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'Be at work and well, or don't be at all': The role of line management for the support of employees with mental health problems.

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Introduction

The vast majority of research that examines the relationship between work and mental health emerges from occupational psychology and focuses on the characteristics of work that predict employee wellbeing (e.g. Warr, 1987; Kahn and Byosiere, 1991). This body of work has an implied agenda suggesting that the appropriate 'management' of mental health will maximise output and efficiency. Moreover, such work has tended to rely on psychological rather than psychiatric definitions of mental health which means that a focus on stress in the workplace are often conceptually confused with severe issues of mental illness.

There is therefore, a dearth of work looking at the real experience of employment for people with mental health problems and examining the barriers that they face and potential for support. In part, academic research is often driven by a critique of practitioner priorities and with Human Resource Management Programmes and publications distressingly deficient in their addressing of mental health there has been a limited impetus to undertake research in the area. The management of mental health is often argued to be the domain of Employee Assistance Programmes, yet the reality is that only larger employers have access to such facilities and even those that do often have low take up from people with mental health problems (Schott, 1999). All these factors have led to almost no research in the area from a labour process or sociological perspective. With a lifetime risk of mental health problems in the UK currently standing at 1 in 4, then the lack of research in the management of employees with mental health problems is remiss.

This paper will report on data from a project funded by the Scottish Association for Mental Health, consisting of 254 survey responses of individuals in employment who have or recently had a mental health problems and 38 semi-structured interviews with participants who have, or have had, on-going mental health problems. Participants came from a wide range of employment sectors and

crossed socio-economic groupings. The majority of participants in this study were affected by depression or anxiety disorders with just under 30 per cent citing work as *the* (or *a*) causal factor of their illness. The focus of this paper is the role that line managers play for people with mental health problems. Employers until now have tended to take the view that work is not an aetiological factor in mental illness, and that therefore neither research nor appropriate action is required. However, whether or not work is a potent cause of mental illness, the sheer prevalence of mental disorders in employees makes it a pressing issue in its own right (Jenkins, 1993).

This paper starts by looking at the stigmatisation of and incidence of mental health and of those with mental health problems at work. We then go on to look at the role of the line manager and how they have a significant impact on the management of individuals with illnesses and disabilities. After discussing the methods of data collection we report on the findings of the study. Much of this section focuses on the voices of our participants. The process of disclosure at work was often viewed as a negative experience because of the hostility and inertia on the part of line management. As line management were generally cited as the first contact for return to work, their handling of the situation was crucial in terms of the sustainability of employment. In some of the better cases, line managers were central to the success of formal initiatives such as time off for counselling appointments or the support for flexible working. However, in many situations, line managers were not only unsupportive of employees but used an individual's mental health problems to discriminate against them and in the worst case scenarios participants suggested that they had been dismissed because of their health problems. Line managers' reactions were frequently based on ignorance of mental health conditions and often led to inappropriate responses or avoidance of addressing the issue with employees. Recommendations arising from this research focus not just on improving awareness among and training for line managers, but also thinking about ways in which responsibilities can be shared, both with the employees themselves, and also with wider support mechanisms such as GPs and specialist mental health services. The effective management of mental health at work is becoming an increasingly important issue for discussion with increasing prevalence in the general population, in addition to the pressures presented by the 'Work Programme' in the UK in imposing employment on a number of vulnerable groups.

Mental Health and Work

There is growing discussion of the global impact of mental illness. Indeed, it has been noted that five out of the ten more common causes of disease and disability worldwide is due to mental health problems (Melzer et al., 2004). Importantly, mental health problems transect age, gender, income and social class and issues associated with mental health appear to be increasing over time (Tse,

2004). In 1993, the Department of Health and the Confederation of British Industry estimated that between fifteen and thirty per cent of the UK population will experience some type of mental health problem during their working life and it has been suggested that at any one time twenty per cent of the UK population and one sixth of the UK's working population is managing a mental health problem (ONS, 2001; 2007).

