**Sociology, Work and Organisations: A Global Context**

**Chapter 11**

# Well-being and Mental Health at Work

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## Introduction

Global policy has increasingly prioritised the importance of mental health (World Health Organization, 2022). This chapter builds understanding of mental health and well-being at work. The World Health Organization (WHO) defines mental health as 'a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their communities' (WHO, 2022). This broad definition recognises that there is a continuum of mental health (WHO, 2022).

The chapter draws on a range of examples including the Global North (UK and Europe) and Global South (including insights into experiences in Bangladesh, India, and Ghana). It begins with a consideration of why mental health matters, reflecting on the extent of mental health problems, their situated context, and the social and economic costs. The discussion suggests that work can promote mental health and well-being as well as harm it, and that difference and intersectional experience may be important in understanding the dynamics of this. Outlining the range of factors that might negatively impact mental health and well-being, the chapter engages with stigma and influences beyond and within the workplace. It considers evidence that the UK is experiencing anxious organisations and a more anxious society in which structural factors and the pandemic context are complicit.

The discussion then moves onto a consideration of different models of disability and mental health, including the biomedical and social models. Some of the controversy that surrounds the social model of disability and its relevance to people with mental health problems is reflected upon. Concepts of the ideal worker and ableism are introduced through a review of recent research on disabled people's experiences in ableist work contexts. An ongoing workplace support gap is identified as contributing to the disadvantage and marginalisation of people with mental health problems.

The chapter then considers what needs to happen to improve the workplace experience of people with mental health problems. It examines the imperative of providing a workplace culture that helps people with mental health problems feel comfortable with disclosing them as a step in accessing support, including through reasonable

adjustments. The role of a range of organisational stakeholders is drawn out, including line managers bridging a policy–practice gap, greater recognition and support for the role of co-workers, the value of learning from lived experience of mental health problems, and also the importance of senior leadership and, where present, HR managers. The chapter then turns to an exploration of the management of mental health at work in a case study of a medium-sized enterprise in England. This provides an opportunity to reflect on some of the issues raised in the chapter, generating insights into the difference that effective interventions can potentially make, as well as challenges that workplaces might encounter in trying to improve mental health policy and practice.

**Addressing Mental Health at Work: Why Does it Matter?**

It is common for people to have mental health problems. A report from the independent Mental Health Taskforce to the National Health Service in England (2016) notes that each year one in four adults experience at least one diagnosable mental health problem. Examples of common mental health problems include anxiety, phobias, obsessive compulsive disorder, depression, and panic disorder. In England the number of people experiencing such issues has been on an upward trajectory, though across all age groups there is a higher incidence of mental health problems experienced by women (Whitty, 2021). Mental health problems need to be explored in their situated context. For example, they can be a symptom of the menopause which may manifest in mood swings and anxiety. In addition, women are overrepresented in unpaid and paid care-giving roles within the family and frontline health and care services. Such roles can have a heavy toll for health and well-being, including through stress, anxiety, and isolation. In response to poorer mental health among women in 2017, the UK government set up a Women's Mental Health Taskforce which started to provide greater recognition of the influence of women's roles as mothers and carers and the impact of domestic violence and abuse (Department of Health and Social Care, 2018). This engagement with household dynamics helps to bring to the fore how structural issues may impact on mental health. The need for action in relation to these issues is arguably all the greater given that the economic consequences of the pandemic may disproportionately affect women in lower-paid and undervalued work.

Further evidence of gendered challenges for the management of mental health and well-being has emerged in the Global South. Venkataraman and Venkataraman (2021) explored reflections of working women during the lockdown in Vadodara, Gujarat, Western India. These scholars report on how the research participants conveyed multifaceted roles during the lockdown, combining paid work and childcare, and this was not acknowledged or valued by people around them, contributing to a sense of loneliness and emotional turmoil. Similar findings emerged in a study of experience in

Ghana, finding that women trying to combine family, care-giving, and career roles experienced stress, with the greatest impact on overall well-being experienced by those without social support (Akuoko et al., 2021).

