issue). doi: 10.1037/a0033227

Black, C. (2008). Working for a healthier tomorrow. London. The Stationary Office, London. https://www.gov.uk/government/publications/working-for-a-healthier-tomorrow-work-and-health-in-britain

Black, C. and Frost, D. (2011) Health at work – an independent review of sickness absence. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf

Black Dog Institute, (2021) Modern Work: how changes to the way we work are impacting on Australians' mental health https://www.blackdoginstitute.org.au/

Bleijenbergh, I., Van Mierlo, J., Bondarouk, T. (2021) Closing the gap between scholarly knowledge and practice: Guidelines for HRN action research. Human Resource Management Review, Volume 31, Issue 2, 2021, https://doi.org/10.1016/j.hrmr.2020.100764.

Bowers, C., Kreutzer, C., Cannon-Bowers, J., & Lamb, J. 2017). Team resilience as a second-order emergent state: A theoretical model and research directions. Frontiers in Psychology, 8(1360), 1–14 https://doi.org/10.3389/fpsyg.2017.01360

Braun V., Clarke V. (2006) Qualitative Research in Psychology, vol. 3, issue 2 (2006) pp. 77-101 https://www.tandfonline.com/doi/abs/10.1191/1478088706qp063oa

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: it's time to consider the causes of the causes.
Public health reports (Washington, D.C.: 1974), 129 Suppl 2(Suppl 2), 19–31. https://doi.org/10.1177/00333549141291S206

British Occupational Health Research Foundation (2005) Workplace interventions for people with common mental health problems https://bohrf.org.uk/downloads/cmh_rev.pdf

Brohan, E., & Thornicroft, G. (2010) Stigma and Discrimination of Mental Health Problems: Workplace Implications. Available at: https://psycnet.apa.org/record/2011-06170-001

Brohan, E, Mojtabai, R., Thornicroft, G. et al., (2012) Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries. Psychological Medicine, Volume 42, Issue 8 (2012) pp. 1741-1752. Available at: https://doi.org/10.1017/S0033291711002558

Brouwer, S., Krol, B., Reneman, M. F., Bültmann, U., Franche, R. L., van der Klink, J. J., & Groothoff, J. W. (2009). Behavioral determinants as predictors of return to work after long-term sickness absence: an application of the theory of planned behavior. *Journal of occupational rehabilitation*, *19*(2), 166–174. https://doi.org/10.1007/s10926-009-9172-5

Brouwers, E. P. M. Joosen, M. C. W. van Zelst, C · Van Weeghel, J., (2019) To Disclose or Not to Disclose: A Multi-stakeholder Focus Group Study on Mental Health Issues in the Work Environment. Journal of Occupational Rehabilitation (2020) 30:84–92 https://doi.org/10.1007/s10926-019-09848-z

Brunner, R. (2007a) Exploring disability disclosure amongst college and university staff in Scotland. Stirling: Equality Forward, in Irvine, A. (2011) 'Something to Declare' The Disclosure of Mental Health Problems at Work Disability & Society, 2011 - Taylor & Francis. Available at: https://www.tandfonline.com/doi/abs/10.1080/09687599.2011.544058

Brunner, E., Feeney A.., Head .J, Marmot M. G., North F., Patel C., Smith G. D., Stansfeld, S., and White, I., (1991) Health inequalities among British civil servants: the Whitehall II study. The Lancet, 337(8754), 1387-1393. https://pubmed.ncbi.nlm.nih.gov/1674771/

Bryant, A., & Charmaz, K. (2007) The SAGE Handbook of Grounded Theory, 'The Discovery of Grounded Theory in Practice: The Legacy of Multiple Mentors', pp: 58-74 SAGE Publications Ltd. http://dx.doi.org/10.4135/9781848607941.n2

Bryan, B.T., Gayed , A., Milligan-Saville, J. S., Madan, I., Calvo, R. A., Glozier, N. & Harvey, S. B. (2018) Managers' response to mental health issues among their staff Occupational Medicine, Volume 68, Issue 7, Pages 464–468, https://doi.org/10.1093/occmed/kqy103

Buck, R., Porteous, C., Wynne-Jones, G., Marsh, K., Phillips, C. J., & Main, C. J. (2011). Challenges to remaining at work with common health problems: what helps and what influence do organisational policies have?. Journal of occupational rehabilitation, *21*(4), 501–512. https://doi.org/10.1007/s10926-011-9288-2

Bültmann U., Siegrist J., (2020). Handbook of Disability, Work and Health, Springer Nature Switzerland AG (2020) https://doi.org/10.1007/978-3-030-24334-0

Burr, V & Dick, P (2017), Social Constructionism. in B Gough (ed.), The Palgrave Handbook of Critical Social Psychology. Palgrave Macmillan, pp. 59-80. https://doi.org/10.1057/978-1-137-51018-1_4

Carmeli, A. (2003). The relationship between emotional intelligence and work attitudes, behaviour and outcomes: An examination among senior managers. Journal of Managerial Psychology, 18(8), 788–813. https://doi.org/10.1108/02683940310511881

Carmichael, F., Fenton, S.-J.H., Pinilla-Roncancio, M.V. et al. (2016) Workplace health and wellbeing in construction and retail: Sector specific issues and barriers to resolving them. International Journal of Workplace Health Management 9(2): 251- 268 http://dx.doi.org/10.1108/IJWHM-08-2015-0053

Carnwell, R., & Daly, W. (2001) Strategies for the construction of a critical review of the literature, Nurse Education in Practice, Vol.1, pp.57-63 https://www.sciencedirect.com/science/article/pii/S1471595301900083

Cates J. R., Young D. N., Bowerman D.S., Porter R. C. An independent AGREE evaluation of the Occupational Medicine Practice Guidelines. Spine J. (2006) Jan-Feb;6(1):72-7. https://pubmed.ncbi.nlm.nih.gov/16413451/

Chadha, N. K., Rathore, D. & Rana, S. (2017) Emotional Intelligence in the Workplace. Psychology, Indian journal of positive psychology https://doi.org/10.15614/IJPP%2F2017%2FV8I2%2F157126

Charmaz, K. (2006) Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis. Thousand Oaks, CA: SAGE. https://uk.sagepub.com/en-gb/eur/constructing-grounded-theory/book235960

Charmaz, K. (2008). Construction and the Grounded Theory. In Holstein, J. A., & Gubrium, J. F. (Eds), Handbook of Constructionist Research (pp. 397-412). New York: The Guilford Press.

Charmaz, K. (2014) Constructing Grounded Theory (2nd Edition) London, Thousand Oaks, California: SAGE Publications, [2014] ISBN: 9780857029140

Charmaz, K & Thornberg, R., (2021) The pursuit of quality in grounded theory, Qualitative Research in Psychology, 18:3, 305-327, DOI: 10.1080/14780887.2020.1780357

Charmaz, K. (2020) ”With constructivist grounded theory you can’t hide”: Social justice research and critical inquiry in the public sphere. *Qualitative Inquiry* 26 (2):165–76. doi:10.1177/1077800419879081

Chartered Institute of Personnel Development (2011) Managing and supporting mental health at work: disclosure tools for managers https://www.cipd.co.uk/knowledge/culture/well-being/mental-health-support-report

Chartered Institute of Personnel Development (CIPD), (2015), Absence management survey https://www.cipd.co.uk/Images/absence-management_2015-private-sector-summary_tcm18-11268.pdf

Chartered Institute of Personnel Development CIPD, (2016), Absence management survey https://www.cipd.co.uk/Images/absence-management_2016_tcm18-16360.pdf

Chartered Institute of Personnel Development (CIPD) (2018), Absence management survey https://www.cipd.co.uk/knowledge/fundamentals/relations/absence/absence-management-surveys

Cherniss, C., Goleman, D., (2002) The Emotionally Intelligent Workplace. Jossey-Bass, Wiley & Sons, Inc. New York ISBN 0-7879-5690-2

Clement S., Schauman O., Graham T., Maggioni F., Evans-Lacko S., Bezborodovs N., Morgan C., Rüsch N., Brown J. S., Thornicroft G. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychol Med. 2015 Jan;45(1):11-27. https://doi.org/10.1017/s0033291714000129

Christensen, M., Saksvik, P. Ø., and Karanika-Murray, M. (2017). The Positive Side of Occupational Health Psychology. Springer Publishing AG 2017. ISBN: 978-3-319-66780-5 https://doi.org/10.1007/978-3-319-66781-2

Cocker, F., Martin, A.J., Scott, J., Venn, A., Otthal, P. & Sanderson, K. (2011), "Factors associated with presenteeism amongst employed Australian adults reporting lifetime major depression with 12 month symptoms", Journal of Affective Disorders, Vol. 135 Nos 1-3, pp. 231-240. https://www.sciencedirect.com/science/article/pii/S0165032711004551

Coghian, D. (2001) 'Insider Action Research Projects: Implications for Practising Managers', *Management Learning*, 32(1), pp. 49–60. doi: 10.1177/1350507601321004.

Coghian, D., & Brydon-Miller, M., (2014) 'Case study' in The SAGE Encyclopaedia of Action Research (pg:87-89) SAGE Publications Ltd. DOI: https://dx.doi.org/10.4135/9781446294406

Collins C. S., Cooper J. E., (2014) Emotional Intelligence and the Qualitative Researcher. International Journal of Qualitative Methods. February 2014:88-103. doi: https://doi.org/10.1177/160940691401300134

Cooper, C.L., Dewe, P.J., & O'Driscoll, M.P. (2001). Organizational Stress . Thousand Oaks/ London: Sage DOI: http://dx.doi.org/10.4135/9781452231235

Cooper C., (2010). Keynote address on the 9th EA-OHP conference, Rome, March 2010. http://www.eaohp.org/publications.html

Corbière, M., Jie Shenb, J., Rouleauc, M., and Dewa, C.S. (2009). A systematic review of preventative interventions regarding mental health issues in organisations Work. 2009;33(1):81-116. doi: https://doi.org/10.3233/wor-2009-0846. PMID: 19597288.

Corrigan, P.W., River, L.P., Lundin, R.K., Penn, D.L., Uphoff-Wasowski, K., Campion, J., Mathisen, J., Gagnon, C., Bergman, M., Goldstein, H. and Kubiak, M. A., (2001). Three strategies for changing attributions about severe mental illness. Schizophrenia bulletin, 27(2), pp.187-195. https://doi.org/10.1093/oxfordjournals.schbul.a006865

Corrigan, P. W, Wassel A. (2008) Understanding and influencing the stigma of mental illness. J Psychosoc Nurs Ment Health Serv. (2008) Jan;46(1):42-8. https://doi.org/10.3928/02793695-20080101-04

Corrigan, P. W., & Shapiro, J. R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. Clinical psychology review, 30(8), 907–922. https://doi.org/10.1016/j.cpr.2010.06.004

Corrigan, P. W., Rao D. (2012) On the self-stigma of mental illness: stages, disclosure, and strategies for change. Can J Psychiatry. 2012;57(8):464-469. doi:10.1177/070674371205700804

Corrigan, P. W., Kosyluk, K. A., Markowitz, F., Brown, R. L., Conlon, B., Rees, J., Rosenberg, J., Ellefson, S., & Al-Khouja, M. (2016). Mental illness stigma and disclosure in college students. *Journal of mental health (Abingdon, England)*, *25*(3), 224–230. https://doi.org/10.3109/09638237.2015.1101056

Cotton, P., Hart, P.M., 2003. Occupational Wellbeing and Performance: A Review of Organisational Health Research. Aust. Psychol. 38, 118–127. doi:10.1080/00050060310001707117

Cousins, R., MacKay, C. J., Clarke, S. D, Kelly, C., Kelly, P. J., & McCaig, R. H., (2004) 'Management Standards' work-related stress in the UK: practical development, Work & Stress, 18:2, 113-136
doi: 10.1080/02678370410001734322

Cox, T. (1993). Stress research and stress management: putting theory to work. Sudbury: HSE Books
https://www.hse.gov.uk/research/crr_pdf/1993/crr93061.pdf

Cox, T., Griffiths, A. Barlowe, C. Randall, R., & Rial-Gonzalez, E. (2000). Organisational Interventions for Work Stress: A Risk Management Approach. Sudbury: HSE Books.
https://www.hse.gov.uk/research/crr_pdf/2000/crr00286a.pdf

Cox, T. Karanika-Murray, M. Griffiths A. Wong Y.Y.V. and Hardy, C. (2009) Developing the management standards approach within the context of common health problems in the workplace: A Delphi study. Research Report 687. HSE Books http://www.hse.gov.uk/research/rrhtm/rr687.htm

Cox, T., Leka, S., Ivanov, I., & Kortum, E., (2004), Work, employment and mental health in Europe. An International Journal of Work, Health & Organisations. Volume 18, 2004 - Issue 2 https://doi.org/10.1080/02678370412331272651

Cox, T., Karanika, M., Griffiths, A., & Houdmont, J., (2007), An International Journal of Work, Health & Organisations, Volume 21, 2007 - Issue 4, Taylor & Francis https://doi.org/10.1080/02678370701760757
Crib, J., Disney, R. & Sibieta, L. (2014) The public sector workforce: past, present and future, Institute for Fiscal Studies, February 2014. https://www.ifs.org.uk/bns/bn145.pdf

Crowe, S., Cresswell, K., Robertston, A. (2011) The Case Study Approach, BMC Medical Research Methodology, Volume 11, Number 1, Page 1, https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-11-100

