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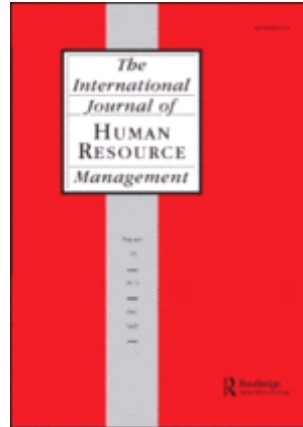
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### **Organizational Accommodation of Employee Mental Health Conditions and Unintended Stigma**

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# Organizational Accommodation of Employee Mental Health Conditions and Unintended Stigma

## ABSTRACT

Despite the growth in the severity and incidence of mental health conditions (MHCs) in wider society and within workplaces, relatively little research has focused on how organizations accommodate employees' MHCs, and how different approaches to accommodating MHCs contribute to their stigmatization. Drawing on in-depth interviews with HR managers from a variety of organizational contexts in Australia, our findings show that approaches to accommodating MHCs vary systematically across organizations, and that common approaches to accommodating employees with MHCs unintentionally stigmatize both employees with MHCs, and MHCs more generally. We identify two new forms of structural stigma, which we respectively label business-based structural stigma and care-based structural stigma, that stem from transactional and paternalist approaches to accommodating employees' MHCs. We explore the implications for de-stigmatizing MHCs in workplaces and for future HRM research that advances understanding of how organizations can better support employees with MHCs.

### Keywords:

Mental Health Conditions, Stigma, Human Resource Management, Workplace Accommodation

# Organizational Accommodation of Employee Mental Health Conditions and Unintended Stigma

## Introduction

Mental health conditions (MHCs) are of growing economic, social and political consequence (Patel et al., 2018) and constitute a grand challenge requiring significant innovation in policy and practice (Collins et al., 2011; Elraz, 2018; St-Hilaire et al., 2019). The current COVID-19 pandemic is intensifying pressure on organizations, managers, and employees, contributing to an increase in MHC prevalence and severity (Giorgi et al., 2020). Addressing MHCs is especially challenging because research demonstrates that MHCs are stigmatized within workplace settings (Beatty, 2018; Follmer & Jones, 2017, 2018). Employees with MHCs are likely to be negatively perceived by managers and colleagues (Elraz, 2018), and stereotyped as unreliable, incapable, crazy, or dangerous (Corrigan et al., 2005). Employees with MHCs are often reluctant to disclose their MHCs because they fear that doing so will undermine their job security, promotion prospects, and co-worker relationships, especially in precarious settings (Elraz, 2018; Lee and Li, 2020; Toth and Dewa, 2014).

In recent years, research on MHCs in organizational settings has grown substantially, both in business and management studies (e.g. Elraz, 2018; Martin et al., 2015; Peltokorpi and Ramaswami, 2019; Shann et al., 2014; St-Hilaire et al., 2019), and in a range of other disciplines including public health, social policy, medicine, psychology and psychiatry, (e.g. Evans-Lacko et al., 2013; Hitch et al., 2013). In parallel to research directly concerned with MHCs, a broader literature has emerged that is concerned with a more diffuse and inclusive notion of employee wellbeing (e.g. Inceoglu et al., 2018; Pagán-Castaño et al., 2020). Research has explored how MHCs impact employee identity and stigma (Elraz, 2018), the difficulties associated with encouraging employees to disclose MHCs (Gonzalez et al., 2019), and the challenging nature of ensuring access to, retention within, and return to work for employees

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2  
3 with MHCs (Durand et al., 2014; Scholz and Ingold, 2020). Other strands of research have  
4 focused on co-worker and managerial attitudes to employees with MHCs returning to work  
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6 (Glozier et al., 2006; Nieuwenhuijsenet al., 2004), the impacts of training on organizational  
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8 responsiveness to employee MHCs (Dimoff, and Kelloway, 2019; Shann et al., 2014), and the  
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10 design of occupational interventions to support employees with MHCs (e.g. Briand et al., 2007;  
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12 Hennekam et al., 2020).