The situated context of mental health and well-being can be particularly challenging in low-income countries. Bangladesh has experienced a growth in the labour market participation of women since the 1980s and Akhter et al. (2017) have drawn attention to the neglect of mental health issues and how structural factors may impact on mental health. Women from low-income families in rural areas experienced changing gender roles arising from taking up paid work in the ready-made garment industry. They moved away from their families to do so, leaving their children in the care of grandparents (Akhter et al., 2017). The research evidence suggested that stress, anxiety, and suicidal thoughts arose due to women's separation from their children, as well as the nature of the work: sewing machine operators working for 10–12 hours per day, often for seven days a week with little holiday. A lack of health system support for their well-being appeared to be exacerbating the situation (Akhter et al., 2017).

The mental health of young people is also a source of concern. The growth in young people with mental health problems is a global phenomenon, and there is a care and support gap in both low- and high-income economies (World Health Organization, 2022). In England, for example, following the COVID-19 pandemic, the percentage of young people aged 17 to 19 estimated to have a probable mental health problem rose from 10 per cent to 26 per cent, and there is concern about services not meeting demand (National Audit Office, 2023).

Having a mental health problem can have a deleterious impact on life chances. People with mental health problems are persistently overrepresented among the unemployed and economically inactive (Hudson et al., 2009; Thornicroft, 2006). However, work has long been recognised as being important to mental health and well-being. A rethinking of recovery in mental health presents 'work as a significant stage in the journey to recovery, rather than recovery as a necessary precursor to work' (Secker et al., 2005: 65, cited in Hudson et al., 2009: 7). Both unemployment and poor-quality employment can have a negative impact on mental health. It is not as simple as finding people work. The sustainability of employment outcomes is important, including in a context where people with a long-term mental health problem, which may fluctuate, might need in-work support in managing periods of poor mental health and well-being. However, that sustainability can be elusive in a context in which stigma, discrimination, and marginalisation are part of everyday experience around mental health. In January 2017, then UK Prime Minister Theresa May commissioned Thriving at work: Stevenson/Farmer review of mental health and employers (Stevenson and Farmer, 2017), which noted that, while there had been a growth in the number of people with mental health problems in work in the UK, and that while 'good work is good for mental health', a significant

number were ‘struggling emotionally, off sick, less productive, or leaving employment’ (Stevenson and Farmer, 2017: 15).

Research continues to demonstrate that poor mental health is costly. For example, Farmer and Stevenson (2017) reported that annually 300,000 people with a long-term mental health condition in the UK were leaving paid employment. A recent study of the economic case for investing in the prevention of mental health conditions in the UK provided the ‘conservative’ estimate that poor mental health was costing the UK economy at least £117.9 billion annually (McDaid et al., 2022). It has been estimated that there is a cost of $1 trillion to the global economy due to depression and anxiety, mostly linked to lost productivity (WHO and ILO, 2022). Those costs have a social dimension. In recent years, public health globally has been dominated by COVID-19. In this period, a Chief Medical Officer’s report for England recognised that short-term negative effects include significant negative mental health impacts, for example, due to loneliness and isolation during lockdown (Whitty, 2021). The World Health Organization Europe identifies three phases that map the social and economic impacts from COVID-19, conveying an escalation of mental health impacts: increases in levels of stress and anxiety in the first phase; as part of the second phase, mental health problems; and long-term ill-health forming part of the third (Welsh Government, 2021). A labour market change which perhaps aligns with this includes the huge dip in economically active older workers since the start of the pandemic – whom the Office for National Statistics are following in their Over 50s Lifestyle Survey (Office for National Statistics, 2022).

**Anxious Organisations and Nations?**

Our experiences within and outside of paid work contribute to, and impact on, our mental health and well-being throughout our lives. Qualitative case studies undertaken by the author across UK public, private, and voluntary sector employers in 2016 suggested that a range of factors within and beyond the workplace were contributing to mental health problems. Outside work, these factors included: bereavement, relationship breakdowns, and family problems; addiction; finance, debt, and housing issues; and genetics. In the majority of cases, such influences were felt to be beyond the control and influence of employers (Hudson, 2016). At the same time, research participants perceived that there was a growing awareness of mental health, accompanied by increased acknowledgement of the need for employers to be mindful of the circumstances and challenges facing individuals in their lives outside of paid work.