Curran, C., Knapp, M., & Beecham, J. (2004), "Mental health and employment: some economic evidence", Journal of Public Mental Health, Vol. 3 No. 1, pp. 13-24. https://doi.org/10.1108/17465729200400003

Cvenkel, N. (2020) Well-Being in the Workplace: Governance and Sustainability Insights to Promote Workplace Health. Springer Nature Singapore Pte Ltd. 2020 eBook ISBN**:** 978-981-15-3619-9 https://doi.org/10.1007/978-981-15-3619-9

Czabała, C., Charzyńska, K., Mroziak, B., Psychosocial interventions in workplace mental health promotion: an overview, Health Promotion International, Volume 26, Issue suppl_1. December 2011, Pages i70–i84, https://doi.org/10.1093/heapro/dar050

Davenport, L.J., Allisey, A.F., Page, K.M., LaMontagne, A.D. and Reavley, N.J. (2016), "How can organisations help employees thrive? The development of guidelines for promoting positive mental health at work", International Journal of Workplace Health Management, Vol. 9 No. 4, pp. 411-427. https://doi.org/10.1108/IJWHM-01-2016-0001

Dawson, A., and Tylee, A., (2001) World Health Organization, London, 2001, Depression: social and economic timebomb: strategies for quality care : proceedings of an international meeting Social Science & Medicine 56(2) ISBN: 9780727915733

Day A., Penney, S.A., Hartling, N. (2019) The psychology potential perils, and practice of leading healthy workplaces, Organizational Dynamics, Volume 48, Issue 3, 2019, Pages 75-84, ISSN 0090-2616, https://doi.org/10.1016/j.orgdyn.2018.10.002. https://www.sciencedirect.com/science/article/pii/S0090261618301876

De Angelis, M., Giusino, D., Nielsen, K., Aboagye, E., Christensen, M., Innstrand, S.T., Mazzetti, G., van den Heuvel, M., Sijbom, R.B.L., Pelzer, V., Chiesa R, Pietrantoni L. (2020) H-WORK Project: Multilevel Interventions to Promote Mental Health in SMEs and Public Workplaces. Int J Environ Res Public Health. 2020 Oct 31;17(21):8035. doi: 10.3390/ijerph17218035. https://pubmed.ncbi.nlm.nih.gov/33142745/

De Lorenzo, M. S. (2003). Absenteeism: Work-Induced Stress Illnesses, and Hidden Mental Illnesses. (PhD thesis, Monash University). International Journal of Business and Management; Vol. 9, No. 12; 2014 http://www.ccsenet.org/journal/index.php/ijbm/article/view/39804

De Lorenzo, M. S., (2013) Employee Mental Illness: Managing the Hidden Epidemic. Employee Responsibilities and Rights Journal (2013) 25:219–238 DOI 10.1007/s10672-013-9226-x

Department of Health, (1992) The Health of the Nation – A Strategy for Health in England. Her Majesty's Stationery Office. ISBN 10: 0101198620 ISBN 13: 9780101198622

Department of Health (DOH), (1998), A First Class Service: Quality in the New NHS. London: The Stationery Office Department

Department of Health, HSE, Funk, World Health Organisation (WHO), (2000). https://www.who.int/mental_health/media/en/712.pdf

Dewa, C. S., Lesage, A., Goering, P., & Caveen, M. (2004). Nature and Amplitude of Mental Illness in the Workplace. Healthcare Papers, 5(2), 12–25. Discussion Paper. https://doi.org/10.12927/hcpap..16820 https://pubmed.ncbi.nlm.nih.gov/15829761/

Dietrich, S., Deckert, S., Ceynowa, M., Hegeerl, U., Stengler K., (2012), Depression in the Workplace: A Systematic Review of Evidence-based Prevention Strategies. International Archives of Occupational and Environmental Health (2012) 85:1–11 DOI 10.1007/s00420-011-0634-7 https://pubmed.ncbi.nlm.nih.gov/21461766/

Dimoff, J. K., & Kelloway, E. K. (2019). With a little help from my boss: The impact of workplace mental health training on leader behaviors and employee resource utilization. Journal of Occupational Health Psychology, 24(1), 4–19. https://doi.org/10.1037/ocp0000126

Dimoff, J. K., & Kelloway, E. K. (2019). Mental health problems are management problems: Exploring the critical role of managers in supporting employee mental health. Organizational Dynamics, Volume 48 (Issue 3), 2019 105-112. ISSN 0090-2616, http://doi.org/10.1016/j.orgdyn.2018.11.003 https://www.sciencedirect.com/science/article/pii/S0090261618301888

Drawert, F. A. A. (2013), Lay Perspectives on Mental Health: A Qualitative Study, University of Twente https://essay.utwente.nl/64063/

Drummond, A., Narayanasamy, M., Geraghty,, J., Coole, C., Nour,i F., Thomson, L., Callaghan P., (2018) MENTOR: MENtal health first aid in The wORkplace: A feasibility study. University of Nottingham, The Institute of Mental Health, London South Bank University. https://iosh.com/resources-and-research/resources/mental-health-first-aid-in-the-workplace/

Dugan, A.G., Farr, D.A., Namazi, S., Henning, R.A., Wallace, K.N., El Ghaziri, M., Punnett, L., Dussetschleger,, J.L., Cherniack, M.G. (2016) Process evaluation of two participatory approaches: Implementing total worker health(R) interventions in a correctional workforce. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5860806/

Dwyer P, Scullion L, Jones K, McNeill J, Stewart ABR. Work, welfare, and wellbeing: The impacts of welfare conditionality on people with mental health impairments in the UK.Soc Policy Admin.2020;54:311–326. https://doi.org/10.1111/spol.12560DWYERET AL.326

Eketu, C. A. & Ayondu, O. A. (2017) Devolving the Thought on Workplace Emotions for Gainful Research: A Theoretical Reflection. Journal of Organisation and Human Behaviour. Volume 6 Issue 3. http://www.publishingindia.com

Ellison M. L., Russinova Z., Macdonald-Wilson K. L., Lyass A. (2003). Patterns and correlates of workplace disclosure among professionals and managers with psychiatric conditions. J Vocational Rehabilitation Volume 18, 3–13. https://escholarship.umassmed.edu/psych_cmhsr/452

Elraz, H. (2018) Identity, mental health and work: How employees with mental health conditions recount stigma and the pejorative discourse of mental illness. Human Relations, Vol. 71(5) 722 –741. https://journals.sagepub.com

Equality Act 2010 Available at: https://www.legislation.gov.uk/ukpga/2010/15

European Agency for Safety and Health at Work (EU-OSHA) (2012) Drivers and barriers for psychosocial risk management: an analysis of the findings of the European survey of enterprises on new and emerging risks. Available at: https://osha.europa.eu/en/publications/drivers-and-barriers-psychosocial-risk-management-analysis-findings-european-survey

Faridi, Z., Grunbaum, J. A., Gray, B. S., Franks, A., & Simoes, E. (2007). Community-based participatory research: necessary next steps. *Preventing chronic disease*, *4*(3), A70. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955426/

Farmer, P., & Stevenson, D. (2017) Thriving at work: The Stevenson/Farmer review of mental health and employers. Department of Work and Pensions and the Department of Health https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

Feltner C. Peterson K. Palmieri Weber R. Cluff L. Coker-Schwimmer E. Viswanathan M. Lohr K.N. The Effectiveness of Total Worker Health Interventions: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop. Available at: https://pubmed.ncbi.nlm.nih.gov/27240022/

Fenton, S-J., Pinilla Roncancio, M., Sing, M., Sadhra, S. & Carmichael, F. (2014) Workplace wellbeing programmes and their impact on employees and their employing organisations: A scoping review of the evidence base A collaboration between Health Exchange & University of Birmingham. Available at: https://www.birmingham.ac.uk/Documents/research/ias/Wellbeing-at-work-review-Jan-31.pdf

Fingret, A. (2000) 'In-Depth Review Occupational mental health: a brief history', Occup. Med. Occup. Med, 50(50), pp. 289–293. Available at: https://pubmed.ncbi.nlm.nih.gov/10975122/

Follmer, K. B., & Jones, K. S. (2018). Mental illness in the workplace: An interdisciplinary review and organizational research agenda. Journal of Management, 44(1), 325–351. https://doi.org/10.1177/0149206317741194

George, J.M. (2000) 'Emotions and Leadership: The Role of Emotional Intelligence', Human Relations, 53(8), pp. 1027–1055. https://doi.org/10.1177%2F0018726700538001

Giga, S. I. Noblet, A. Cooper, G. L, (2003) The UK perspective: a review of research on organisational stress management interventions. Australian Psychologist, Volume 38, 2003 - Issue 2, Pages 158-164 | Published online:16 Aug 2006. DOI: https://doi.org/10.1080/00050060310001707167

Gill, P., Stewart, E., Treasure, E., Chadwick, B. (2008) Methods of data collection in qualitative research: Interviews and focus groups. British Dental Journal, Volume: 204 Issue 6 Pages: 291-295 https://pubmed.ncbi.nlm.nih.gov/18356873/ DOI: 10.1038/bdj.2008.192

Glaser, B. G. (1978). Theoretical Sensitivity: Advances in the Methodology of Grounded Theory. United States: Sociology Press. ISBN: 9781884156014, 1884156010

Glaser, B. (2002). Constructivist Grounded Theory? Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 3(3), Art.12. Available at: http//www.qualitative-research.net/fqs-texte/3-02/3-02glaser-e.htm

Glesne, C., & Peshkin, P. (1992). Becoming qualitative researches: An introduction. New York, NY: Longman.

Gobo, B. Sampling, representativeness and generalizability. In: Seale C, Gobo G, Gubrium JF, Silverman D, eds. Qualitative Research Practice. London, England: SAGE Publications, 2004. https://ggobors.ariel.ctu.unimi.it/repository/ggobors/sage2004.pdf

Goetzel, R. Z., Ozminkowski R. J. 'What's holding you back: why should (or shouldn't) employers invest in health promotion programs for their workers?' N C Med J. 2006 Nov-Dec;67(6):428-30. PMID: 17393704. https://www.ncmedicaljournal.com/content/ncm/67/6/428.full.pdf

Goetzel, R. Z., Long, S.R., Ozminkowski, R. J, Hawkins, K., Wang, S. & Lynch, W. (2004) 'Health, Absence, Disability, and Presenteeism Cost Estimates of Certain Physical and Mental Health Conditions Affecting U.S. Employers', Journal of occupational and environmental medicine, vol. 46, no. 4, pp. 398-412. https://doi.org/10.1097/01.jom.0000121151.40413.bd

Goldman, H. H., Grob, G. N. (2006) Defining 'Mental Illness' in Mental Health Policy. Health affairs vol. 25, no. 3: Mental Health: Progress & Pitfalls. https://doi.org/10.1377/hlthaff.25.3.737

Goleman, D. (1995). Emotional intelligence. Bantam Books, Inc. https://psycnet.apa.org

Graveling, R., Crawford J., Cowie H., Amati C., Vohra S. (2008). A review of workplace interventions that promote mental wellbeing in the workplace. Edinburgh: Institute of Occupational Medicine; 2008. University of York. https://www.ncbi.nlm.nih.gov/books/NBK75294/

Gray, N.S., Davies, H. & Snowden, R. J. (2020) Reducing stigma and increasing workplace productivity due to mental health difficulties in a large government organization in the UK: a protocol for a randomised control treatment trial (RCT) of a low intensity psychological intervention and stigma reduction programme for common mental disorder (Prevail). *BMC Public Health* 20, 896 (2020). https://doi.org/10.1186/s12889-020-09054-0

Greden, J. (2017) Workplace Mental Health Programmes: The role of managers. The Lancet Psychiatry, Volume 4, issue 11 pages: 821-823 DOI: https://doi.org/10.1016/S2215-0366(17)30405-4 www.thelancet.com/psychiatry

Greenwood, D. J. (2002). Action Research: Unfulfilled promises and unmet challenges. Concepts and Transformation, 7(2), 117-139. https://www.jbe-platform.com/content/journals/10.1075/cat.7.2.02gre

Greenwood, D. J., & Levin, M. (1998). Introduction to Action Research: Social research for social change. Thousand Oaks: Sage Publications.

Grice, T., Alcock, K., & Scior, K. (2018). Factors associated with mental health disclosure outside of the workplace: A systematic literature review. *Stigma and Health, 3*(2), 116–130. https://psycnet.apa.org/doi/10.1037/sah0000079 https://psycnet.apa.org/record/2017-05278-001

Griffith, A., Cox T., Barlow C. Employers responsibilities for the assessment and control of work-related stress. Health and Hygiene 1996; 17: 62-70. https://osha.europa.eu/en/publications/report-research-work-related-stress

Guba, E., and Lincoln, Y., (1989) *Fourth Generation Evaluation*. Newbury Park, CA: Sage.