Individuals with mental health problems confront significant hurdles in obtaining equal treatment and specifically face attitudinal barriers that lead to social exclusion (Boardman, 2011). Such exclusion exacerbates existing issues and goes hand with the social stigmatization of mental illness (Baldwin and Marcus, 2006). As such, social inclusion through appropriate employment can be key to the success of the management of a mental health problem. Work is at the very core of contemporary life for many and frequently offers financial stability, social identity and engagement within a community. Whilst it is difficult to be specific about the value of employment to good mental health, it can be argued that for some, inclusion in the labour market can improve self-esteem (Scheider and Bramley, 2008). Yet, not only do workplaces frequently deny any causal influence on employees' mental health they often aggravate problems by inappropriate handling of psychological and psychiatric disorders and at worst poor treatment of those with mental health problems can lead to redundancy or dismissal (Hallier and Lyon, 1996).

One of the reasons for discrimination against employees with mental illness is the stigmatisation of psychiatric disorders. Major and O'Brien (2005), suggest that stigma is a response to collective habitation which cause individuals with specific attributes to be excluded (or stigmatised). There are many accounts of people with mental illness being ostracized and stigmatised within society. Historically, mental illness represented a 'possessed' individual (Kinzie, 2000). Yet, despite a supposedly more illuminated society and vast progress in medical research, mental illness is still considered one of the most stigmatized and discriminated against medical conditions (Alexander and Link, 2003)

A study in America of 2000 people with a mental illness found that 53 per cent disclosed incidents of discrimination and that key domain for this discrimination was at work (51 per cent) (Corrigan, 2003). Consequently, employees with mental health problems are reluctant to disclose their condition at work which limits the capacity of an employer to make appropriate workplace accommodation. Other research has noted that working with employees who have a mental health problem is often very difficult for managers and frequently becomes a weakness for even the most

competent manager (Schott 1999). For the most part, it is the line manager that holds the direct responsibility for managing an employee with an on-going health problem (Shift, 2009).

The Role of the Contemporary Line Manager

There is no absolute consensus on what sets apart and makes the role of the line manager distinct from other management roles, such as that of a supervisor or middle manager. However, as Sims et al (2001) suggest, what usually defines contemporary line management is the responsibility for employees who are typically non-managerial, and the line manager is usually responsible for accomplishing goals set at a higher organisational level by directing employees working for them. What also defines contemporary line management centres on the impact of the external environment on such practice. For instance, it has been suggested that the nature of line management has changed since the advent of the 'new economy', with new external pressures leading to 'lean' or 'flatter' management structures. Consequently, pressures to make management systems more efficient have led to line managers taking on more middle-management roles, the sharing of business management responsibilities with middle managers, as well as a greater concentration on routine supervision (Hale, 2005).

There is reasonable evidence to suggest that the role of a line manager is increasingly characterised by an involvement in front-line HRM-related activities. Indeed, a quick literature search suggests the devolution of HRM policy and practice to line management commands a relatively wide and expansive body of literature. Purcell and Hutchinson (2007) believe a key role of line managers is to bring HRM policies to life, particularly in terms of improving performance through teams and individual employees. Thornhill and Saunders (1998) argue that an over-arching pressure for the devolution of HRM activities to line managers arises out of downward pressures to increase productivity and how line managers can play a key part in nurturing front-line employee attitudes towards quality initiatives. Larsen and Brewster (2003) suggest that the growth in responsibility for HRM activities is related to the wider trend of managing through cost-centres; the need to link HRM with day-to-day management; the need for businesses to increasingly identify with customers and the pressures to make quicker decisions. Kuvaas and Dysvik (2007) point out the importance of line managers in HRM practice as they are seen to be best able influence how such practices are perceived by front-line employees. Renwick (2003), moreover, suggests line manager involvement in HRM activities is not something demanded by line managers and instead an expectation imposed upon them by senior managers. Overall, there is a suggestion that the impetus to widen the role of

the line manager to include HRM activities arises from pressures to channel employee-orientated organisational productivity initiatives through the managerial chain of command.

Whilst there is a broad body of literature on the impact of devolving HRM activities on for example managing diversity (Sims et al, 2001), counselling employees (Nixon and Carroll, 1994), prevention of sexual harassment (Thomann and Strickland, 1990), human resource development (Beattie, 2006), work-life balance initiatives (Dick and Hyde, 2007; McCarthy et al, 2010) and supporting older workers (Leisink and Knies, 2011). There is a limited body of work on the role of managers in supporting workers with illnesses or disabilities.