Current socioeconomic and demographic changes in the workforce – for instance, the cost-of-living crisis and growth in older workers and the demands on carers – suggest that the interfaces between private lives and workplace experience are increasingly

interlinked. The anxious organisation has been discussed in terms of personality conflicts and destructive organisational politics (Miller, 2019). However, broader trends towards work intensification (and, as will be discussed in the following text, atypical work), which it is assumed are beneficial for organisational productivity, have less well-documented impacts around mental health. The author found that, while organisational change is normal, downsizing, growing workloads, and pressure at work showed signs of impacting negatively on mental health, and stress at work contributed to staff resignations (Hudson, 2016). While stress tends not to be classified as a medical condition, it can have serious health consequences and cause, or exacerbate, other mental health problems, such as anxiety. The anxious organisation reflects ongoing employer struggles to manage change effectively, alongside an increasing pressure for improved organisational performance that fed into workers feeling unable to cope. Management culture echoed the anxiety rather than contained it. Challenging workplace contexts are ongoing. Reports of an escalating mental health crisis in the National Health Service, with doctors and nurses feeling 'brutalised' and burnt out, provides a stark example (Savage, 2022). Healthcare workers from ethnic minority backgrounds have been disproportionately affected (Qureshi et al., 2022).

Clark and Wenham (2022) have raised the question of whether Britain has become an 'anxiety nation', with anxiety becoming a more prominent mental health problem. These authors highlight the fragile underpinning of material life for a substantial section of the population, and its contribution to poor mental health. The Understanding Society survey is the largest annual longitudinal household panel study of its kind and has been providing evidence on life changes and stability since 2009. Undertaking new analysis of this survey, Clark and Wenham (2022) analysed twelve indicators which provided strong evidence that a more insecure society is linked to a more anxious society. For example, they found that mental distress was higher for renters than for homeowners, and that insecure work was a marker of mental distress. The authors tentatively suggest 'the overriding importance of assets and debts in mental health, with work playing a secondary, but still important role' (Clark and Wenham, 2022: 32).

As Clark and Wenham (2022: 32) imply, there is a need for more research on the links between insecure work and mental health. Irvine and Rose (2022) provide some answers in a scoping review and thematic synthesis of the relationship between precarious employment and mental health (see also Chapter 5, 'Precarious and Gig Work in the Global Economy'). The focus is on what they describe as 'objectively insecure' forms of employment, engaging with temporary agency, fixed-term, casual, zero-hours, and gig work (Irvine and Rose, 2022: 3). Adopting a broad definition of mental health, their literature search terms included 'stress', 'anxiety', and 'depression', and Western sociocultural understanding such as 'well-being' and 'lived experience' (Irvine and Rose, 2022). Outlining their approach to the thematic synthesis of their findings, Irvine and Rose describe how they mapped four 'core experiences' of

precarious employment; that is, financial instability, temporal uncertainty, marginal status, and employment insecurity. Each led to economic, sociorelational, behavioural, and physical experiences of, and responses to, precarious employment. Via a range of routes involving dynamics around work–family conflict and deprivation, a variety of mental health effects were found, including 'stress, anxiety and depression' and 'low morale, low self-esteem, frustration and guilt' (Irvine and Rose, 2022: 8). As the authors note, there is lack of research on how people living with long-term mental health conditions experience precarious employment.

**Different Perspectives on Mental Health and Mental Illness**

Mental health and mental illness continue to be contested concepts and the UK context is a good example of this (Beresford, 2002). The dominant understanding of mental health has been the biomedical model, with its emphasis on the individual's illness, their impairment and limitations, and the roles of psychiatric care and medication as a treatment response. Beresford (2002) argues that stigma has been complicit in labelling mental health service users as a danger to society. He suggests that mental health service users and progressive practitioners have an important role in challenging that stigma and biomedical approaches. Some mental health service users have drawn on a social model of disability, which highlights the significance of discrimination and social exclusion in their everyday lives. The focus shifts from the individual (and the notion of impairment) to the contexts in which people with mental health problems are living their everyday lives. This may help in addressing barriers to inclusion, for example, by discouraging presenteeism and encouraging more flexible support to facilitate employment retention for people with fluctuating mental health problems, including return to work policies that support sustainable outcomes.