Guest, D. E. & Conway, N. (2009). Pressure on Work and the Psychological Contract, in International Handbook of Work and Health Psychology, Third Edition https://onlinelibrary.wiley.com/doi/10.1002/9780470682357.ch2

Guest, G., MacQueen, K.M., Namey, E., Validity and Reliability (Credibility and Dependability) in Qualitative Research and Data Analysis. In: Applied Thematic Analysis, Chapter doi: https://dx.doi.org/10.4135/9781483384436.n4

Hanisch, S. E., Twomey, C. D., Szeto, A. C. H., Birner, U. W., Nowak, D. and Sabariego, C. (2016), "The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review", BMC Psychiatry, Vol. 16, pp. 1-11 https://doi.org/10.1186/s12888-015-0706-4

Harnois, G. & Gabriel, P. (2000) Mental health and work: Impact, issues and good practices. World Health Organization & International Labour Organisation. (2000). https://www.who.int/iris/handle/10665/42346

Hart, E., and Bond, M., (1995) Action Research for Health and Social Care. Buckingham: Open University Press. https://doi.org/10.1177/002087289603900213

Harvey, S. B., Joyce S., Tan L., Johnson A., Nguyen H., Modini M., Groth M., (2014) Developing a mentally healthy workplace: A review of the literature. A report for the National Mental Health Commission and the Mentally Healthy Workplace Alliance http://www.headsup.org.au/docs/default-source/resources/developing-a-mentally-healthy-workplace_literature-review.pdf?sfvrsn=2

Harvey, S.B., Modini M., Joyce S., et al., (2017). Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems. Occupational and Environmental Medicine 2017;74:301-310. http://dx.doi.org/10.1136/oemed-2016-104015

Hasle, P., Seim, R. and Refslund, B. (2019) 'From employee representation to problem-solving: Mainstreaming OHS management', Economic and Industrial Democracy, 40(3), pp. 662–681. doi: 10.1177/0143831X16653187.

Hassan, E., Austin, C., Celia, C., Disley, E., Hunt, P., Marjanovic, S., Shehabi, A., Villalba-van Dijk, L., and van Stolk, C. (2009). NHS Workforce Health and Wellbeing Review: Health and Wellbeing at Work in the United Kingdom Literature Review. Boorman Review Interim and Final Report. https://www.researchgate.net/publication/229012264_Health_and_wellbeing_at_work_in_the_United_Kingdom

Hassard, J. , Cox, T., Murawski, S., DE Meyer, S., Muylaert, K., Flintrop, J. and Podniece, Z., 2011. Mental health promotion in the workplace – a good practice report. Luxembourg: Publications Office of the European Union. http://doi.org/10.2802/78228

Health & Safety at Work etc. Act, 1974 (HSWA, 1974)
Health and Safety at Work etc Act 1974 - HSE
Health and Safety Executive (HSE, 2004) Psychosocial Working Conditions in Great Britain in 2004 https://www.hse.gov.uk/statistics/causdis/pwc2004.pdf

Health and Safety Executive (HSE, 2016) Summary Statistics in Great Britain 2016 https://www.hse.gov.uk/statistics/overall/hssh1516.pdf

Health and Safety Executive (HSE, 2017) Summary Statistics in Great Britain 2017 https://www.hse.gov.uk/statistics/overall/hssh1617.pdf

Health and Safety Executive, (HSE) (2017) Work -elated stress and psychological health, Position Paper, HSE Workplace Health Expert Committee https://www.hse.gov.uk/aboutus/meetings/committees/whec/assets/docs/whec-04.pdf

Health and Safety Executive (HSE, 2018) Summary Statistics in Great Britain 2018 https://www.hse.gov.uk/statistics/overall/hssh1718.pdf
Health and Safety Executive, (HSE) and the Labour Force Survey (LFS) (2020). Work Related Stress, Anxiety & Depression Statistics https://www.hse.gov.uk/statistics/causdis/stress.pdf

Helman, C. G. (1985) Psyche, soma, and society: the social construction of psychosomatic disorders. Cult Med Psych 9, 1–26 (1985) https://doi.org/10.1007/BF00048535

Henderson, M., Harvey S. B., Overland S., Mykletun A., Hotopf M. (2011) Work and common psychiatric disorders. J R Soc Med. 2011 May;104(5):198-207. doi: 10.1258/jrsm.2011.100231. PMID: 21558098; PMCID: PMC3089873. https://pubmed.ncbi.nlm.nih.gov/21558098/

Hennekam, S., Follmer, K., Beaty, J. (2021) Exploring mental illness in the workplace: the role of HR professionals and processes. The International Journal of human resource management 2021, Vol. 32, no. 15, 3135–3156 https://doi.org/10.1080/09585192.2021.1960751

Henning, R., Warren N., Roberston M., Faghri P., Cherniack M., (2009) Workplace Health Protection and Promotion through Participatory Ergonomics: An Integrated Approach. Public Health Rep. 2009; Jul-Aug 2009; 124 (Suppl 1):26-35. https://doi.org/10.1177/00333549091244s104

Hernandez, C.A. & Andrews, T. (2012). Commentary on "Constructing New Theory for Identifying Students with Emotional Disturbance". The Grounded Theory Review, 11(2), 59–63. http://groundedtheoryreview.com/wp-content/uploads/2012/06/CommentaryVol111.pdf

Hesketh, R., Strang, A., Pollitt, A., Wilkinson, B. (2020) What do we know about the effectiveness of workplace mental health interventions? The Policy Institute, Kings College, London.
https://www.kcl.ac.uk/policy-institute/assets/what-do-we-know-about-the-effectiveness-of-workplace-mental-health-interventions.pdf

Hill, D., Lucy, D., Tyers, C. & James, L.. (2007), What Works at Work? Review of evidence assessing the effectiveness of workplace interventions to prevent and manage common health problems. ISBN: 978-1-84712-291-9 https://www.employment-studies.co.uk/resource/what-works-work
HM Government (2011) No Health Without Mental Health. London: Department of Health https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-outcomes-strategy

Hodgett, D., Chamberlain, K. The Social Negotiation of People's Views on the Causes of Illness. *Journal of Health Psychology*. 2000;5(3):325-336. https://journals.sagepub.com/doi/10.1177/135910530000500304

Hoepfl, M. C. (1997). Choosing qualitative research: A primer for technology education researchers. Journal of Technology Education, 9(1), 47-63. http://scholar.lib.vt.edu/ejournals/JTE/v9n1/pdf/hoepfl.pdf

Houdmont, J., Jachens, L., Randall, R., Colwell, J., Gardner, S. (2020) Stress management competency framework in English policing. Occupational Medicine, 70 (1). pp. 31-37. ISSN 0962-7480 https://doi.org/10.1093/occmed/kqz143

Health and Safety Executive (2006), Health and Safety Statistics: 2005/2006, Online report: www.hse.gov.uk/statistics/overall/hssh0506.pdf

Hussey, L., Turner S., Thorley K., McNamee R., Agius R. Work-related sickness absence as reported by UK general practitioners. Occup Med. 2012;62(2):105–111. https://pubmed.ncbi.nlm.nih.gov/22234964/

Ipsen, C., Karanika-Murray, M., & Nardelli, G. (2020) Addressing mental health and organisational performance in tandem: A challenge and an opportunity for bringing together what belongs together, Work & Stress, 34:1, 1-4, https://doi.org/10.1080/02678373.2020.1719555

Ipsen C., Bergmann S.T. (2021) Designing Sustainable Organizations - A Framework with a Joint Focus on Wellbeing and Organizational Performance in Workplaces. In: Kantola J.I., Nazir S., Salminen V. (eds) Advances in Human Factors, Business Management and Leadership. AHFE 2021. Lecture Notes in Networks and Systems, vol 267. Springer, Cham. https://doi.org/10.1007/978-3-030-80876-1_42

Irvine, A. (2008) Managing mental health and employment. Department for Work and Pensions, Great Britain. Research Report No: 537 ISBN 978 1 84712 453 1 https://www.york.ac.uk/inst/spru/pubs/pdf/rrep537summ.pdf

Irvine, A. (2011) 'Something to declare? The disclosure of common mental health problems at work', Disability and Society, 26(2), pp. 179–192. doi: 10.1080/09687599.2011.544058 https://www.tandfonline.com/doi/abs/10.1080/09687599.2011.544058

Ivandic, I., Freeman A., Birner U., Nowak D., Sabariego C. (2017) A systematic review of brief mental health and well-being interventions in organizational settings. Scand J Work Environ Health. https://pubmed.ncbi.nlm.nih.gov/28042963/

Jain, A. (2018). Holistic View of Emotional Intelligence in the Workplace: View on Utilization & Benefits. *Journal of Services Research*, *18*(2). https://scholar.google.com/citations?view_op=view_citation&hl=en&user=BYvVAZkAAAAJ&alert_preview_top_rm=2&citation_for_view=BYvVAZkAAAAJ:u5HHmVD_uO8C

Jenkins, R. (1993) 'Mental health at work - why is it so under-researched?', Occup. Med, 43, pp. 65–6793. https://academic.oup.com/occmed/article-abstract/43/2/65/1527255?redirectedFrom=fulltext

Jenkins, R., Bhugra, D., Bebbington, P., Brugha, T., Farrell, M., Coid, J., Fryers, T., Weich, S., Singleton, N., & Meltzer, H. (2008). Debt, income and mental disorder in the general population. *Psychological medicine*, *38*(10), 1485–1493. https://doi.org/10.1017/S0033291707002516
Johnson, A. (1996). 'It's Good to Talk': The Focus Group and the Sociological Imagination. *The Sociological Review, 44*, 517 - 538. https://journals.sagepub.com/doi/10.1111/j.1467-954X.1996.tb00435.x

Johnson, K. J. (2016). The dimensions and effects of excessive change. Journal of Organizational Change Management, 29(3), 445–459. doi:10.1108/JOCM-11-2014-0215 https://www.emerald.com/insight/content/doi/10.1108/JOCM-11-2014-0215/full/html

Jordan, J., Gurr, E., Tinline, G., Giga, S., Faragher, B., & Cooper, C. (2003). Beacons of excellence in stress prevention. Health and Safety Executive Report: RR133. Sudbury, England: HSE Books. https://www.hse.gov.uk/research/rrpdf/rr133.pdf

Jorm, A. F. (2000) Mental health literacy. Public knowledge and beliefs about mental disorders. Br J Psychiatry. 2000;177:396–401. https://pubmed.ncbi.nlm.nih.gov/11059991/

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Medical Journal of Australia, 166, 182–186. https://pubmed.ncbi.nlm.nih.gov/9066546/

Joyce S., Modini, M., Christensen H., Mykletun A., Bryant R., Mitchell P., & Harvey S. (2016). Workplace interventions for common mental disorders: A systematic meta-review. Psychological Medicine, 46(4), 683-697. https://doi.org/10.1017/S0033291715002408

Joyce, J., (2013), "Facing the challenge of mental ill health in the workplace", Journal of Public Mental Health, Vol. 12 No. 2, pp. 93-97. https://www.emerald.com/insight/content/doi/10.1108/JPMH-01-2013-0003/full/html

Karanika-Murray, M. and Weyman, A.K. (2013), "Optimising workplace interventions for health and well-being: A commentary on the limitations of the public health perspective within the workplace health arena", International Journal of Workplace Health Management, Vol. 6 No. 2, pp. 104-117. https://doi.org/10.1108/IJWHM-11-2011-0024

Karanika-Murray M., & Biron C. (2015) Why do Some Interventions Derail? Deconstructing the Elements of Organizational Interventions for Stress and Well-being. In: Karanika-Murray M., & Biron C. (eds) Derailed Organizational Interventions for Stress and Well-Being. Springer Science+Business Media Dordrecht 2015 ISBN: 9789401798662 https://doi.org/10.1007/978-94-017-9867-9

Karanika-Murray M., Gkiontsi D., Baguley T., (2018) "Engaging leaders at two hierarchical levels in organizational health interventions: Insights from the intervention team", International Journal of Workplace Health Management, Vol. 11 Issue: 4, pp.210-227, https://doi.org/10.1108/ IJWHM-07-2018-0086

Karanika-Murray M., (2015). Workplace Management Practices, Expert Paper & Evidence, (pg:3. NICE, 2016). NICE Guidline [NG13] Published 2015 Updated: 2016 https://www.nice.org.uk/guidance/ng13/evidence

Karasek, R., Theorell, T., (1990). Healthy Work: Stress, Productivity, and the Reconstruction of Working Life. Basic Books, New York, NY. ISBN-10**:** 0465028977

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. Journal of urban health : bulletin of the New York Academy of Medicine, *78*(3), 458–467. https://doi.org/10.1093/jurban/78.3.458

Kerr, R., McHugh M.., McCrory M. (2009). HSE Management Standards and Stress-Related Work Outcomes. Occupational Medicine 2009;59:574–579 https://academic.oup.com/occmed/article/59/8/574/1370885

Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. Journal of Health and Social Behavior, 43, 207– 222. https://psycnet.apa.org/record/2002-15089-006

Keyes, C. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of health. Journal of Consulting and Clinical Psychology, 73(3), 539–548. https://psycnet.apa.org/record/2005-06517-016

King, D.D., Newman, A., & Luthans, F. (2016). Not if, but when we need resilience in the workplace. Journal of Organizational Behavior, 37(5), 782–786. https://doi.org/10.1002/job.2063

Kinman, G. & Jones F. (2005) Lay representations of workplace stress: what do people really mean when they say they are stressed? Work and Stress 19(2): 101–20. https://www.tandfonline.com/doi/abs/10.1080/02678370500144831

Kirby M. J. I., & Keon W. J. (2004) Mental health, mental illness and addiction: issues and options for Canada (interim report). Parliament of Canada, Ottawa https://sencanada.ca/Content/SEN/Committee/381/soci/rep/report1/repintnov04vol1-e.pdf

Kitchener, B.A., Jorm, A.F. (2002) Mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behavior. BMC Psychiatry 2, 10 (2002). https://doi.org/10.1186/1471-244X-2-10 https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-2-10#citeas