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18 Limited research has directly examined variation in how organizations accommodate  
19 employees with MHCs, the role of HR professionals in MHC accommodation, and how  
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21 variations in accommodation approach shape MHC stigmatization (McDowell and Fossey,  
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23 2015; Rotenberg et al., 2016). One significant challenge regarding MHC accommodation is the  
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25 subjectivity inherent in determining the forms and extent of accommodations that are  
26  
27 considered 'reasonable' (Harlan and Robert, 1998). A gap persists in understanding how  
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29 organizations navigate the specific issues that arise from supporting employees living with  
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31 MHCs, and the role that approaches to accommodating employees with MHCs plays in MHC  
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33 stigmatization (Elraz, 2018; Gonzalez et al., 2019). While human resource managers play a  
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35 critical role in shaping organizational accommodation of employees with MHCs (Cavanagh et  
36  
37 al., 2017), the diversity of needs and experiences among employees with MHCs suggest a need  
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39 for further empirical research that explores how HR managers accommodate employee MHCs  
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41 in practice (Gonzalez et al., 2019; Mellifont, 2019).

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48 In this study, we address the need for empirical research that explores how  
49 organizations accommodate employee's MHCs, and what role differences in MHC  
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51 accommodation plays in MHC stigmatization. Because HR managers often play an important  
52  
53 role in determining and implementing how MHCs are responded to in organizations (Beatty et  
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55 al., 2019), we examine the perspectives and experiences of HR managers in relation to the  
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57 accommodation and support of employees with MHCs. Employment law in many countries  
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3 has for some time placed significant obligations on employers in relation to providing safe  
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5 working conditions (including avoiding psychological injury), non-discrimination against  
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7 employees with MHCs, and supporting employees with MHCs (Australian Human Rights  
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9 Commission, 2010). In Australia, legislation requires employers to consult with employees  
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11 who have disclosed an MHC about whether they require workplace accommodations (Safe  
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13 Work Australia, 2019, p. 31). For this paper, we draw on 39 in-depth interviews with Australian  
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15 HR managers who support the retention, recovery, and reintegration of employees with MHCs  
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17 in a range of organizational and industry settings. Our evidence enables us to explore how  
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19 organizations vary in relation to the nature of their accommodation climate in respect of MHCs,  
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21 and how these differences in accommodation affect MHC stigmatization. Specifically, we ask:  
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23 how do organizations vary in relation to their accommodation of MHCs, and how do different  
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25 approaches to accommodating employee MHCs influence MHC stigmatization?  
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32 We make two contributions. First, we provide novel empirical evidence regarding how  
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34 organizations accommodate MHCs, and of the role of HR managers in shaping the organization  
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36 MHC accommodation climate. We extend prior research that suggests that organizations are  
37  
38 largely unprepared to manage and respond to employees with MHCs (Shann et al., 2014), and  
39  
40 that managers lack the conceptual and procedural knowledge necessary for aiding vulnerable  
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42 employees (Martin et al., 2015). We characterize four distinct approaches to accommodating  
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44 MHCs in organizations, identifying the key dimensions along which they differ, and describing  
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46 their relative prevalence within our data. Second, we deepen understanding of the processes of  
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48 stigmatization of MHCs as they arise in workplace settings. We identify how MHC  
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50 accommodation occurs in organizations and show that organizations' approach to MHC  
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52 accommodation shape the extent and nature of MHC stigmatization in workplaces. We find  
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54 that the two most common approaches to accommodating MHCs in organizations generate two  
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56 sub-types of structural stigma which we label business-based and care-based stigma. From  
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3 these contributions we propose HRM interventions aimed at reducing structural stigma and  
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5 improving opportunities for employees with MHCs.  
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### 8 **MHCs, stigmatization, workplace disclosure and accommodation**

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11 Prior research has struggled to define MHCs (Evans-Lacko et al., 2013). Establishing a  
12  
13 clear definition and empirical boundary conditions for research on MHCs is critical in the  
14  
15 context of HRM research because discrete mental illnesses have specific implications for  
16  
17 employees' work capacities. MHCs encompass the experience of individuals with  
18  
19 schizophrenia, bi-polar disorder, post-traumatic stress disorder (PTSD), obsessive compulsive  
20  
21 disorder, depression, and anxiety, among other diagnoses and labels. Past research has focused  
22  
23 on HRM managers' experiences of supporting employees with possibly transient and common  
24  
25 conditions (Irvine, 2011) such as depression and anxiety (Fryers et al., 2005), and diagnosable  
26  
27 long-term conditions such as Post-Traumatic Stress Disorder (PTSD) (Booth et al., 2014).  
28  
29 Employee MHCs, therefore can encompass both widely experienced, episodic, and transient  
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31 conditions and longer term and chronic MHCs where employees may, or may not, identify as  
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33 being disabled. This reflects developments in mental health diagnosis, classification, and  
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35 treatment, which have tended to lower the threshold of what is considered a diagnosable MHC  
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37 (Rosenberg, 2013).  
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### 44 ***Stigmatization of MHCs in the workplace***