Subsequent research by Beresford et al. (2010) found that some people with mental health problems want to distance themselves from disabled people because it may be implied that they have a permanent impairment. The researchers express concern that mental health service users might be disadvantaged by this, given the rights-based policies that have been emerging in relation to disabled people. Where the links between mental health and disability are salient, for example, is how, if a person's mental health problem means that they are disabled under UK anti-discrimination legislation, they can potentially get support at work from their employer in the form of reasonable adjustments. Under the Equality Act 2010, a mental health problem is considered a disability if it has a long-term effect on a person's normal day-to-day activity – for example, the ability to interact with other people or to work at particular times. The problem is 'long-term' if it lasts, or is likely to last, twelve months.

To support progressive and nuanced policy and practice, it is arguably important to recognise that 'mental health is not a binary state: we are not either mentally healthy or mentally ill' (World Health Organization, 2022: 35). People with mental health problems can have high levels of mental health well-being when those problems are well-managed. Public policy debates are beginning to take a human rights approach that considers the need to imbue health and well-being interventions with ethical and equity considerations (Berghs et al., 2019). In this vein, recent criticisms of the medicalised framing in the UK welfare system have argued for a more holistic assessment of capacity for work, engaging with the range of social, personal, and economic circumstances, and types of support, that may influence an individual's prospects for sustainable employment outcomes (Irvine and Haggar, 2023).

**The Ideal Worker and Organisational 'Fit'**

As already outlined, mental health problems can be a disability potentially providing a pathway to protection under UK anti-discrimination law. When people feel that access to workplace support has been unfairly discriminatory, they can try to take a claim to a judicial body with responsibility for workplace justice called an employment tribunal (ET). Foster and Wass (2013) undertook an analysis of four ET claims taken forward by employees. In so doing, these researchers provided a critical perspective on employers' perception of an ideal worker. For example, they discuss the case of a police constable in South Yorkshire Police who experienced chronic anxiety syndrome, which prevented him from undertaking face-to-face contact with the public. Initially he was given a back-office role on a community service desk. However, within a couple of years work reorganisation led to a job description change requiring all those in his team to undertake face-to-face interactions with the public and clients. A subsequent chain of events saw him placed in an unsatisfactory performance procedure, which prompted a period of sickness absence followed by medical retirement. This case was used to help illustrate how employers' assumptions, ideas and behaviour – for example, inflexible job descriptions – marginalise and disable people with an impairment.

Disabled people do exercise agency, as illustrated in the research of Jammaers et al. (2016), who explored their efforts in the context of ableist discourses of disability as lowering productivity. Echoing notions of the ideal worker, ableism presumes able-bodiedness in workplace practices and social relations, and casts disabled people as less employable and capable. These scholars undertook a discourse analysis of in-depth interviews with thirty disabled employees in Belgium, to explore how they tried to construct positive identities in their workplaces. Research participants were found to display a variety of responses to being constructed in terms of what they were unable to do. Some participants proactively tried to create a work environment that supported their productivity – for example, advance booking of a meeting space more suitable to

their disability. Others tried to redefine the meaning of productivity. For example, a woman with chronic depression emphasised her high motivation to perform well during periods of good mental health (Jammaers et al., 2016). Participants again challenged the meaning of productivity by presenting their lived experience of disability as an advantage in building understanding and empathy for colleagues and clients who were unwell (Jammaers et al., 2016).

While the research of Jammaers et al. (2016) implies that people with mental health problems may not be passive victims in the face of challenges encountered, and arguably urges us to move towards a more moral economy, the evidence base suggests a mental health and well-being support gap. This may be exacerbated by the reluctance of a person with a mental health problem to disclose it and by the fact that mental health problems can be less visible than physical ones. Human resource management (HRM) can be more reactive than proactive, as found in research on the experiences of disabled academics in the higher education sector (Sang et al., 2022).