Kitchener, B.A., Jorm, A.F. (2004) Mental health first aid training in a workplace setting: A randomized controlled trial [ISRCTN13249129]. BMC Psychiatry 4, 23 (2004). https://doi.org/10.1186/1471-244X-4-23 https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-4-23#citeas

Kitzinger, J. (1994a). The methodology of focus groups: The importance of interaction between research participants. Sociology of Health and Illness 16(1), 103–121. http://dx.doi.org/10.1111/1467-9566.ep11347023

Knapp, M., McDaid, D. and Parsonage, M., (2011) Mental health promotion and mental illness prevention: the economic case. Department of Health, London, UK. http://eprints.lse.ac.uk/32311

Kompier, M., (2004). Commentary: Does the "Management Standards" approach meet the standard? Work & Stress, 18, 137-139. https://www.tandfonline.com/doi/abs/10.1080/02678370412331291434

Korstjens, I., & Moser, A., (2018) Practical Guidance to Qualitative Research, Trustworthiness and Publishing, European Journal of General Practice, (2018), vol. 24, no. 1, 120–124 https://doi.org/10.1080/13814788.2017.1375092

Kristensen, T. (2005). Intervention studies in occupational epidemiology. Occupational and Environmental Medicine, 62(3), 205–210. https://doi.org/10.1136/oem.2004.016097

Krupa, T., Kirsh, B., Cockburn L., Gewurtz, R., (2009) Understanding the stigma of mental illness in employment. Work. 2009;33(4):413– 425. https://doi.org/10.3233/wor-2009-0890. https://pubmed.ncbi.nlm.nih.gov/19923664/

Kunnanatt, J. T., (2004). Emotional Intelligence: The New Science of Interpersonal Effectiveness. Human Resource Development Quarterly, 15(4), 489-495. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.390.3615&rep=rep1&type=pdf

Kuoppala J., Lamminpaa A., Husman P., (2008) Work health promotion, job well-being, and sickness absences: A systematic review and meta-analysis. Journal of Occupational and Environmental Medicine. 2008;50(11):1216-27. https://pubmed.ncbi.nlm.nih.gov/19001948/

Kutcher, S., Wei ,Y., Coniglio, C. (2016) Mental Health Literacy: Past, Present, and Future. The Canadian Journal of Psychiatry. 2016;61(3):154-158. https://journals.sagepub.com/doi/10.1177/0706743715616609

Labour Force Survey (2016) Estimates of self-reported stress, depression or anxiety caused or made worse by work. In Work-related Stress, Depression or Anxiety Statistics in Great Britain 2017 http://www.hse.gov.uk/statistics/causdis/stress/stress.pdf

LaMontagne A. D., Keegel ,T., Louie, A. M., Ostry, A., Landsbergis, P. A., (2007) A systematic r,eview of the job-stress intervention evaluation literature, 1990-2005. International Journal of Occupational and Environmental Health. 2007;13(3):268-80. https://pubmed.ncbi.nlm.nih.gov/17915541/

LaMontagne, A. D., Keegel, T., Vallance, D., (2007b) Protecting and promoting mental health in the workplace: developing a systems approach to job stress. Health Promot. J. Austr. 18, 221–228. https://pubmed.ncbi.nlm.nih.gov/18201165/

LaMontagne, A. D., Martin, A., Page, K.M. et al. (2014) Workplace mental health: developing an integrated intervention approach. BMC Psychiatry 14 131 (2014). https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-14-131

Leka, S. & Cox, T., (2008) The Future of Psychosocial Risk Management and the Promotion of Well-Being at Work in the European Region: A PRIMA Time for Action. In: Leka, S. and Cox, T., Eds., The European Framework for Psychosocial Risk Management, I-WHO, Nottingham, 174-184. https://repository.tudelft.nl/islandora/object/uuid:465ef8b8-03db-4fe9-a8bf-5860217c55f4/datastream/URL/download

Leka, S., Houdmont, J., (2010) Occupational Health Psychology. Blackwell Publishing, John Wiley & Sons Ltd., United Kingdom ISBN: 9783540773405

Leka, S., Jain A., Cox T., Kortum, E., (2011) The development of the European framework for psychosocial risk management: PRIMA-EF. J Occup Health 2011;53:137–143. https://pubmed.ncbi.nlm.nih.gov/21325735/

Leka ,S., & Jain A., (2017) Mental Health in the Workplace in the European Union: Consensus Paper. Brussels, Belgium: European Commission, Directorate General for Health, 2017. https://ec.europa.eu/health/sites/health/files/mental_health/docs/compass_2017workplace_en.pdf

Leka S., & Nicholson P., (2019) Mental Health in the Workplace. Occupational Medicine 2019; 69:5–6 doi:10.1093/occmed/kqy111. https://pubmed.ncbi.nlm.nih.gov/30753713/

Lelliott P., Tulloch S., Boardman J., Harvey S., Henderson M., Knapp M., (2008) Mental Health and Work, Health, Work, Wellbeing. http://www.workingforhealth.gov.uk/documents/mental- health-and-work.pdf

Leung, L., (2015) Validity, reliability, and generalizability in qualitative research. Journal of Family Medicine and Primary Care, 2015;4(3):324-27. doi: 10.4103/2249- 4863.161306. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4535087

Lewin, K., (1944) in MacDonald, C., (2012) Understanding Participatory Action Research: A Qualitative Research Methodology Option. Canadian Journal of Action Research Volume 13, Issue 2, 2012, pages 34-50 https://journals.nipissingu.ca/index.php/cjar/article/view/37

Lewin, K. (1946) Action research and minority problems. Journal of Social Issues, 2, 34–46. http://www.fionawangstudio.com/ddcontent/Instructions/action_research/readings/Lewin_1946_action%20research%20and%20minority%20problems.pdf

Liimatainen, M., & Gabriel, P.S., (2000). Mental Health in the Workplace: Situation Analyses, United Kingdom. Geneva: International Labour Organisation https://www.ilo.org/skills/pubs/WCMS_108226/lang--en/index.htm
Little, K., Henderson, C., Brohan, E., Thornicroft, G. (2011). Employers' attitudes to people with mental health problems in the workplace in Britain: changes between 2006 and 2009. Epidemiology and Psychiatric Sciences 20,73–81. https://pubmed.ncbi.nlm.nih.gov/21657118/

Lincoln, Y.S., Guba, E.G., *Naturalistic Inquiry* Newbury Park, CA: Sage Publications 1985

Local Government Association (2017) Local Government Workforce Survey https://www.local.gov.uk/sites/default/files/documents/Workforce%20Survey%202015-16%20report%20final%2020171216.pdf

Local Government Association (2019) Understanding absenteeism and presenteeism in local government https://www.localgov.co.uk/Understanding-absenteeism-and-presenteeism-in-local-government/47257

Local Government Association (2019) Local Government Workforce Survey https://www.local.gov.uk/sites/default/files/documents/publication%20-%20Local%20Government%20Workforce%20Survey%202017-18.pdf

Luft, J. (1961) 'The Johari Window: A graphic model of awareness in interpersonal relations'. Human Relations Training News, 5 (1), 6–7 in Oliver, S. and Duncan, S. (2019) 'Editorial: Looking through the Johari window'. Research for All, 3 (1): 1–6. DOI https://doi.org/10.18546/RFA.03.1.01

Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., Swartz, L., & Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Social science & medicine (1982)*, *71*(3), 517–528. https://doi.org/10.1016/j.socscimed.2010.04.027

Mackay, C., Cousins, R., Kelly, P., Lee, S., & McCaig, R.H. (2004). Management standards and work-related stress in the UK: Policy background and science. Work & Stress, 18,91-112.
https://www.hse.gov.uk/stress/assets/docs/techpart1.pdf

Marmot, M. (2010). Fair society, healthy lives: Strategic review of health inequalities in England post 2010. London: UCL/The Marmot Review
https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Martin, A, Sanderson, K, Cocker, F. (2009) Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. Scandinavian Journal of Work. 2009; 35(1):7-18.
https://www.ncbi.nlm.nih.gov/books/NBK77200/

Martin, A., Sanderson, K., Cocker, F., (2009a) Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. Scand. J. Work Environ. Health 35, 7–18.
https://www.ncbi.nlm.nih.gov/books/NBK77200/

Martin, A., Sanderson, K., Scott, J., Brough, P., (2009b). Promoting mental health in small- medium enterprises: an evaluation of the "business in mind" program. BMC Public Health 9. http://dx.doi.org/10.1186/1471-2458-9-239

Martin, A., Karanika-Murray, M., Biron, C., Sanderson, K., (2014). The psychosocial work environment, employee mental health and organizational interventions: improving re- search and practice by taking a multilevel approach. Stress. Health http://dx.doi.org/10.1002/smi.2593

Martin, A., Karanika-Murray, M., Biron, C., Sanderson, K. (2016)
The Psychosocial Work Environment, Employee Mental Health and Organizational Interventions: Improving Research and Practice by Taking a Multilevel Approach. Stress & Health, Volume32, Issue3, August 2016, Pages 201-215
First published: 14 July 2014_2016. © 2014 John Wiley & Sons, Ltd.
https://doi.org/10.1002/smi.2593

Martin, A., Woods, M. and Dawkins, S. (2018), "How managers experience situations involving employee mental ill-health", International Journal of Workplace Health Management, Vol. 11 No. 6, pp. 442-463.
https://doi.org/10.1108/IJWHM-09-2017-0069

Mayer, J. D., Salovey, P., & Caruso, D. R. (2004). Emotional intelligence: Theory, findings, and implications. Psychological Inquiry, 60, 197–215.
https://www.jstor.org/stable/20447229

McCormick, J. (1997). An attribution model of teachers' occupational stress and job satisfaction in a large educational system. Work and Stress , 11,17?/ 32. https://psycnet.apa.org/record/1997-06416-003

McDaid, D., (2007). The economics of mental health in the workplace: what do we know and where do we go? Epidemiologiae psichiatria sociale 16, 294–298. https://pubmed.ncbi.nlm.nih.gov/18333424/

McDaid, D., King, D., Park, A. & Parsonage, M. (2011). Promoting wellbeing in the workplace. In: Knapp, M., Mcdaid, D. & Parsonage, M. (eds.) Mental health promotion and mental illness prevention: the economic case. London Department of Health.

McDaid, D., E. Hewlett and A. Park (2017), "Understanding effective approaches to promoting mental health and preventing mental illness", *OECD Health Working Papers*, No. 97, OECD Publishing, Paris. https://doi.org/10.1787/bc364fb2-en.

McManus, S., Mowlam, A., Richard Dorsett, R., Stansfeld, S., Clark, C., Brown, V., Wollny, I., Rahim, N., Morrell, G., Graham, J., Whalley, R., Lee, L., and Meltzer, H. (2012) Mental health in context: the national study of work-search and wellbeing https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193392/rrep810.pdf

McVicar, A., Munn-Giddings, C. and Seebohm, P. (2013), "Workplace stress interventions using participatory action research designs", International Journal of Workplace Health Management, Vol. 6 No. 1, pp. 18-37. https://www.emerald.com/insight/content/doi/10.1108/17538351311312303/full/html

Memish, K., Martin, A., Bartlett L., Dawkins S., Sanderson K. (2017) Workplace mental health: An international review of guidelines. Prev Med. 2017 Aug;101:213-222. https://pubmed.ncbi.nlm.nih.gov/28347696/

Mendel, R., Kissling, W., Reichhart, T., Bühner, M., & Hamann, J. (2015). Managers' reactions towards employees' disclosure of psychiatric or somatic diagnoses. *Epidemiology and psychiatric sciences*, *24*(2), 146–149. https://doi.org/10.1017/S2045796013000711

Meunier, S., Roberge, C., Coulombe, S., & Houle, J. (2019). Feeling better at work! Mental health self-management strategies for workers with depressive and anxiety symptoms. Journal of affective disorders, 254, 7–14. https://doi.org/10.1016/j.jad.2019.05.011

Milburn, K., (1996). The importance of lay theorising for health promotion research and practice. Health Promotion International, 11(1), 41-46. https://academic.oup.com/heapro/article-abstract/11/1/41/582760

Miller, D. M., (1997) Improving mental well-being in the workplace, *Occupational Medicine*, Volume 47, Issue 8, November 1997, Pages 463–467, https://doi.org/10.1093/occmed/47.8.463

Milligan-Saville, J.S., Tan, L., Gayed, A., Barnes, C.W., Madan, I., Dobson, M., Bryant, R.A., Christensen, H., Mykletun, A., & Harvey, S.B. (2017). Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial. *The lancet. Psychiatry, 4 11*, 850-858. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(17)30372-3/fulltext

Milliken, F.J., Morrison, E.W. Patricia F., Hewlin, P.F. (2003) An Exploratory Study of Employee Silence: Issues that Employees Don't Communicate Upward and Why. Journal of Management Studies Volume:40, Issue:6 September 2003, Pages 143-1476 https://doi.org/10.1111/1467-6486.00387

Minker, M. (2000). Using participatory action research to build health communities. Public Health Reports, 115(2/3), 191-197. https://dx.doi.org/10.1093%2Fphr%2F115.2.191

Moll, S., Eakin, J., Franche, R. L, Strike, C. When health care workers experience mental ill health: Institutional practices of silence. Qual Health Res. 2013; 23(2):167–179. doi:10.1177/1049732312466296. https://pubmed.ncbi.nlm.nih.gov/23132130/

Moll, S,. Zanhour M., Patten S. B., Stuart H., MacDermid J. (2017) Evaluating Mental Health Literacy in the Workplace: Development and Psychometric Properties of a Vignette-Based Tool. Journal of Occupational Rehabilitation 2017 v.27 issue 4 601-611 https://pubmed.ncbi.nlm.nih.gov/28120136/

Morgan, P.B.C., Fletcher, D., & Sarkar, M. (2017). Recent developments in team resilience research in elite sport. Current Opinion in Psychology, 16, 159–164. https://doi.org/10.1016/j.copsyc.2017.05.013

Malterud K. 2001. Qualitative research: standards, challenges, and guidelines. Lancet. 358(9280):483–488.