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46  
47 MHCs tend to provoke more adverse reactions, than physical illnesses and injuries  
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49 (Colella & Stone, 2005). Employees' with MHCs frequently experience stigmatization within  
50  
51 workplace settings (Beatty, 2018; Follmer & Jones, 2017, 2018) and are therefore more likely  
52  
53 to experience discrimination, victimization, bullying or harassment than other employees  
54  
55 (Follmer & Jones, 2018; Foster, 2007). Stigmatization is a "process by which individuals are  
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57 devalued and alienated from specific types of social interactions, because they are perceived to  
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3 possess a negatively valenced characteristic” (Summers et al., 2016, 853). Jones et al. (1984)  
4  
5 developed a framework of six elements that shape the likelihood that stigmatization occurs:  
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7 concealability, course, disruptiveness, peril, origin, and aesthetic qualities, the first four of  
8  
9 which are most significant in relation to MHCs in workplace settings. The “invisibility” of  
10  
11 many MHCs means they are not directly observable or recognizable, may not equally affect all  
12  
13 aspects of an individual’s work, and generate issues regarding employee decisions to disclose  
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15 (Clair et al., 2005; Jammaers & Zanoni, 2020). Concealability therefore reflects that some  
16  
17 potentially stigmatizing attributes (e.g., race, gender, some disabilities) are relatively visible  
18  
19 while others, including perhaps many MHCs, are less visible and are potentially concealed.  
20  
21 Course connotes the temporal variability in the severity of a potentially stigmatizing attribute  
22  
23 over time. Some attributes diminish or intensify relatively predictably over time, while others,  
24  
25 including many MHCs, vary significantly in their day-to-day effects and severity. The variety,  
26  
27 relative unobservability, and uncertain temporality of MHCs introduce complexity to processes  
28  
29 of determining appropriate organizational accommodations (Gonzalez et al., 2019; Harlan &  
30  
31 Robert, 1998). Disruptiveness relates to how significantly a potentially stigmatizing attribute  
32  
33 affects day-to-day social interactions, including physical and cognitive work activities. MHCs  
34  
35 are especially associated with disruptive stereotypes of incompetence, which may lead to label-  
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37 avoidance through non-disclosure. Peril relates to the extent to which a potentially stigmatizing  
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39 attribute is perceived to be dangerous to others and reflects one of the most enduring  
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41 stereotypes associated with MHCs.  
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50 Research has shown that stigmas can take numerous specific forms, each associated  
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52 with a distinct underlying process (Sheehan et al., 2017; Summers et al., 2016) and can have  
53  
54 several individual and organizational consequences (Beatty, 2018; Follmer & Jones, 2018;  
55  
56 Stone & Colella, 1996). Sheehan et al. (2017) build upon Pryor and Reeder’s (2011) typology  
57  
58 of stigma to suggest how MHC stigma is rooted in three social stereotypes: dangerousness,  
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3 incompetence, and permanence. Such stereotypes can lead to employees being excluded from  
4 opportunities, and cause employees to be attributed with specific adverse characteristics (Jones  
5 et al., 1984). Perceptions that people with MHCs are dangerous promote public stigmas in  
6 which society discriminates against individuals with MHCs by withholding opportunities or  
7 access to services (Pryor and Reeder, 2011). Stereotypes of  
8 incompetence about MHCs also lead to either self-stigmas in which the affected internalise  
9 public perceptions and withdraw from society, or to label-avoidance in which people  
10 experiencing MHCs choose not to disclose their illness to friends, family-members or  
11 employers (Sheehan et al., 2017). Stereotypes of permanence contribute to structural  
12 stigma through the unintentional restriction of opportunities predicated upon perceptions of  
13 enduring incapacity and fragility. Structural stigma which can be defined as “public and private  
14 sector policies that unintentionally restrict the opportunities of the minority group” (Sheehan  
15 et al., 2017, p. 51). Finally, stigma by association can lead to employees with MHCs being  
16 avoided in the workplace, because of the ways in which “companions of stigmatized persons  
17 are discredited” (Pror et al., 2012, p. 224).