**Managing Mental Health and Well-being at Work**

Workplaces still have much to do to improve how mental health and well-being is managed at work. Employers need to engage with people, policies, processes, and mental-health-related support services. Support needs to be tailored, acknowledging that there are a variety of mental health problems that vary in severity. Looking at the UK experience, examples of interventions that may help include consciousness raising around the importance of talking about mental health and learning from people with lived experience of mental health problems. Training and support are needed, particularly for line managers, to help build skills and confidence in recognising signs of mental health problems, fostering conversations that may support disclosure and signposting to relevant support and services. The role of other social actors, including co-workers and senior leaders, should not be neglected. It is important that interventions are sensitive to workplace circumstances, which vary across organisations of different workforce size.

Recent years have seen UK mental health charities spearhead several high-profile campaigns aiming to challenge the stigma and discrimination faced by people with mental health problems. The campaigns have encouraged more workplace conversations about mental health that may be beneficial for nurturing workplace cultures that erode fears surrounding disclosure of mental health problems and encourage self-care and care for others. This has included days and weeks designated for organisations to run initiatives raising mental health consciousness and awareness. Learning from innovative HRM practice in the mental health services sector, Wang et al. (2023) are among those advocating the organisational benefits of employing people

with experience of mental health problems in roles that can have a positive influence on workplace practices and cultures. People feed their lived experience into the inclusive design and delivery of mental health services (Wang et al., 2023).

Poor management needs to be addressed. The Chartered Institute of Personal Development (CIPD) 'health and wellbeing at work' survey, carried out across a range of organisation sizes in 2022, found a positive UK workplace impact of the pandemic in the form of greater employer focus on well-being, including people's mental health. However, only a minority of organisations provided guidance and training for line managers to help people with health problems avoid absence and stay in work. This is despite most organisations surveyed indicating that they relied upon line managers to manage both short- and long-term absence (CIPD, 2022). Mental Health First Aid courses have become part of the training landscape in the UK, engaging with the signs of mental health problems and how to respond. A subsequent CIPD health and well-being survey found that two-thirds of respondents were training staff in Mental Health First Aid (CIPD, 2023).

As discussed earlier, workplace adjustments are an important part of mental health support, with the potential to help facilitate equitable employment experiences. While numerous countries have placed a legal duty on employers to make reasonable adjustments/accommodations for disabled people, in low- and middle-income countries there has been a lack of focus on promoting social rights (Read et al., 2020). In discussing the negative work experiences of people with mental health diagnoses in Ghana, Read et al. (2022) suggest social activism is needed to promote the rights of people with mental health problems and mobilise change.

The implementation of adjustments can be pivotal in supporting a sustainable return to work after a period of mental-health-related absence, not least for people with more severe mental health problems. Despite progress on social rights in the UK, there is room for improvement. Foster (2007) undertook a qualitative study of employee experiences of disability and the negotiation of adjustments in the public sector workplace. She found that managers lacked understanding of their legal obligations to employees. Greater line manager training in this area may support an organisational approach that recognises that proactive tailored adjustments made for people with mental health problems, in discussion with them, to support their inclusion, must be a part of everyday working life.

HR managers have a role in the proactive action needed to foster workplace equity and inclusion. This might be aided by having influence within senior management teams. A strong understanding of mental health can help to foster a leadership approach that creates a climate for people to talk about their mental health and well-being and access appropriate support. As in many areas relating to equality and diversity, transformational leadership is potentially important in cultivating a shared vision and

supporting the building blocks of sustainable change. This includes providing access to internal or external employee assistance programmes with trained mental-health-related professionals. The author found that designating a senior manager with responsibility for overseeing the development of mental health policy and practice could be beneficial for progress on inclusion (Hudson, 2016). Where there are signs of damaging workplace contexts – for example, in the form of 'anxious organisations' that may be complicit in poor mental health – it is important that the structural and material conditions that may impact mental health are also addressed.