Munn-Giddings, C., Hart C., Ramon S. A participatory approach to the promotion of well-being in the workplace: lessons from empirical research. International Review of Psychiatry. 2005;17(5):409-17. doi: 10.1080/09540260500238546

Munir, F., Leka, S., & Griffiths, A. (2005). Dealing with self-management of chronic illness at work: predictors for self-disclosure. Social Science & Medicine, 60, 1397–1407. https://pubmed.ncbi.nlm.nih.gov/15626533/

Munir, F., Yarker, J. and Haslam, C. (2008) 'Sickness absence management: Encouraging attendance or "risk-taking" presenteeism in employees with chronic illness?', Disability and Rehabilitation, 30(19), pp. 1461–1472. http://dx.doi.org/10.1007/s10672-015-9275-4

Munir, F., Randall, R., Yarker, J., & Nielsen, K. (2009). The influence of employer support on employee management of Chronic Health Conditions at Work. Journal of Occupational Rehabilitation, 19, 333–334.

Murta, S.G., Sanderson, K., & Oldenburg, B. (2007). Process evaluation in occupational stress management programs: A systematic review. American Journal of Health Promotion, 21, 248-254 https://pubmed.ncbi.nlm.nih.gov/17375490/

Narayanasamy, M., Geraghty, J., Coole, C., Fiona Nouri, F., Louise Thomson, L., Callaghan, P., & Drummond, A. (2018). Mental Health First Aid in the Workplace – MENTOR study (Summary) https://hansard.parliament.uk/Commons/2019-01-17/debates/5CBB31E9-12AB-4FDE-9FA7-4E0134E2E7D4/MentalHealthFirstAidInTheWorkplace

Nardelli, G., & Broumels, M. (2018). Managing innovation processes through value co-creation: a process case from business-to-business service practise. International Journal of Innovation Management, 22(3), [1850030]. https://doi.org/10.1142/S1363919618500305

National Institute for Health Care Excellence, (NICE) (2015). Updated: (2016). Workplace health: management practices (NG13). www.nice.org.uk/guidance/ng13

Nexø, M.A., Kristensen, J.V., Grønvad, M.T., Kristiansen, J., Poulsen, O.M., (2018) Content and quality of workplace guidelines developed to prevent mental health problems: results from a systematic review. Scand J Work Environ Health. 2018 Sep 1;44(5):443-457. doi: 10.5271/sjweh.3731. Epub 2018 Apr 30. PMID: 29717327. www.ncbi.nlm.nih.gov/pubmed/29717327

National Institute for Health Care Excellence, (NICE) (2009), Mental Health at Work https://www.nice.org.uk/guidance/ph22

Nicholson P. J., (2018) Common mental disorders and work. Br Med Bull 2018; 126:113–121 https://pubmed.ncbi.nlm.nih.gov/29684103/

Nielsen, K., Taris, T. W., & Cox, T. (2010). The future of organizational interventions: Addressing the challenges of today's organizations. Work & Stress, 24(3), 219–233. https://psycnet.apa.org/doi/10.1080/02678373.2010.519176

Nielsen, K., and Randall, R. (2012). The importance of employee participation and perceptions of changes in procedures in a teamworking intervention. Work Stress 26, 91–111. doi: 10.1080/02678373.2012.682721

Nielsen, K., and Randall, R. (2013). Opening the black box: presenting a model for evaluating organizational-level interventions. Eur. J. Work Organizational Psychol. 22, 601–617. https://doi.org/10.1080/1359432X.2012.690556

Nielsen, K., & Miraglia, M. (2017). Critical essay: What works for whom in which circumstances? On the need to move beyond the "what works?" question organisational intervention research. Human Relations, 70, 40–62 https://doi.org/10.1177/0018726716670226

Nielsen, K., and Noblet, A. (eds) (2018). Organizational Interventions for Health and Well-Being: A Handbook for Evidence-Based Practice. London: Routledge. doi: 10.4324/9781315410494

Nieuwenhuijsen, K., Bültmann, U., Neumeyer-Gromen, A., Verhoeven, A. C., Verbeek J. H. A. M, van der Feltz-Cornelis C. M. (2008). Interventions to improve occupational health in depressed people (Cochrane Review). In Cochrane Database of Systematic Reviews, Issue 2 John Wiley & Sons, Ltd, Chichester.
PMID: 18425942 https://doi.org/10.1002/14651858.cd006237.pub2

Noordik, E., van der Klink, J. J., Geskus, R. B., de Boer M. R., van Dijk, F. J. H., Nieuwenhuijsen, K. Effectiveness of an exposure-based return-to-work program for workers on sick leave due to common mental disorders: a cluster-randomized controlled trial. Scand J Work Environ Health. 2013;39(2):144–154. https://doi. org/10.5271/sjweh.332

Pachankis, J. E. (2007) The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. Psychol Bull 2007; 133:328–45. https://pubmed.ncbi.nlm.nih.gov/17338603/

Patel, V., Weiss, H. A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S., De Silva, M. J., Bhat, B., Araya, R., King, M., Simon, G., Verdeli, H., & Kirkwood, B. R. (2010). Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. Lancet (London, England), 376(9758), 2086–2095. https://doi.org/10.1016/S0140-6736(10)61508-5

Pearlin, L. I., Lieberman, M. A., Menaghan, E. G., & Mullan, J. T. (1981). The stress process. *Journal of health and social behavior*, *22*(4), 337–356. https://pubmed.ncbi.nlm.nih.gov/7320473/

Pech, R. & Slade, B. (2006), "Employee disengagement: is there evidence of a growing problem?", Handbook of Business Strategy, Vol. 7 No. 1, pp. 21-25. https://doi.org/10.1108/10775730610618585

Perry, R. W., and Mankin, L. D. (2004), Understanding employee trust in management: conceptual clarification and correlates'', Public Personnel Management, Vol.33 No.3, Fall, pp.277-91. In Pech, R. and Slade, B. (2006), "Employee disengagement: is there evidence of a growing problem?", Handbook of Business Strategy, Vol. 7 No. 1, pp. 21-25.
https://doi.org/10.1108/10775730610618585

Polit, O. F., & Hungler, B. P., (1993). Essentials of nursing research: Methods, appraisals and utilisation. 3rd edition. Philadelphia: Lippincott-Raven Publishers. https://pubmed.ncbi.nlm.nih.gov/27702222/

Pollock, K. (1988). On the nature of social stress: Production of a modern mythology. Social Science & Medicine , 26, 381-392. https://psycnet.apa.org/doi/10.1016/0277-9536(88)90404-2

Pomaki G., Franche R., Khushrushahi N., Murray E., Lampinen T., Mah P., (2010) Best Practices for Return-to-Work/Stay-at-Work Interventions for Workers with Mental Health Conditions: Final Report. Vancouver, BC: Occupational Health and Safety Agency for Healthcare; 2010. https://www.ncbi.nlm.nih.gov/books/NBK567953/

Pomaki, G., Franche R. L., Murray, E., Khushrushahi, N., Lampinen, T. M., (2012) Workplace-based work disability prevention interventions for workers with common mental health conditions: a review of the literature. In: Database of Abstracts of Reviews of Effects (DARE): Quality-assessed Reviews [Internet]. York (UK): Centre for Reviews and Dissemination (UK);1995. https://www.ncbi.nlm.nih.gov/books/NBK99472/

Prati, L. M., Douglas, C., Ferris, G. R., Ammeter, A. P., & Buckley, M. R. (2003). Emotional intelligence, leadership effectiveness, and team outcomes. International Journal of Organizational Analysis, 11(1), 21-41. https://www.proquest.com/docview/198627805

Proper, K.I. and van Oostrom, S.H. (2019). The effectiveness of workplace health promotion interventions on physical and mental health outcomes – a systematic review of reviews. Scandinavian Journal of Work, Environment and Health, 45(6), 546-559. https://pubmed.ncbi.nlm.nih.gov/31134284/

Quirk, Helen, Crank, Helen, Carter, Anouska et al. (2018) Barriers and facilitators to implementing workplace health and wellbeing services in the NHS from the perspective of senior leaders and wellbeing practitioners: a qualitative study. BMC public health 18(1): 1362 https://doi.org/10.1186/s12889-018-6283-y

Ragins, B.R. 2008. Disclosure disconnects: Antecedents and consequences of disclosing invisible stigmas across life domains. Academy of Management Review 33, no. 1: 194–215. https://journals.aom.org/doi/abs/10.5465/amr.2008.27752724

Rathore, D., Chadha, N. K., & Rana, S. (2017). Emotional intelligence in the workplace. Indian Journal of Positive Psychology. 8. 162-165. Indian Association of Health and Welfare. ISSN-p2229-4937e-2321-368X https://www.academia.edu/47722769/Emotional_intelligence_in_the_workplace

Reason, P. (1994). Three approaches to participative inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 324-339). Thousand Oaks, CA: Sage Publications.

Reavley, N. J., Ross A., Killackey E. J., Jorm A. F. (2012). Development of guidelines to assist organisations to support employees returning to work after an episode of anxiety, depression or a related disorder: a Delphi consensus

study with Australian professionals and consumers. BMC Psychiatry 2012 Sep;12:135. http://dx.doi.org/10.1186/1471-244X-12-135

Reavley, N. J., Ross, A., Martin, A., LaMontagne, A. D., & Jorm, A. F. (2014). Development of guidelines for workplace prevention of mental health problems: A Delphi consensus study with Australian professionals and employees. Mental Health and Prevention https://psycnet.apa.org/doi/10.1016/j.mhp.2014.07.002

Rebergen, D. S., Bruinvels, D. J., Bezemer P. D., van der Beek A. J., van Mechelen W. (2009) Guideline-based care of common mental disorders by occupational physicians (CO-OP-study): a randomized controlled trial. J Occup Environ Med. 2009;51(3):305–312. https://doi.org/10.1097/jom.0b013e3181990d32

Richardson, K. M. & Rothstein, H. R. (2008). Effects of occupational stress management intervention programs: a meta-analysis. Journal of Occupational Health Psychology. 13 (1): 69–93. https://pubmed.ncbi.nlm.nih.gov/18211170/

Robbins, S. (2001). Organisational behaviour: Concepts, controversies, and applications, (9th ed). Upper Saddle River, NJ: Prentice-Hall, New York.

Rogers, A., & Pilgrim, D. (2005). A Sociology of Mental Health and Illness. Maidenhead, UK: Open University Press

Rolfe, G., (1996), Going to extremes: action research, grounded practice and the theory-practice gap in nursing https://doi.org/10.1111/j.1365-2648.1996.tb01040.x

Royal College of Psychiatrists (RCPsyc) (2010), Public Mental Health: the case for action. https://www.rcpsych.ac.uk/improving-care/public-health-and-its-role-in-mental-health

Ruestow, J. (2008). The effect of a leader's emotional intelligence on follower job satisfaction and organizational commitment: An exploratory mixed methodology study of emotional intelligence in public human services Capella University. ProQuest Dissertations Publishing, 2008. https://www.proquest.com/openview/a34b5772e9371706ff15d273cec640c7/1?pq-origsite=gscholar&cbl=18750

Ryan, K. D., Oestreich D. K. (1991). Driving Fear Out of the Workplace: Creating the High-Trust, High- Performance Organization. San Francisco: Jossey-Bass. ISBN: 978-0-787-93968-7

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. Journal of Personality and Social Psychology, 57(6), 1069–1081. https://psycnet.apa.org/doi/10.1037/0022-3514.57.6.1069

Saju, M. D. Rajeev, S. P. Scaria, L., Benny A.M. & Anjana, A. Gabriela Topa (Reviewing editor) (2019) Mental health intervention at the workplace: A psychosocial care model, Cogent Psychology, 6:1 https://www.tandfonline.com/doi/full/10.1080/23311908.2019.1601606

Salovey, P. & Mayer, J. (1990). Emotional intelligence. Imagination, Cognition, and Personality, 9, 185–211. https://doi.org/10.2190/DUGG-P24E-52WK-6CDG

Sanderson, K. & Andrews G. (2006). Common mental disorders in the workforce: recent findings from descriptive and social epidemiology. Canadian Journal of Psychiatry 51(2), 63-75. https://doi.org/10.1177%2F070674370605100202

Sartori, R., Costantini, A., Ceschi, A. & Tommasi, F. (2018) How Do You Manage Change in Organisations? Training, Development, Innovation, and Their Relationships. Front. Psychol. 9:313. https://doi.org/10.3389/fpsyg.2018.00313

Schott, R. L. (1999). Managers and Mental Health: Mental Illness and the Workplace. Public Personnel Management, 28, 161 - 183. doi:10.1177/009102609902800201

Scantlebury, A., Parker, A., Booth, A. et al. (2018) Implementing mental health training programmes for non-mental health trained professionals: A qualitative synthesis. PLoS ONE 13(6): e0199746 https://doi.org/10.1371/journal.pone.0199746

Schultz I.Z., & Gatchel R.J., (2016) Handbook of Return to Work, From Research to Practice. Springer, Boston, MA ISBN: 978-1-4899-7626-0 https://doi.org/10.1007/978-1-4899-7627-7

Semmer, N. K. (2011). Job stress interventions and organization of work. In J. C. Quick & L. E. Tetrick (Eds.), Handbook of occupational health psychology (pp. 299–318). American Psychological Association. https://psycnet.apa.org/record/2010-06010-016

Seymour, L. & Grove, B. (2005). Workplace interventions for people with common mental health problems: evidence review and recommendations. British Occupational Health Research Foundation, London. Available at: https://bohrf.org.uk/downloads/cmh_rev.pdf

Seymour, L. (2010) 'Common mental health problems at work interventions . A progress review', p. 19. https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/BOHRF_common_mental_health_problems_at_work.pdf

Shaffer, R. D., & Shaffer, M. A. (2005). Emotional Intelligence Abilities, Personality and Workplace Performance. https://doi.org/10.5465/ambpp.2005.18778994

Sidle, S. D. (2008) Workplace Stress Management Interventions: What Works Best? Academy of Management Perspectives 2008;22(3):111–2 http://dx.doi.org/10.5465/AMP.2008.34587999.