However, from the limited literature that is available we can see the centrality of the line manager in supporting employees with mental health problems. This is helpfully encapsulated by this quote by Shift (2009, p. 1):

A supportive, responsive and inspiring line manager who works to understand the needs of employees can make an enormous difference to the individual whilst also helping to break down the stigma and discrimination barrier surrounding mental health issues... Line managers are unique in workplace support structures because they are constantly in contact with the employees for whom they are responsible. They are therefore able to identify problems early, before they manifest in sickness absence. Early intervention by a line manager can restore an employee's confidence thus strengthening their mental health, and protecting them from potentially damaging long term sickness absence.

Further, Sainsbury et al (2008) highlight how line managers can make a positive difference by making minor adjustments to the employee's work schedule, such as allowing an employee to commence work when there is less demand expected of the employee. Munir et al (2009), moreover, believe that line managers can play an important part in supporting employee self-efficacy. In other words, line managers can support the employee in taking the lead in terms of suggesting reasonable adjustments, taking medication and managing symptoms at work.

Arguments as to why line managers provide inadequate levels of support for employees with an illness or disability varies somewhat. Cunningham et al (2004) found line managers to be stymied in attempts to better manage employees with disabilities because of weaknesses in training, lack of support for the manager themselves. Importantly, both Sainsbury et al (2008) and Cunningham et al (2004) noted that there was often a conflict for line manager between having to ensure the

achievement their unit's targets and maintaining good relationships with individual employees which often undermined most basic attempt to support an employee with a disability or illness.

While the inherently contradictory nature of line management has been widely documented and evidently situated in a discourse surrounding the rational response of organisations to external competitive pressures, the focus of the vast majority of studies that inform such debates seem bereft of subjects' accounts of line managers under devolved HRM regimes. Particularly apparent is a deficit of knowledge in relation to subjects' with health problems or disability issues accounts of line management under devolved HRM regimes

Research Design and Methods

A mixed-methods research design collecting both quantitative and qualitative data was adopted for this research. The survey was used to gather data from a range of employees in Scotland to ascertain the prevalence and nature of mental health problems and to gather information about a range of workplace experiences in the management of mental health. Interviews with a cross section of employees who had experienced mental health problems was designed to provide a more holistic insight into the lived experiences of working while at the same time experiencing or developing a mental health problem. The interviews were carried out in autumn 2011 and winter 2011/12. The survey data was collected between autumn 2011 and autumn 2012.

The survey was distributed widely through, for example, the Scottish branches of the Chartered Institute of Personnel and Development (CIPD) and via supporters of SAMH's '*Dismissed*' campaign. By autumn 2012 there were 366 respondents to the survey of those 254 stated that they had mental health problems. It is the data from these 254 respondents that is reported in this paper. The survey asked people about support for their problems (both organisational and other), the impact of their mental health problems on work and on relationships with managers and colleagues.

Of the 254 survey respondents with mental health problems, three-quarters respondents worked either in the public sector or third sector. Eighty per cent were female which may reflect both the sectors of employment, the propensity of women to respond to surveys as well as the higher prevalence of some mental health problems in women (NHS, 2009). In terms of age, the majority were aged 40 or older. Forty seven per cent of survey participants described themselves as working class and fifty per cent as middle class, while 61 per cent of survey participants had an undergraduate degree or higher qualification. Full demographic details of the survey participants are shown in Table 1.

SOCIO-DEMOGRAPHIC CHARACTERISTIC	PER CENT
Men	18.1
Women	80.1
Do not wish to disclose	1.9
Self-defined as working class	46.3
Self-defined as middle class	49.1
Don't know/prefer not to say	4.7
No formal school qualifications	1.8
O levels/Standard grades	6.9
A levels/Highers	9.2
HNC/HND/BTEC	15.2
Undergraduate degree	35.5
Higher degree	25.8
Other	5.5
Under 30	18.9
31-40	26.3
41-50	35.9
51-60	15.7
60+	3.2

Table 1: Profile of survey respondents

The skewing of the survey sample to highly educated white collar workers required the demographic profiles of the interview participants to be broader in order to capture a wider spectrum of work experiences and contexts. In total, 38 respondents were interviewed. Just over three-quarters of the interview participants were female and the average age of the interviewees was 45 years. The interview sample also included a wider range of jobs and professions than did the survey sample as can be seen in the next section of this paper. The interviews asked participants about the nature of the individual's work, stress at work, workplace support for individuals with mental health problems, management of absence and the impact of mental health problems on workplace relationships.