Smaller organisations are unlikely to have HR managers and, on a day-to-day basis, co-workers may have an important support role for people with mental health problems. However, what works for managing workplace mental health can be a complex issue. Recent research on managing people with mental health problems in UK small and micro-workplaces has described a difficult balancing act in which emerging tensions are rarely resolved (Suter et al., 2023). For example, while co-workers can be empathetic in providing workplace support and adjustments for colleagues with mental health problems, this can be an emotional strain and, alongside work pressures, they can experience harm to their own mental well-being (Suter et al., 2023).

**Case Study**

**The Introduction o Mental Health First Aid in FamCo, a Case Study rom the Project Sharing Better Practice in the Management o Mental Health at Work with Employers in the County o Essex**[1]

A few years ago the human resources (HR) manager at FamCo attended an external Mental Health First Aid training course which emphasised that looking after mental health is as important as caring for physical health. FamCo was a medium-sized family-run business in England, with 150 workers. The HR manager was proactive in taking the course, due to her awareness of FamCo's lived experience of mental health. FamCo had a small senior management team (SMT), which included the sole HR manager, who felt that there was a gap in the SMT understanding of the lived experiences of the manual workforce. For some staff, the working conditions were hard and unpleasant, with long working hours and a lack control over the pace of work. The HR manager felt that this work context was having a knock-on effect on mental health and well-being. Moreover, relationship breakdowns, debt, and gambling were all complicit in staff experiencing

[1] This case study draws on research undertaken as part of an Employer Action Learning project, 'Sharing better practice in the management of mental health at work with employers in the county of Essex', which was funded by the University of Essex Economic and Social Research Council Impact Acceleration Account.

mental health problems. The HR manager was concerned about a high degree of presenteeism.

Historically the FamCo HR management offering was reactive, including in relation to mental health. While the company had an external occupational health provider, their focus was on physical health, although workers were signposted to external mental health support where a need was identified. Feeling that FamCo could and should improve the management of mental health after taking the Mental Health First Aid course, the HR manager designed a two-hour Mental Health First Aid training session. This was targeted at colleagues who staff might approach if they had a problem – for example, team leaders and forklift trainers. Delivering this training was a real eye-opener for the HR manager, as she discovered that some participants were already having some conversations with co-workers about their mental health. Given the small numbers of staff in work teams, it was often easy for them to get to know each other and pick up on when someone was feeling ill. The Mental Health First Aid course was also an eye-opener for some of the participants, who were given the opportunity to reflect on how people management is more than about managing workload (important as that might be), but also about caring for colleagues and signposting them to the support they needed.

The HR manager worked on providing opportunities for disclosure of mental health conditions at the start of employment and encouraged colleagues to approach each other and speak about their own mental health problems. She had been open about her own mental health and found this to make her more approachable. While good relationships at work were felt to be very important in supporting disclosure, some negative and dismissive mindsets about mental health remained. In addition, the HR manager felt that it had been easier to make reasonable adjustments for people with mental health problems on the retail side of the business, compared to in manufacturing. For example, in retail it was possible for staff to swap days, and easy to decrease and increase hours, including getting additional staff in for peak periods. A part-time working culture in retail was felt to make this more acceptable. Despite such challenges, an increase in the disclosure of absence related to mental health problems at FamCo was seen as a sign of less stigma surrounding mental health, supported by a more proactive approach to its management.

## Conclusion

This chapter has shown that poor mental health and well-being has significant economic and social costs. We all have mental health, and it is common for people to experience problems, influenced by factors within and beyond the workplace and events across the life course. Biomedical and social models provide contrasting

recommendations for the amelioration of those problems. There is much that workplaces can do to challenge ableist norms, help bridge the workplace support gap for people with mental health problems, and foster the equitable management of difference.

Key learning points from the FamCo case study include having a mental health champion with lived experience of mental health can help to foster organisational change through their leadership and commitment. If the champion is part of the senior management team, this can further help to facilitate change. There needs to be sensitivity to how people's mental health can fluctuate. Line managers and co-workers need to be aware of this in being part of networks of support for inclusion and signposting to support where needed. Having Mental Health First Aid embedded in the organisation, while not a panacea for the challenges of managing mental health at work, can increase emotional intelligence and literacy around mental health and, in so doing, enable manager and co-worker support for colleagues with mental health problems.