Sim, J. & Waterfield, J., (2019). Focus group methodology: some ethical challenges. Quality & Quantity, 53(6), pp.3003-3022. https://link.springer.com/article/10.1007/s11135-019-00914-5

Simpson, G. W. Byrne, P. Gabbay, M. B. & Rannard, A. (2015) Understanding illness experiences of employees with common mental health disorders Occupational Medicine 2015;65:367–372 https://www.ncbi.nlm.nih.gov/pubmed/26732796

Sivris, K. C., & Leka, S. (2015). Examples of Holistic Good Practices in Promoting and Protecting Mental Health in the Workplace: Current and Future Challenges. *Safety and health at work*, *6*(4), 295–304. https://doi.org/10.1016/j.shaw.2015.07.002

Spurgeon, A. 2007. Stress as an occupational disease. In 'The Industrial Injuries Advisory Council'. London Occupational Medicine (London) 2015;65:367–372. Available at: https://pubmed.ncbi.nlm.nih.gov/25957346/

Smith, L. (1978). An evolving logic of participant observation, educational ethnography, and other case studies. In L. Shulman (Ed.), Review of researching education (pp. 316- 377). Itasca, IL: F. E. Peacock.

Stake, R. E. (1995). The art of case study research: Perspectives on practice. Thousand Oaks, CA: Sage.

Stake, R. E. (2005). Qualitative case studies. In Edited by: N. K. Denzin & Y. S. Lincoln (Eds.), The SAGE handbook of qualitative research (3rd ed., pp. 443–466). Thousand Oaks, CA: Sage.

Stanley, N., J. Ridley, J. Manthorpe, J. Harris, and A. Hurst. (2007a). Dangerous disclosures. Mental Health Today June: 24–7. https://pubmed.ncbi.nlm.nih.gov/17632823/

Stansfeld, S., & Candy, B. (2006). Psychosocial work environment and mental health--a meta-analytic review. Scandinavian journal of work, environment & health, 32(6), 443–462. https://doi.org/10.5271/sjweh.1050

Stansfeld, S. A., Pike, C., McManus, S., Harris, J., Bebbington, P., Brugha, T., Hassiotis, A., Jenkins, R., Meltzer, H., Moran, P., & Clark, C. (2013). Occupations, work characteristics and common mental disorder. Psychological medicine, 43(5), 961–973. https://doi.org/10.1017/S0033291712001821

Stratton, E., Einboden, R., Ryan, R., Choi, I., Harvey, S. B., & Glozier, N. (2018). Deciding to Disclose a Mental Health Condition in Male Dominated Workplaces; A Focus-Group Study. *Frontiers in psychiatry*, *9*, 684. https://doi.org/10.3389/fpsyt.2018.00684. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6305748/

Strauss, A. and Corbin, J. (1998) Basics of Qualitative Research – Techniques and Procedures for Developing Grounded Theory. (2nd ed). CA: Sage.

Sweet, S. N, Fortier M. S, Srachan, S. M, Blanchard, C. M. (2012) Testing and integrating self-determination theory and self-efficacy theory in a physical activity context. Can Psychol/ Psychol Can 2012;53:319–327. https://psycnet.apa.org/record/2012-33135-008

Tennant, C. (2001). Work-related stress and depressive disorders. Journal of Psychosomatic Research, 51(5), 697–704. https://psycnet.apa.org/doi/10.1016/S0022-3999(01)00255-0

Tetui, M., Zulu, J. M., Hurtig, A. K., Ekirapa-Kiracho, E., Kiwanuka S. N. & Coe, A. (2018)Elements for harnessing participatory action research to strengthen health managers' capacity: a critical interpretative synthesis. Health Res Policy Sys 16, 33 (2018). https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-018-0306-0

The Mental Health Foundation (2016), "How to look after your mental health", https://www.mentalhealth.org.uk/publications/how-to-mental-health

Theis, K. A., Roblin, D. W., Helmick, C. G., Luo, R., (2018). Prevalence and causes of work disability among working-age US adults, 2011–2013. NHIS. Disabil. Health J. 11, 108–115. https://pubmed.ncbi.nlm.nih.gov/28476583/

Thisted, C. N., Nielsen, C. V., & Bjerrum, M. (2018). Work Participation Among Employees with Common Mental Disorders: A Meta-synthesis. Journal of occupational rehabilitation, 28(3), 452–464. https://doi.org/10.1007/s10926-017-9743-9

Tinline, G., Cooper,C. (2019) Work-related stress: The solution is management not mindfulness, Organizational Dynamics, Volume 48, Issue 3, 2019, Pages 93-97, ISSN 0090-2616, https://doi.org/10.1016/j.orgdyn.2019.03.004 https://www.sciencedirect.com/science/article/pii/S0090261619300555

Toth, K.E., Dewa, C.S. Employee Decision-Making About Disclosure of a Mental Disorder at Work. J Occup Rehabil 24, 732–746 (2014). https://doi.org/10.1007/s10926-014-9504-y

Tsutsumi, A., Nagami ,M., Yoshikawa, T., Kogi, K., Kawakami, N. (2009) Participatory intervention for workplace improvements on mental health and job performance among blue-collar workers: a cluster randomized controlled trial. J Occupational Environ Med. 2009 May;51(5):554-63. Doi: https://doi.org/10.1097/jom.0b013e3181a24d28
Tsutsumi, A. (2011), "Development of an evidence-based guideline for supervisor training in promoting mental health: literature review", Journal of Occupational Health, Vol. 53, pp. 1-9 https://doi.org/10.1539/joh.R10002

Uçok, A., Brohan, E., Rose, D., Sartorius, N., Leese, M., Yoon, C. K., Plooy, A., Ertekin, B. A., Milev, R., Thornicroft, G., & INDIGO Study Group (2012). Anticipated discrimination among people with schizophrenia. Acta psychiatrica Scandinavica, 125(1), 77–83. https://doi.org/10.1111/j.1600-0447.2011.01772.x

UK Government, (2017) A Framework for Mental Health Research, Department of Health https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/665576/A_framework_for_mental_health_research.pdf

Vakkayil, J., Torre, E. D., & Giangreco, A. (2017). "it's not how it looks!" exploring managerial perspectives on employee wellbeing. European Management Journal, 35(4), 548–562. https://psycnet.apa.org/doi/10.1016/j.emj.2016.12.002

Vargas-Prada, S., Demou, E., Lalloo, D., Avila-Palencia, I., Sanati, K. A., Sampere, M., Freer, K., Serra, C., & Macdonald, E. B. (2016). Effectiveness of very early workplace interventions to reduce sickness absence: a systematic review of the literature and meta-analysis. Scandinavian journal of work, environment & health, 42(4), 261–272. https://doi.org/10.5271/sjweh.3576

von Thiele Schwarz, U., Nielsen, K., Edwards, K., Hasson, H., Ipsen, C., Savage, C., Simonsen Abildgaard, J., Richter, A., Lornudd, C., Mazzocato, P. and Reed, J.E., (2021). How to design, implement and evaluate organisational interventions for maximum impact: The Sigtuna Principles. European Journal of Work and Organizational Psychology, 30(3), pp.415-427. https://doi.org/10.1080/1359432X.2020.1803960

Vickerstaff, S., Phillipson, C., Wilkie, R., (2012) Work, Health and Wellbeing: The Challenges of Managing Health at Work. Bristol: Policy Press, 2012. ISBN 978-1447301110

Waddell, G. & Burton, A. K (2004), Concepts of rehabilitation for the management of common health problems. TSO. https://huddersfield.box.com/s/eofgc4nev85r9vopfr41idj6p1bcp0t4

Waddell, G. & Burton, A. K. (2006). Is Work Good for Your Health and Well-Being? London: TSO. https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

Waddell, G., Burton, A. K., Kendall, N. (2008). Vocational Rehabilitation What Works for Whom, and When? Vocational Rehabilitation. Task Group 1–309. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf

Waddell, G. & Burton, A. K. (2013) What works, for whom, and when, page:10). https://www.gov.uk/government/publications/vocational-rehabilitation-scientific-evidence-review

Wagner, S. L., Koehn, C., White, M. I., Harder, H. G., Schultz, I. Z., Williams-Whitt, K., Warje, O., Dionne, C. E., Koehoorn, M., Pasca, R., Hsu, V., McGuire, L., Schulz, W., Kube, D., & Wright, M. D. (2016). Mental Health Interventions in the Workplace and Work Outcomes: A Best-Evidence Synthesis of Systematic Reviews. The international journal of occupational and environmental medicine, 7(1), 1–14. https://doi.org/10.15171/ijoem.2016.607

Wang, P. S., Simon, G. E., Avorn, J., Azocar, F., Ludman, E. J., McCulloch, J., Petukhova, M. Z. & Kessler, R. C. (2007) Telephone screening, outreach and care management for depressed workers and impact on clinical and work productivity outcomes. A randomized controlled trial. JAMA, 298 (12) 1401-1411. https://pubmed.ncbi.nlm.nih.gov/17895456/

Warr, P. & Payne, R. (1983). Affective outcomes of paid employment in a random sample of British workers. Journal of Occupational Behaviour, 4,91?/ 104. https://www.jstor.org/stable/3000047

Wasserman, J. A. and Clair, J. M. (2011) 'Housing Patterns of Homeless People: The Ecology of the Street in the Era of Urban Renewal', *Journal of Contemporary Ethnography*, 40(1), pp. 71–101. doi: 10.1177/0891241610388417

Waugh, W., Lethem, C., Sherring, S. & Henderson, C. (2017) Exploring experiences of and attitudes towards mental illness and disclosure amongst health care professionals: a qualitative study, Journal of Mental Health, 26:5, 457-463. https://doi.org/10.1080/09638237.2017.1322184

Wheat, K., Brohan, E., Henderson, C., & Thornicroft, G. (2010). Mental illness and the workplace: conceal or reveal?. Journal of the Royal Society of Medicine, 103(3), 83–86. https://doi.org/10.1258/jrsm.2009.090317

Wilkinson, E, Elander, E, Woolaway, M. (1997) Exploring the use of action research to stimulate and evaluate workplace health promotion. Health Education Journal, 1997: 56: 188-198. https://doi.org/10.1177%2F001789699705600209

World Health Organisation (2001). The World health report: 2001: Mental health: new understanding, new hope. World Health Organisation. https://apps.who.int/iris/handle/10665/42390

World Health Organisation (2004). Promoting mental health: concepts, emerging evidence, practice (Summary Report) Geneva: World Health Organization; 2004. https://www.who.int/mental_health/evidence/en/promoting_mhh.pdf
World Health Organisation (2005). Promoting Mental Health: Concepts, Emerging Evidence. https://www.who.int/mental_health/evidence/en/promoting_mhh.pdf

World Health Organisation. (2008). The global burden of disease: 2004 update. World Health Organisation. https://apps.who.int/iris/handle/10665/43942

World Health Organisation (2010). Healthy workplaces: A model for action. For employer, workers, policymakers and practitioners. Geneva: World Health Organisation.
https://www.who.int/occupational_health/publications/healthy_workplaces_model_action.pdf

World Health Organisation (2012), Risks to Mental Health: An overview of Vulnerabilities and Risk Factors.
https://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf

World Health Organisation (2017), Mental Health in the Workplace.
https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/mental-health-in-the-workplace

World Health Organisation (WHO), (2019), Workplace Health Promotion,
https://www.who.int/occupational_health/topics/workplace/en/

World Health Organisation (WHO). (2019) Mental health in the workplace
http://www.who.int/mental_health/in_the_workplace/en/.

Yazan, B. (2015). Three Approaches to Case Study Methods in Education: Yin, Merriam, and Stake. The Qualitative Report, 20(2), 134-152.
https://doi.org/10.46743/2160-3715/2015.2102

Yin, Robert. (1984/1994). Case Study Research: Design and Methods. Thousand Oaks, London, New Delhi: Sage

Appendices

Appendix 1 – Focus Groups Recruitment Poster [Employees]

MINDFUL EMPLOYER

We're supporting The Mind Blue Light Programme

Improving Mental Health Awareness

Would you like to help shape the pathway to help improve mental health research in Cornwall Council?