Four interviewees volunteered when completing the survey. The remaining 34 were recruited via a professional company with experience in policy-related research. The recruitment company was instructed to recruit participants with a range of socio-economic backgrounds in order to extend the relevance of the findings to a broader spectrum of people and work contexts. The interviewees were drawn mainly from the Central Belt of Scotland. The interviews ranged from 45 minutes to two hours in length, and were fully transcribed and were a combination of face-to-face and telephone interviews.

When reporting the qualitative data from the survey, due to reasons of anonymity we have not attributed job roles or type of mental health condition. For the interviews we have attributed the health problem and job role to the quotations but changed the name of the participants.

The Nature and Prevalence of Problems

By far the most commonly experienced problems were depression (75 per cent) and anxiety disorders (64 per cent). A substantial number of respondents experienced both of these conditions together. Between eight and 12 per cent of respondents with mental health problems reported experiencing other mental illnesses such as bipolar disorders, phobias, eating disorders or post-natal depression. The full profile of problems experienced is provided in Table 2. It is also worth noting the total number of conditions experienced: 39 per cent of respondents reported one condition; 44 per cent reported two; 28 reported three; 2 per cent four and 1 per cent (3 individuals) reported experiencing 5 out of the list of 9 conditions.

MENTAL ILLNESS	PER CENT
Depression	78.0
Schizophrenia	0.4
Bipolar Disorder	9.1
Phobias	7.3
Obsessive Compulsive Disorder	5.6
Eating Disorders	10.3
Anxiety	64.2
Postnatal Depression	10.3
Personality Disorders	1.7
Other ¹	10.5

Table 2: Profile of mental health problems experienced (multiple responses allowed)

The profile of problems experienced by the interview participants was very similar to that of the survey respondents with the majority of the interviewees also reported some form of depression or anxiety-related problem.

Nearly half of the survey respondents (49 per cent) described the severity of their problems as 'moderate'; 17 per cent categorised their problems as 'mild'; and 29 per cent felt their problems to be 'severe' (ten people could not provide a categorisation). One-way Anova showed that a higher number of reported conditions was associated with a higher perception of severity ($F=4.35$; $p<0.05$). It should be noted that individuals with severe mental health problems are often not in employment therefore the fact that the only just over a quarter of respondents defining their problem as severe

¹ These included: sleep problems, Seasonal Affective Disorder, self-harming, Post-traumatic Stress Disorder.

is unsurprising. Indeed, Crowther et al. (2001) suggested that about 75 per cent of people with mental illnesses are out of work.

The Management of Mental Health at Work

As Table 3 shows, non-work sources of support vastly outweighed support in the workplace. By far the most common sources of support were the respondent’s family and friends (63 per cent)², followed by GP (53 per cent) or specialist medical or counselling support (91 per cent). Within work, support from colleagues (28 per cent) and line managers (23 per cent) were the most commonly experienced. From the survey, of those individuals that disclosed their condition, thirty eight per cent of respondents were either dissatisfied or very dissatisfied with their employers' response, twenty two per cent were neither satisfied or dissatisfied, and forty per cent were either satisfied or very satisfied with the response. However, this question was broader than the specific response of the line manager.

SOURCE OF SUPPORT	PER CENT
HR/Personnel	8.1
Occupational health (work)	8.6
Line manager/supervisor	22.9
Colleagues	27.6
Trade union representative	5.7
Health and safety representative	0
Citizens Advice Bureau	1.0
Occupational Health (outside work)	3.3
GP	52.9
Counsellor/psychologist/psychiatrist	43.3
Family and friends	62.9

Table 3: Sources of support for those experiencing mental health problems at work (multiple responses allowed)

As part of the survey, participants were asked what support they did or did not receive from work and how this could have been improved. A text analysis using SPSS found that the most commonly used term within this section was ‘line manager’ with 22 per cent of the 108 individuals that filled in this section mentioning their line manager. Out of these comments, sixteen provided rather negative accounts, five presented positive accounts, three made neutral comments or mentioned changing line managers, so it was difficult to judge, and one made an interesting observation about the constraints faced by the line manager in their opportunity to support.

² A subsidiary question indicated that spouse/partner was the favoured source of support in this sub-category.

The comments about poor line management behaviour were commonly based on the manager being somewhat ignorant about mental health conditions for example,

‘Line Manager failed to acknowledge the seriousness of the illness and presented a ‘well you don’t look unwell’ stance’

‘I was sectioned following a manic episode, my line manager was annoyed that I did not ‘give them any notice’ to get my workload covered! I was in hospital for 3 months and when I went back to work it was clear that everyone in the office knew where I had been and why. I resigned 2 months later’

However, one of the respondents referred to lack of training for line managers and another provided a positive account of line management but acknowledged that they were constrained in their ability to act due to formal procedures.