18  
19 As Summers et al., note, “imputed characteristics associated with a stigmatizing  
20 attribute may deny a qualified applicant a job or a deserving employee a promotion” (Summers  
21 et al., 854). Consistent with theories of stigma, employee MHCs are associated with low  
22 workplace performance and pejorative attributions, oppression, social rejection, isolation,  
23 discrimination, unemployment, and low income (Tsang et al., 2007).

### 24 ***Disclosure and Accommodation of MHCs in the workplace***

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26 Supporting employees with MHCs presents organizations with two distinct challenges:  
27 encouraging disclosure and making accommodations. Because disclosure requires awareness  
28 on behalf of the discloser, the high, and growing, rate of undiagnosed MHCs in wider society  
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3 is especially problematic for organizational responses (Martin et al., 2015). Because  
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5 stigmatizing processes require that individual differences be made visible, those with invisible  
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7 differences tend to try and “pass” for “someone without a discredited or devalued social  
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9 identity” (Clair et al., 2005, 82) to avoid stereotypes, prejudice and an undermining of their  
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11 career prospects (Follmer et al., 2020; Martin et al., 2015; Martin, 2010). Limited self-  
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13 disclosure has other harmful impacts on employees, including limited access to treatment and  
14  
15 workplace accommodations, self-stigma, and anxiety about under-performance (Follmer et al.,  
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17 2020; Gelb & Corrigan, 2008). Consequently, some individuals with MHCs are trapped in a  
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19 cycle of unemployment and low-status jobs.  
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25       Discrimination legislation in many countries requires that employers provide  
26  
27 reasonable workplace accommodations to enable sick or disabled persons to fulfill the  
28  
29 requirements of their job (Foster, 2007). Examples of accommodations include changes to  
30  
31 scheduling, job tasks, social support, or other workplace conditions (e.g. special equipment).  
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33 While accommodation seeking is an expected response to having an MHC, research has found  
34  
35 achieving reasonable accommodations to be complicated in practice because many employees  
36  
37 are either unaware of their right to seek accommodations or reluctant to do so (Baldrige &  
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39 Veiga, 2001; Schur et al., 2014). Evidence suggests that employer reluctance to recognize an  
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41 employee’s MHC as being something requiring accommodation presents a barrier to  
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43 employees’ seeking accommodations (Harlan & Robert, 1998), an issue that is especially  
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45 severe among those with invisible conditions.  
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51       Additionally, job demands and their evolving nature play an important role in shaping  
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53 perceptions of the viability of making accommodations (Harlan & Robert, 1998) and  
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55 employees experience varying interpretations among employers of the need to make  
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57 adjustments to the work environment versus adjustments to the work itself (Foster, 2007; Schur  
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59 et al., 2014). It is noteworthy that challenges encountered in relation to accommodation often  
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3 relate to the reliance on line-managers for their implementation (Martin et al., 2015). As Harlan  
4 and Robert (1998) note, “because supervisors often have a central role in [the process of  
5 agreeing to accommodations], the variability in their actions is particularly important” (Harlan  
6 & Robert, 1998, 419).  
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13 Finally, employment that is precarious and involves low autonomy can adversely affect  
14 the wellbeing of employees with MHCs (Kirk-Brown & Van Dijk, 2016; Wang et al., 2019),  
15 particularly when their work includes low job control and high job strain (Peltokorpi &  
16 Ramaswami, 2019). While limited empirical evidence exists about the mechanisms by which  
17 precarious work effects employee mental health (Rönblad et al., 2019), research by Lewchuk  
18 et al. (2008) suggests that experiences commonly associated with precarious employment - job  
19 insecurity, active job searching, and low levels of employment relationship support - are  
20 associated with poorer health outcomes. The combination of temporary employment,  
21 unpredictable work hours, and a lack of employer support (Rönblad et al., 2019) may therefore  
22 exacerbate the challenges already experienced by employees with MHCs, by reinforcing  
23 negative feelings about self-esteem and self-efficacy, by reducing (or denying) access to the  
24 accommodations that are available to employees in permanent employment, and by reinforcing  
25 patterns of structural stigma (Sheehan et al., 2017).  
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43 Having reviewed the extant literature, we now describe the methodological approach  
44 that we use to examine how organizations vary in relation to their accommodation of MHCs,  
45 and how different approaches to accommodating employee MHCs influence MHC  
46 stigmatization.  
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## 52 53 **Methods**