There is an opportunity for YOU to take part in a major research project into mental health problems and early interventions.

Would you like to take part in a focus group looking at?

- The general understanding or misunderstanding of common mental health problems in the workplace
- Whether barriers exist within the workplace and if so what they?
- What tools/support would managers/employees find beneficial to assist them?

The focus groups will last approximately 1 hour and the group responses will contribute crucial data for the research project. **Please note**: The information you provide will be kept confidential and anonymous, ensuring that personal information is not identifiable.

If you would like to take part in a focus group please call [redacted]

Be positive about mental health

Tel: 01872 [redacted]
www.cornwall.gov.uk

one and all onen hag oll
CORNWALL COUNCIL

Appendix 2 – Focus Groups Recruitment Poster [Managers]

MINDFUL EMPLOYER

We're supporting The Mind Blue Light Programme

Improving Mental Health Awareness

Are you a manager?

Would you like to help shape the pathway to help improve mental health research in Cornwall Council?

There is an opportunity for YOU to take part in a major research project into mental health problems and early interventions.

Would you like to take part in a focus group looking at?

- The general understanding or misunderstanding of common mental health problems in the workplace (i.e. anxiety and depression)
- Whether barriers exist within the workplace and if so what they?
- What tools/support would managers find beneficial to assist them?

The focus groups will last approximately **1 hour** and the group responses will contribute crucial data for the research project.

Please note: The information you provide will be kept confidential and anonymous, ensuring that personal information is not identifiable.

Dates and venues to be arranged

If you would like to take part in a focus group please email: [redacted]

one and all / oll hag omen

CORNWALL COUNCIL

Appendix 3 - Letter of Invitation

Dear Participant

Thank you for contacting me and registering your interest in taking part in my ongoing PhD research.

I am a Strategic Health Safety and Wellbeing Consultant in the corporate Health, Safety & Wellbeing Service at Southwest Council. I am also a student at Nottingham Trent University working towards a PhD in Social Sciences.

The research is based on Southwest Council, exploring early workplace intervention methods in relation to common mental health problems. The study adopts an overarching participatory action research (PAR) approach exploring with you as managers and what you believe is meant by '*early*' and what would support you in terms of instigating early interventions proactively within the workplace.

In order to collect good qualitative data, I have chosen to undertake a range of purposive focus groups selecting participants from variable management/employee levels and from a variety of occupational groups (the employee groups have been run and analysed).

The focus groups are **not** based on workplace/job stress; although if you wish to comment on stress interventions you may have had; in addition to a diagnosed mental health problems please let me know and I arrange a 121 with you?

The focus groups will last approximately 1.5 hours and the groups responses will contribute crucial data for the research project but will also allow for reflecting, refining, revising and iteration of the data with participants as the research develops. The analysis will feed back into the organisation to help develop change and resilience; therefore, this is your chance to help with those changes.

The information you provide will be kept confidential and anonymous, ensuring that personal information is not identifiable.

Further information will be provided should you indicate your interest in taking part, however, if you require further information prior to making a decision, please contact me by email: [redacted] My supervisor, Prof Dianne Bailey, Division of Psychology, Nottingham Trent University and can be contacted on [redacted]

Please indicate below whether or not you would be willing to take part.
I am/am not willing to take part in the research study (Delete as appropriate)

If you are willing to participate may I take this opportunity to thank you

Name:	
Signature:	**Date:**

Appendix 4 - Focus Group Participant Information Sheet

Early Intervention for Common Mental Health Problems *"How early is early?"*

The aim of the study is to explore within the workplace and through collaborative inquiry employer and employee factors that either enhance or hinder proactive early management interventions in the workplace for those diagnosed with common mental health problems (stress, anxiety and depression).

The study will be undertaken in a Participatory Action Research (PAR) approach, which is collaborative and allows for all participants of the focus groups to discuss the research problem. The cycles of participatory action research moves back and forth through cycles allowing for you as participants to reflect on the emerging data, provide feedback and assist with the building of theory and to offer the possibility of facilitating organisational change.

What is the purpose of this study?

A key question that will be explored in this study; and one which is not addressed by current research is; "*when instigating interventions for common mental health problems in the workplace - how early is early*?" and does "*early*" differ in terms of what employees would find beneficial and what management currently provide.

The research objectives:

- Explore whether barriers to intervening early exist and if so what these are for example: lack of management awareness, training or support?
- What targeted intervention strategies could be implemented to benefit the manager, employee and the organisation in the proactive management of those with common mental health problems and
- What organisational change might be needed to allow improved interventions to happen

Why have I been invited?

- You have been invited because you had responded to the 'call for participants' to take part in this study.

- You have therefore been selected and invited to take part in a focus group to explore common mental health problems including common issues and barriers that may identify gaps in policy and practice what is meant by 'early' and what 'early' interventions might look like.

Do I have to take part?

As a research participant, you will only take part voluntarily, and will not be subject to any coercion or undue influence; their rights, dignity and autonomy will be respected and appropriately protected. If you decide to accept you will be asked to sign a consent form to confirm that you have agreed to take part. You can withdraw at any time without reason.

- *As part of the consent procedure, if I hear or see something that gives cause for concern in respect of safeguarding or whistle blowing procedures, I will have a duty to act, but will talk with you first about what I am required to do. That might mean that I will encourage the person to talk to someone who could help or agree that I will talk to someone else on their behalf.*

What happens if I take part?

The PAR process will be undertaken in ongoing cycles of group discussions, questioning and reflecting that engages and explores with you as participants and stakeholders to enable an understanding of your perspectives that allows for a deeper understanding of the key issues in regard to common mental health problems and evaluating what early interventions could be implemented to support both employees and managers. The study is dependent on your participation, however, to ensure that the PAR study is effective it may require a significant amount of your time.

Will my taking part in the study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about will have your name removed so that you cannot be recognised.

I will ensure that:

- Any group/individual research participant's anonymity preferences are respected and secured.
- All participant requirements concerning the confidential nature of information and personal data will be respected and secured.
- All response/focus group data will be scanned into a secure, locked digital file that will not be accessible by others. Any paper copies/notes etc. will then be destroyed by confidential shredding.
- Once the research has been completed all collected data will be permanently deleted from the secure folder. This will be within 2 months of the project end; at the latest.

- As the researcher, I have signed Southwest Council's confidentiality agreement with regards to accessing individual's confidential information – In addition I am bound by the Data Protection Act, the Medical Records Act, workplace and professional codes of conduct.
- Any written-up answers will be anonymised, all discussions will be kept anonymous, and no one will be identifiable from the results presented.

What if there is a problem?

- 24/7 counselling is available if you at any exhibit any signs of distress.

- I have also been trained in Mental Health 1st Aid and have appropriate links, referral and support mechanisms available to me through our team (which includes occupational health) in addition I am a trained domestic and sexual abuse (DASH) assessor and have direct links with a wider support team if required.

What will happen if I don't carry on with the study?

If you decide to withdraw from the study, I will destroy all your identifiable data but I will need to use the data collected up to your withdrawal.

Contact details: The contact details are included on the letter of invitation

Appendix 5 – Research Project Consent Form

Consent Form

Common mental health problems in the workplace – exploring management interventions

Please read the following statements and circle yes or no to let us know that you understand what is involved in agreeing to take part in this study.

I have read and understood the information sheet.	**Yes**	**No**
I have been able to ask questions about the study if there is anything I am unsure about.	**Yes**	**No**
I understand that participation in the study is entirely voluntary and I can withdraw my consent and participation at any-time without giving a reason.	**Yes**	**No**
I understand and give permission for information I contribute to be recorded and used in accordance with the conditions of confidentiality outlined in the information sheet.	**Yes**	**No**
I understand that the information I provide will be entirely confidential and anonymous. However, if I provide information that suggests that I am at risk of harm I am aware that the researcher would need to pass this information on to a relevant professional.	**Yes**	**No**
I agree to take part in this research project	**Yes**	**No**
Name:		

Signature:
Date:

Data collected from this study will be confidential and anonymous. This consent form will be stored separately from your data and in order to protect your right to withdraw your data following your immediate involvement, you are asked to provide a code name. This code name will be used to identify your data so that it can be removed from the final analysis if you wish. Your participation in this study is entirely voluntary and you have the right to withdraw at any time during the experiment and for any reason.
If, during the study, you have any queries or questions regarding the nature of the research please feel free to contact me[redacted]

Appendix 6 - Focus Group Research Discussion – Topic Guide

Focus Group Research Discussion – Topic Guide

- Aim of the discussion and expected duration (1 hour)
- General purpose of the overall research project and the methodology being used **–** for example: The Participatory Action Research Process, Iteration etc.

"*When instigating interventions for common mental health problems in the workplace - how early is early*?" and does "*early*" differ in terms of what employees would find beneficial and what management currently provide.
The focus group collaboratively will explore:

- The group's general understanding of common mental health problems and would they be able to happy to disclose them to a manager at an early stage?
- Whether barriers exist in terms of intervening at an early stage and if so what they?
- What tools would assist employees and managers in managing a common mental health problem in the workplace?

- It will be explained who is involved in the process (other participants) and why the participants' cooperation is important
- Confirm that the collected information will be anonymised and kept confidential as required by NTU Research Ethics and South West Council procedures
- Ground rules will be defined, for example:
    - It is important to hear everyone's ideas and opinions.
    - There are no right or wrong answers to questions – just ideas, experiences and opinions, which are all valuable.
    - It is important to hear all sides of an issue – the positive and the negative.
    - Confidentiality will be assured. "*What is shared in the room stays in the room*."
    - Consent to participate will be obtained and recorded
    - A participant can withdraw at any time or if they find the discussion difficult, upsetting or prefers to discuss in a 121

During the focus group emergent issues will be mapped as they arise in the session on a flipchart or board. This will display to the group what has been generated enabling and encouraging ownership, reflection and iteration in order to move the research forward. The group might be asked to add to the list, but more importantly it will serve as a framework for further discussion.

Topic **Common mental health problems in the workplace**	**Probes and sub-topics**
What is your general understanding of common mental health problems?	Tell me about your perception of common mental health problems – what does it mean? **Probe**: Talk about what kinds of common mental health problems you have experienced within the workplace as an employee? What do you do when these problems arise? **Probe:** Can you relate any recent experiences when you have had to divulge a diagnosed common mental health problem? Did you seek support and if so where from? Did you seek support of others that have had similar experiences of common mental health problems? What were the reasons for taking these steps? **Probe**: What methods would support you as an employee?
Would you be able to disclose a problem at an early stage?	Can you describe what support/response you think would get? **Probe**: Can you explain what steps you would take if any? When is it good for a manager to intervene?
Do barriers exist in terms of managers intervening at an early stage and if so what they?	Discuss what you perceive to be a barrier to enabling early intervention **Probe**: Is it the managers themselves, lack of confidence in tackling the individual and/or lack of training and awareness?
Managers that are managing employee(s) with a common mental health problem	Can you describe how this was/is being done? What methods are they implementing and how effective are they? How has the employee interacted with the intervention methods? Is there anything else that would support you in the process and if so what?
What tools would assist you and your manager in managing employee(s) that have a common mental health problem?	Have you found out about any tools that could/would support you and your manager where you have disclosed a common mental health problem? **Probe**: Flexible working, working at home, keeping in touch days, workload? How effective have these tools been? Are a range of tools needed and if so what?
Closing Check if there is anything else anyone would like to add anything we have not talked about in these initial discussions? Is there anything that participants want to discuss confidentially and in a 121?	