‘My line manager could have tried to encourage me to see my GP or a counsellor sooner. I found it difficult to open up to her about the reasons for my anxiety and depression. It would help if managers could get training in handling such difficult conversations’

‘My line manager was actually quite nice to me, but the rules and regulations had to be followed and she wasn’t able to be flexible in any way. She knew I wasn’t lying about my problems and said as much which was good of her, but she was stuck as a cog in a wheel of a big organisation and had to follow NHS policy which I feel is (ironically) discriminatory’

Within these responses there were still some very positive comments including the two examples given below,

‘Time off for weekly counselling appointments (often almost half days), flexibility with leave at short notice, reduced workload, sensitivity with workload/type, regular contact with Line and Section managers, reassuring emails/support from Line and Section manager, confidentiality, awareness, trust, encouragement. I wouldn’t have survived if it hasn’t been for the support from my Line and Section managers’

‘Allowed to work half time on return to work to enable me to be at work and even had flexibility within these hours so I can do less on a ‘bad’ day and more on a ‘good’ day. Line manager has been instrumental in my recovery – supportive, interested in my welfare, regular checking in to see that all OK – without this am sure I would be off sick so

everyone gains – me and my recovery and the University as I am getting work done well as no pressure is put on me to ‘achieve’”

These quotes also illustrate the types of support given by line managers: both instrumental (practical) and emotional (Barrera, 1986).

The interviews allowed for much deeper interrogation of the role of the line manager for employees with mental health problems. It was clear that in some cases, line managers were not only unsupportive of employees but used an individual’s mental health problems to discriminate against the employee. The case presented below provides a clear illustration of this.

Anna was working as a manager for a voluntary organisation. While her role predominantly involved co-ordinating activities and managing a small number of staff, rather being hands on with the people her employer ultimately served, she enjoyed the job and got on well with the people she worked with and managed.

However, Anna began to increasingly sense she was being bullied by her line manager. Moreover, Anna strongly believed the bullying to be racially motivated. At the same time Anna began to get heart pains, not sleeping well, not eating as much as she used to do, constantly crying, not wanting to do things with family and friends, having morbid thoughts, and just did not want to go to work. She tried to resolve the matter through filing a grievance against her manager but her deteriorating emotional and mental health and a reluctant human resources department led to several periods of absence, although the problem was still there every time she returned to work.

Anna reports how she found the human resources department to be a "brick wall" between herself and her quest for some level of justice. Anna knew her employer had the policies in place to deal with such matters, yet sensed her case was like "opening a can of worms" and human resources just "didn't want to go there".

After a further period of absence Anna gave notice of her intention to leave, yet received no specific correspondence from her employer on her decision, nor was she invited to an exit interview that she herself routinely carried out as a manager. Following a brief period of unemployment Anna found a job that both suited her and allowed her a chance to champion the causes of people who have been badly treated at work.

Her current job is not as well paid and more precarious than her previous job, but Anna is now on the road to recovery.

As with the survey data, the interviews revealed how crucial line manager support was in facilitating a successful return to work. The following quotes are indicative of two contrasting experiences:

‘Yeah I feel [my line manager] was fine. I mean she asked me if I was ready to come back and I said “yeah” and she was like “are you sure, it’s maybe a bit quick for you?” and she was no wanting me to relapse and be off again, but no I says to her “I don’t know how other people would be but in my way I need to get out of here”’

‘No support from managers at all. Had indicated that I was unable to do all that was being asked of me at work but there was just continued pressure to carry out more and more tasks. Treated poorly on return to work. I was put in a room on my own on my return to work. I was not told what job I would return to although that had been a stipulation of my GP that I needed to be aware of what I was going to be doing on my return to work’

Again as with the survey data, there was some indication in the interviews that line managers were in a very compromised position. They were not only bound by organisational rules but they were also measured by their unit’s performance and the line manager sometimes took a difficult approach towards the individual with the mental health problem as they were concerned that this person would impact upon the group’s performance. Such a scenario is described by Lisa, a public sector worker who was suffering from stress and depression.