**STUDENT ACTIVITY**

**Vignette**[2]

Sally has been a long-standing, respected and valued member of staff at a further education college. However, she has been absent from work for four months due to mental health problems, in part influenced by the menopause alongside the pressures of juggling work and looking after ageing parents. Her employer has a broad set of policies in place that are widely and effectively implemented and actively supported by the executive management team. However, in this instance Sally has received no contact from her colleagues or management within her department throughout her period of absence. Through engaging with support provided by her GP, local mental health team and mental health charities, Sally feels she has reached a point where returning to work would assist in her continuing recovery. This view is supported by her care team. Sally has a latent fear and reluctance to return to work, given the lack of communication she has had with her employer. She is concerned about what might have changed and how her co-workers will treat her.

To allay some of her concerns, Sally has identified and accessed the company's relevant mental health policies on the internal company intranet. As per policy, Sally reached out to human resources and advised them of her desire to return to work. Sally's departmental manager and human resources agreed a return date between

[2] This exercise draws on a vignette co-produced with Brentwood Community Print, an organisation that was run by people with mental health problems and supporting people with mental health problems. It is part of work undertaken on the project 'Sharing better practice in the management of mental health at work with employers in the county of Essex'.

them, but failed to discuss appropriate workplace adjustments that might need to be made. Sally was not a party to these discussions. Upon returning to work, it becomes apparent to Sally that the expectation of her departmental team is that she will pick up where she left off. It becomes clear to her that there has been no discussion of reasonable adjustments. Work expectations prove to be too much for Sally and her mental health deteriorates to the extent that she is again signed off from work. Through a casual conversation with one of Sally's co-workers, a mental health champion from the company reaches out to Sally and provides her with an opportunity to share her experience and engage in a new initiative to refine policy and procedures in respect of returning to work. This results in renewed firm-wide training with regards to people reintegrating into the workforce following a period of absence, and the promotion of positive management of their mental health.

**Discussion Questions**

1. Despite a supportive culture and management within the firm, what went wrong? How did this impact on Sally?
2. Reflecting on her experience, including her life and work contexts, what might have been better done to support Sally?
3. How can active communication facilitate a transition back to work?
4. What benefits could be gained by inclusion of those with lived experience in the formulation of mental health policy?

**Practice Questions**

- What are the business and human cases for better management of mental health at work?
- Why might it be important to take an intersectional approach in an effort to understand workplace mental health?
- What is the difference between the biomedical and social models of disability?
- Why might ableism be problematic for the quality of working life of people with mental health problems?
- What can be done to improve the management of mental health at work? How can different stakeholders (for example, organisational leaders, HR managers, line managers, co-workers, and people with mental health problems) make a difference?

**Key Terms**

Ableism
the discrimination and social prejudice against disabled people, underpinned by a belief that typical abilities are superior.

Ableist norms
shared social beliefs about how society should be organised that do not recognise the needs of disabled people, instead presuming able-bodiedness.

Anxious organisation
where an organisation experiences an ongoing struggle to manage change effectively, an increasing pressure to perform better, and a management culture that mirrors the anxiety in the workforce rather than contains it.

Biomedical model of disability
emphasises the individual's mental illness, their impairment and limitations,and the roles of psychiatric care and medication as a treatment response.

Mental health
a state of mental well-being that empowers people to cope with the stresses of life, fulfil their capabilities, learn and work well, and contribute to society.

Mental Health First Aid
a training course which raises people's awareness of how to identify, understand, and help someone who may be experiencing a mental health problem.

Presenteeism
when an individual comes to work even though they are not feeling well enough to work.

Reasonable adjustments
changes an employer makes to remove or reduce a disadvantage related to someone's disability – for example, modifying a person's working hours.

Social model of disability
describes people as being disabled by barriers in society, not by impairment or difference.

Stigma
negative attitudes and beliefs about a particular group. Stigma is often attached to a person labelled with mental illness.

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