Appendix 7 – Open & Focused Coding

Open Coding	**Focused Coding**	**Focus Group Coverage** ***'n' / 8 groups***
Work environment, organisational change, positive role models	Culture Positive supporting managers Motivational Leadership	4
Workloads Government pressures Austerity Redundancies	Organisational Pressures	5
Lack of recognition Judgmental Support Processes & Return to work Full support/No Support Manager, Peer Support, OH Support Stress v anxiety and/or depression Knowledge of available support	Disconnected Disengaged Poor Culture Mental health problems v workplace stress	6
Stigma, trust and understanding, empathy, judgmental, lack of recognition, stereotypes	Barriers to disclosure Disengagement	5
CMHPs is seen as a negative Broken leg v broken head Invisible illness Lacking knowledge	Stigma Discrimination	5
Colleague and Manager Attitudes Negative, Positive, Variable Each case is different Intervention v Ignoring problem Triggers Legislation	General knowledge, understanding and behaviours Interventions – positive/negative	6
Mental health and work Stress Confidentiality Disclosure Discrimination Inconsistent treatment The role of the Workplace Outcomes Support Tools Stress Reasons for lack of awareness Skills set Empathy Culture and	Managers Knowledge, behaviours and skillsets Colleague Attitudes Manager Attitudes	6

Open Coding	**Focused Coding**	**Focus Group Coverage** ***'n' / 8 groups***
change		
Low v high empathy = EMI Social Skills – empathy, Organisational awareness Relationship management – influence, coach/mentor, conflict management, teamwork, inspirational leadership Self-awareness – Emotional self-awareness Self-management – emotional self-control, adaptability, achievement orientation, positive outlook Motivation	Emotional Intelligence Mental health and work Attitudes and behaviours	4 6
Capabilities, competencies, and skills that influence a manager's ability to succeed in coping with environmental demands and pressures. No knowledge of legislation and application	Mandatory Core Skills Reasonable Adjustments	2
Empathy, culture, lack of awareness, tools, change, manager support, peer support, outcomes, sickness absence and stress	Skills set and training Stress focused	5
Positive experiences, early interventions, early support	Positive supporting managers	3
Includes colleague and manager attitude - negative's, positives, variable, triggers, physical v mental health, combined issues, confidentiality, family problems, each case is different	General understanding and attitudes of Common Mental Health Problems	6
Ignoring the issues, not keeping in touch, not undertaking 121's PDS, remote working No action, no change, ignores the problem	Negative outcomes Reactive	3
	Positive	4

Open Coding	**Focused Coding**	**Focus Group Coverage** ***'n' / 8 groups***
Family Problems Personal Problems Physical health v mental health Combined issues Defining CMHP Stress General Awareness	Workplace understanding of CMHP	4
Colleague Attitudes v Manager Attitudes Negative, Positive, Variable Each case is different Triggers & Stress	Support Stereotypes	6
Team dynamics, relationships	Know your team	2
Full support, no support, OH support	Proactive v Reactive	2
Supportive managers Discusses issues with others Information not kept confidential	Trust in managers Lack of trust Confidentiality	2

Appendix 8 – Grounded Theory Analysis Code Book, Coding Distribution Table & Constructed Themes and Sub-Themes

<table>
<tr><th colspan="5">Focused Coding and Distribution Table</th></tr>
<tr><td colspan="5"></td></tr>
<tr><td>Focused Coding</td><td>Focus Group Coverage

'n'/8</td><td>Coded References

'n'</td><td>Total Coded Emergent Themes

'n'</td><td>Comparing and Contrasting Memo Notes</td></tr>
<tr><td>Culture</td><td>4</td><td>75</td><td rowspan="2">Organisational Culture

'n' coded 107</td><td rowspan="2">Organisational, and teams
Workloads
Government pressures
Austerity
Redundancies</td></tr>
<tr><td>Organisational Pressures</td><td>5</td><td>32</td></tr>
<tr><td>Disconnected</td><td rowspan="2">6</td><td rowspan="2">60</td><td rowspan="6">Disclosure

Disengagement

Stigma

Barriers to disclosure

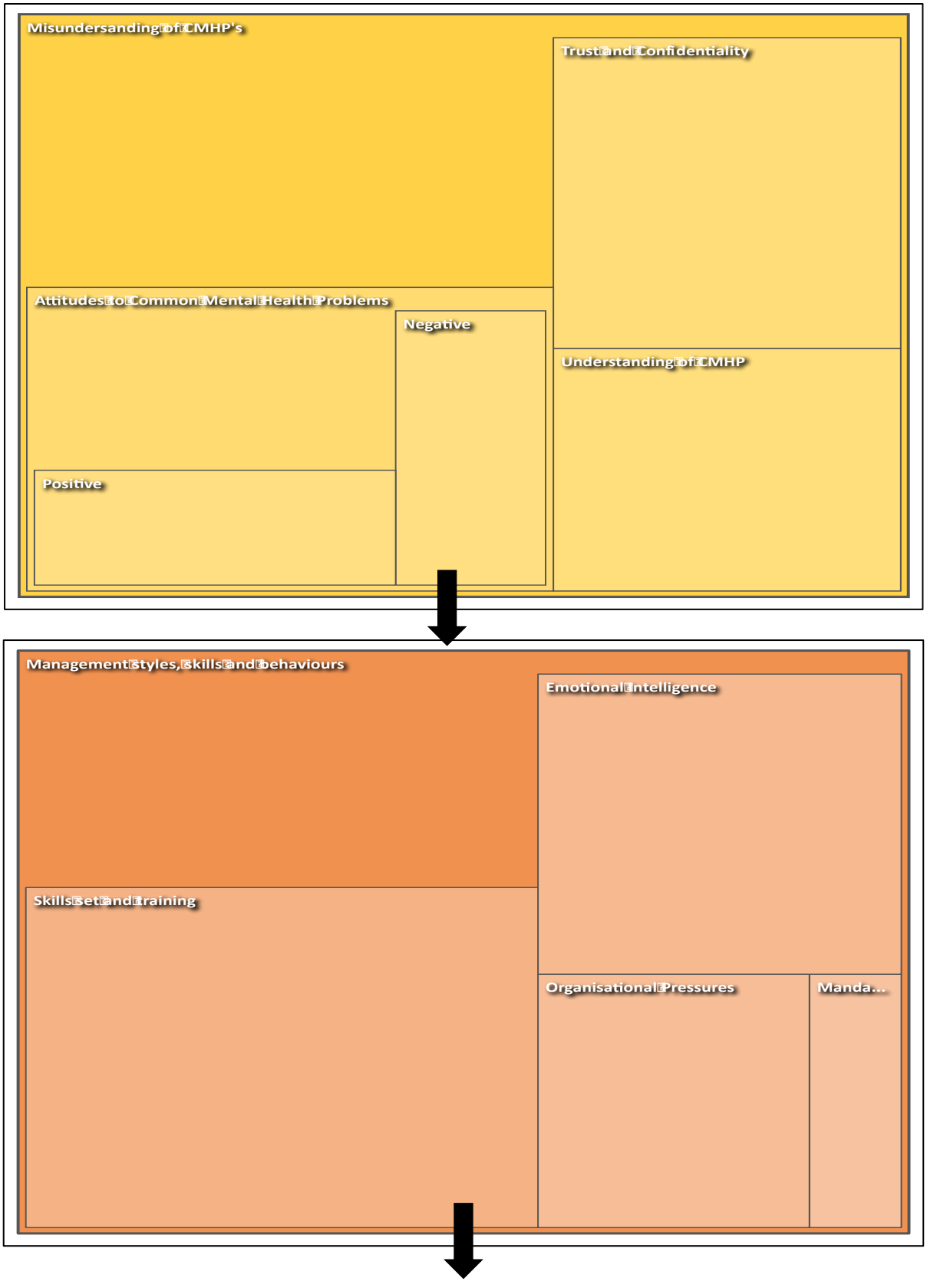
Trust

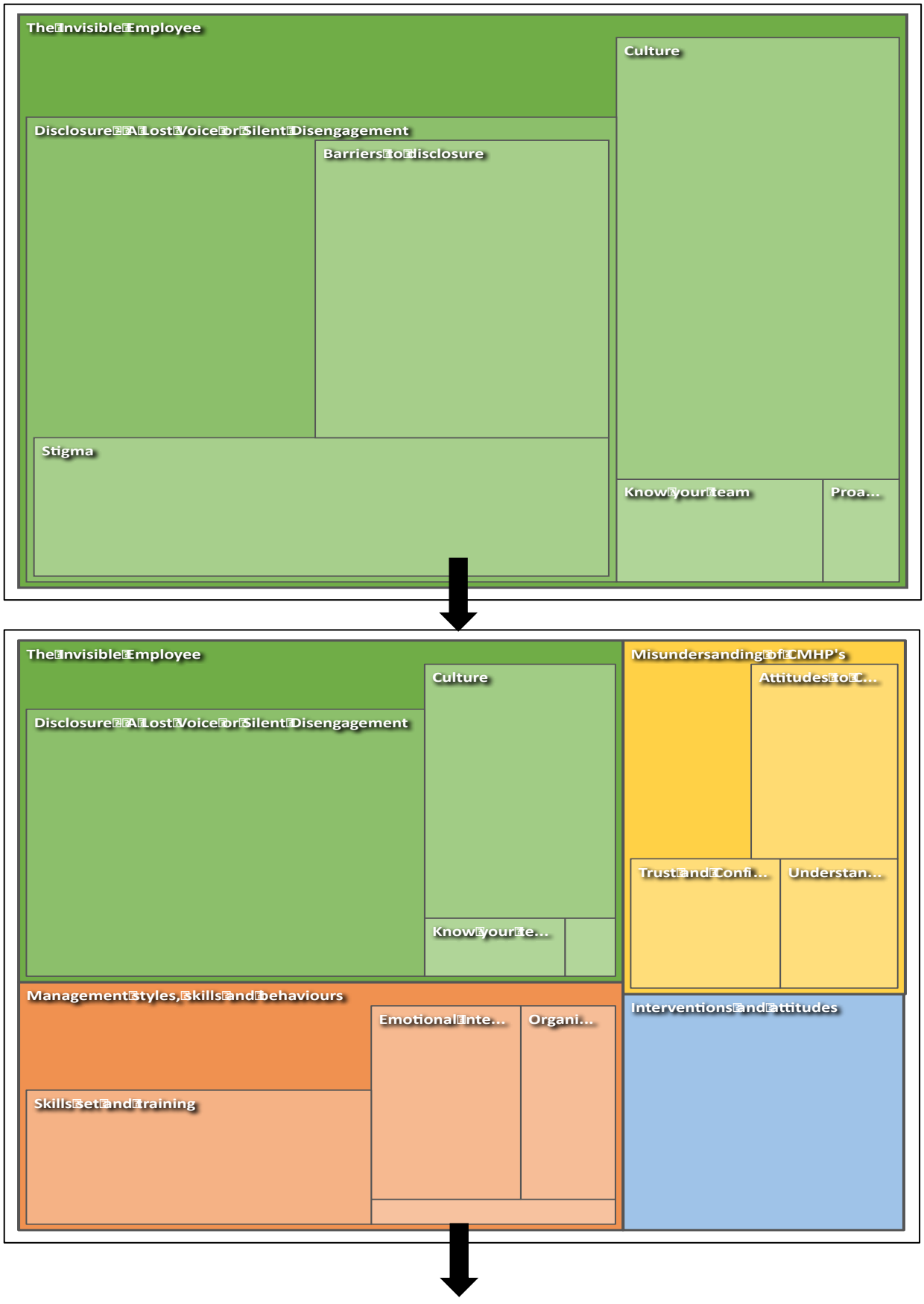
'n' coded 217</td><td rowspan="6">Lack of recognition
Judgmental
Support Processes & Return to work
Full support/No Support
Manager, Peer Support, OH Support
Stress v anxiety and/or depression
Knowledge of available support
Colleague Attitudes v Manager
Attitudes Negative, Positive, Variable
Each case is different
CMHP Triggers & Stress</td></tr>
<tr><td>Disengaged</td></tr>
<tr><td>Barriers to disclosure</td><td>5</td><td>40</td></tr>
<tr><td>Stigma</td><td>5</td><td>47</td></tr>
<tr><td>Support</td><td>6</td><td>32</td></tr>
<tr><td>Trust and Confidentiality</td><td>6</td><td>38</td></tr>
<tr><td>General understanding of CMHPs</td><td>6</td><td>109</td><td>Early Interventions &</td><td>Colleague and Manager Attitudes Negative, Positive, Variable</td></tr>
</table>

Manager Behaviours Interventions Positive v Negative			**Lack of Interventions Manager knowledge and understanding of CMHPs** ***'n' coded 109***	Each case is different Intervention v Ignoring problem Triggers Legislation
Managers Knowledge, behaviours and skillsets	6	56	**Management styles & skills** **Culture** **Manager behaviours** **Emotional Intelligence** **Mandatory Core Skills** **Skills set and training** ***'n' coded 178***	Mental health and work Stress Confidentiality Disclosure Discrimination Inconsistent treatment The role of the Workplace - Culture and change Outcomes Support Tools - Skills set Stress Reasons for lack of awareness Low v high EMI - Empathy, Social Skills – organisational awareness Relationship management – influence, coach/mentor, conflict management, teamwork, inspirational leadership Self-awareness –
Emotional Intelligence	4	42		

Core Management Skills set and training	7	80		Emotional self-awareness Self-management – emotional self-control, adaptability, achievement orientation, positive outlook Motivation Capabilities, competencies, and skills that influence a managers ability to succeed in coping with environmental demands and pressures
General understanding and attitudes of Common Mental Health Problems	6	48	**Understanding** **V** **No Understanding** ***'n' coded 89***	Includes colleague and manager attitude - negative's, positives, variable, triggers, physical v mental health, combined issues, confidentiality, family problems, each case is different Ignoring the issues, not keeping in touch, not undertaking 121's, PDS, remote working Family Problems Personal Problems Physical health v mental health Combined issues Defining CMHP General Awareness - CMHPs often tagged as stress
Negativity	3	9		
Positive experiences	4	14		
Workplace understanding of CMHP	4	18		

Example Hierarchal Coding charts from NVivo 12




The Invisible Employee
Culture
Disclosure - A Lost Voice or Silent Disengagement
Barriers to disclosure
Stigma
Know your team
Proa...
The Invisible Employee
Culture
Disclosure - A Lost Voice or Silent Disengagement
Know your te...
Misundersanding of CMHP's
Attitudes to C...
Trust and Confi...
Understan...
Management Styles, Skills and behaviours
Emotional Inte...
Organi...
Skills set and training
Interventions and attitudes

Constructed Themes and Sub-Themes
Theme 1: "Mis-understanding of CMHPs"
▪ *Misconception of a CMHP and Stress* ▪ *Understanding v Misunderstanding* ▪ *Recognition of CMHP's* ▪ *'Early' Interventions* ▪ *CMHP v Physical Problems*
Theme 2: "Management Styles, Skills, and Behaviours "
▪ *Mandatory core skills and training* ▪ *Hard Skills v Soft Skills* ▪ *Emotional Intelligence* ▪ *Consistent management or inconsistent management?*
Theme 3: "The Invisible Employee"
▪ *Barriers to disclosure* ▪ *Stigma* ▪ *A lost voice or silent disengagement*