‘To be quite truthful... nobody would listen to me ... and as far as I was concerned I was really let down by my work. I was definitely let down by the people I was working with, someone should have listened to me, but my boss, he was just too, he done what... he played the game. He was too scared to say anything to anybody but the one above him just wanted everything to look as if it was running smoothly and it wasn’t and he didn’t want to know what I had to say’

Many of the participants were very self-conscious about their illness for example, Catherine a hairdresser who suffered from depression noted ‘If you tell someone you’ve a mental illness they are uncomfortable and you end up feeling sorry for them ... it’s definitely something to be ashamed of’. This feeling was often exacerbated by managers who were uncomfortable with discussing

mental health problems and stigmatised colleagues who were open about their condition. Such a scenario is described by Gina, a domestic assistant suffering from depression.

‘I hadn’t been off with it or anything, I think I was in a meeting with her (line manager) and I just brought something up and she had asked me if I was feeling a wee bit low and I said ‘I can do sometimes’ but I made out that I didn’t want it to affect my work or anything like this and she said that there was sort of counselling thing you could go to, but then I’ve never even brought up that I was feeling horrible like this or anything and she’s never asked... you’re quite scared to take time up because there’s a girl that works during the week that’s had sickness and seemingly her sickness wasn’t too bad and she got like paid off, sacked for it. I got pulled up (for being absent) a couple of months ago and I was told that ...it’s like a scare tactic ... so it’s ‘your job’s in jeopardy’ that sort of thing

As can clearly be seen from many of the stories that we have reported, there were some very uncomfortable scenarios where an employee did not receive the full support of their line manager. Yet, from some of the situations where participants felt unsupported by their direct manager, there were often colleagues and other managers who were able to provide support and guidance for individuals. One very traumatic story we encountered was a security guard who had experienced a number of significant traumas in his life (including drug addiction) and whilst he was at work he witnesses a suicide from a man living above the shop in which he was working. Keith, was not employed by the shop but had good relationships with the staff he worked with. His own line manager allowed him two days off work and insisted he returned on day three. Over time he was diagnosed as suffering from depression and post traumatic disorder. Through this, he received an amazing amount of support from his colleagues in the store as this quote shows.

‘it was like even the area manager XXXXX from XXXXX, he took me basically under his wing, he’d say ‘you’re part of my staff’, do you know what I mean, and it was like ‘if you need anything just phone the shop and tell them you’re going to be late, we’ll organise to get you booked on so you don’t lose anything’ and it was like ‘why can’t my boss be like you?’ so down to earth.’

As with the survey responses there were still a number of positive accounts of direct line manager behaviour. As Colin a lorry driver who suffers from depression describes,

‘Well the employer I’m under just now, I actually know him, I know him pretty well, my boss, he understand that I suffer from depression and that and he kind of allows it, well

not allows it but he just tells me to give him a phone when I'm feeling between and then I go back to work'³

This section will end with a detailed account of an occasion where line management were supportive and behaved in a professional and caring manner.

Paula works as a bank associate and has been in her current job for approximately 10 years. The work involves having a "good head for figures", working with a small team and is "very hands on", with "lots of deadlines to meet".

However, seven years ago Paula's life changed dramatically with the loss of her baby in the advanced stages of pregnancy and shortly after her father died from a relatively brief illness.

During time off to recover from the first bereavement Paula was diagnosed with depression by her GP and prescribed anti-depressants. Paula felt uncomfortable with the idea of taking anti-depressants and instead began to plan a return to work after approximately two months of absence.

The return to work process began informally with such discussions between Paula's managers and Paula being held in a city centre cafe. Over the coming months Paula's employer organised regular visits for her to the company nurse, in company time, and also arranged for private bereavement counselling close to where she lived.

Paula also points out how kind and thoughtful comments and gestures by colleagues played a part in the recovery process too.

Since her return to work Paula has had no period of absence due to depression and reports high levels of job satisfaction and an employer more than satisfied with her efforts and commitment. Paula says she is now over the worst and making good progress.

³ It should be noted that Colin was still not paid for the days he has had to take of work due to depression.

Discussion and Conclusions: The good, the bad and the compromised

Work brings with it both pressures on mental health and positive opportunities (Pilgrim et al. 2008). Whilst Sayce (2000) argues that unemployment is damaging to individuals with already impaired mental health, poorly paid and insecure employment is equally damaging (Rogers and Pilgrim, 2003). Yet, we also found that employees, in reasonably 'good' jobs and were suffering from mental ill health could be also impaired by poor and unsupportive management. Although we encountered many positive accounts of line management behaviour, the dominant narrative from both survey and interview participants was of poor handling of employees with mental health problems by their direct managers. Our data confirmed Tse's (2003) position that mental health problems are indiscriminate in affecting individuals regardless of age, gender, income and social class and that problems with line management's appropriate handling of employees occurred irrespective of the type of work in which an individual was engaged.

For many of our participants, the difficulties with line management occurred at the point of disclosure. Often the experience of disclosure was a negative one, either because of the reaction they had received or because they had not actively chosen to disclose their condition. Negative reactions included hostility and inertia, often on the part of an individual's line manager who frequently did not know what to say or how to react so they either said nothing or acted, in the eyes of the individual with the condition, inappropriately. This sort of situation can quickly descend into a vicious circle as the employee with the mental health condition feels it is easier not to tell people. Our findings showed that a sizeable proportion of people had not disclosed their condition, nor felt they should do so. We know from research in other areas (e.g. sex orientation) that keeping such 'secrets' at work, far from being easier, places a considerable burden on the employee, often with a concomitant effect on their work performance (Guasp and Balfour, 2008).

For those that did disclose, there was a perception of stigmatisation both by the employee themselves and by the line manager (Baldwin and Marcus, 2006). Historically, those with mental health problems have always been a stigmatised group located somewhere between the deserving and the underserving poor and viewed as emotionally deviant as well as being feared and distrusted (Rogers and Pilgrim, 2003). Whilst such an extreme position was not explicitly found in our data the anxiety of disclosure was partly embedded in the potential and real reactions that participants experienced in the workplace.

In the most positive cases, line managers played a vital role in supporting employees with mental health problems, both in terms of emotional support, but also delivering practical help, e.g.

facilitating flexible working or adjusting workloads. It is clear that this dual roles that line managers play, and providing training and support for them, is crucial. As Shift (2009) established, a supportive and responsive line manager can play a role beyond just supporting the employee in question but can also assist in unpicking the stigma and discrimination that surrounds mental health issues. Moreover, in cases of effective line management employees appear to also have fewer problems with sickness absence issues.

So, why is it so difficult for line managers to provide such support universally and what scope do line managers require to effectively manage employees with mental illness? Many line managers have reached their positions because of technical ability – they are not automatically good people managers and are certainly not automatically mental health experts. As previous research and our own work has established, many line managers were insufficiently trained in appropriate management of employees with mental health problems (e.g. Cunningham et al., 2004) and participants were aware of this fact.

Line managers are in a challenging position. On the one hand they are often responsible for devolved HRM responsibilities, yet frequently have little control over HRM issues and have limited information or training as to how to handle ‘people management’ matters. Moreover, echoing the work of Sainsbury et al. (2008), we found that one of the priorities of line managers is employee productivity and taking responsibility for the effectiveness of their cost centres. This, in many scenarios, contradicts their other role which involves supporting and nurturing employees. If line managers identify HRM responsibilities as operating against activities that they believe enhance or maintain productivity (such as perceiving that those with mental health problems may have high levels of absenteeism) they may not perform their HRM duties appropriately. Moreover, as we noted previously, line managers may have neither the training to recognise how to manage people with mental health problems nor the scope to operationalize this.

In the cases that described above where employees were treated with sensitivity as well as being given the necessary flexibility to arrange work around their health requirements we can only assume that as well as possessing appropriate interpersonal skills, the line manager had sufficient devolved responsibility for facilitating flexible working or adjusting workloads. It should also be noted that not all people with mental health problems need adjustments at work and can manage with almost no, or minimal intervention.

Overall, there are a number of factors that could, or rather should, improve the ability of line managers to look after employees with mental health problems. Importantly, managers need

awareness training about mental health problems as well as training in how to appropriately support employees with ill health. Line managers need to be given scope to adjust workload or the location of work for employees without any penalty to the performance of their unit to avoid the tension between performance targets and good management.

Line managers and colleagues can provide valuable practical and emotional support to people with mental health problems and general levels of awareness and knowledge about mental health issues would help them to provide this support. A clear finding from the current study was that active involvement and dialogue between employees who have mental health problems and their line manager and other relevant staff yields the most positive and mutually beneficial results. As well as promoting control for those experiencing the problem, this also serves to take some of the burden away from the line managers.

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