### 54 *Design and data collection*

55 Findings are based on in-depth phone interviews conducted between 31st Jan and 13th  
56 March 2020 with 39 Australian Human Resource Managers. Notably, our data collection  
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3 occurred before the COVID-19 pandemic had led to any material economic, policy, or social  
4 impact in Australia. As little is known about how organizations accommodate employees with  
5 MHCs, qualitative research “can provide insights that are difficult to produce with quantitative  
6 research” (Gephart, 2004: 455). Participant recruitment was performed via the Australian  
7 Human Resources Institute (AHRI), the national association representing human resource and  
8 people management professionals. All interviewees had managed, or assisted line managers,  
9 in responding to employees living with diagnosed MHCs and most interviewees identified as  
10 female (N=27). Fully informed consent was obtained by all the interviewees prior to the  
11 interviews.  
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24 Most interviewees worked in large (N=24) or medium (N=9) businesses, with only 6  
25 working in small organizations. Approximately 21 per cent of our interviewees worked in  
26 government departments and another 21 per cent worked in professional services. Other sectors  
27 represented in the sample are Not-For-Profit (13%), Healthcare (8%), Education (5%),  
28 Transportation (5%), Entertainment (5%), Research (5%), as well as Manufacturing, Fast-  
29 Moving Consumer Goods, Construction, Aged Care, Legal and Natural Resources (approx. 2%  
30 each). Interviewees had a wealth of experience in HR with approximately twenty-eight per cent  
31 having over 25 years’ experience in an HR role, approximately thirty-one per cent over 20  
32 years’ experience, eighteen per cent between 15 and 20 years of experience and just over  
33 twenty-three per cent between 10- and 15-years’ experience in an HR role. Given the sensitive  
34 nature of the data, we code interviewees as P1 through to P39.  
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Notably, we take an inclusive approach to examining organizational responses to MHCs, by including HR experiences of responding to both common, episodic, and transient conditions as well as longer term and chronic MHCs where employees may, or may not, identify as being disabled. Additionally, we explore MHCs as they present in organizational contexts, irrespective of whether these have been formally medically diagnosed or treated. This

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3 approach is chosen because it recognizes the limitation of researching HR responses to  
4 disclosed employee MHCs, while also maximizing the conceptual and empirical variation in  
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6 our study and increases our capacity to identify new phenomena and novel insights.  
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8 Additionally, this approach reflects developments in mental health diagnosis, classification,  
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10 and treatment, which have tended to lower the threshold of what is considered a diagnosable  
11  
12 mental health condition (Rosenberg, 2013).  
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17 The interviews, which were audio-recorded and transcribed verbatim, were semi-  
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19 structured and lasted approximately 60 minutes. The interview schedule was designed to elicit  
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21 examples of how HR managers had dealt with, or advised on, employee return to or recovery  
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23 at work or accommodation after a mental health disruption over the course of their careers. The  
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25 schedule included questions directly about managing employee MHCs and allowed scope for  
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27 the interviewees to raise issues salient to their own practice.  
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### 31 *Data Analysis*

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33 Interview data was subjected to an inductive thematic coding procedure using NVivo  
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35 12 following Gioia, Corley and Hamilton (2012). Drawing on Saldaña (2016, p. 4), we  
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37 understand a code as “a word or short phrase that symbolically assigns a summative, salient,  
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39 essence-capturing and/or evocative attribute for a portion of language-based or visual data”.  
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41 As qualitative researchers, when we code, we look for patterns in the data and understand  
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43 coding to be an interpretive, cyclical act that allows us to consolidate meaning and develop  
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45 explanation (Grbich, 2013). Coding began with immersion in the interview transcripts and  
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47 familiarization with their range and diversity. Transcripts were coded in-vivo to generate first  
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49 order categories based upon phrases used by participants, such as “you have a responsibility to  
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51 be a decent human”, “you still have a duty of care”, “impact on business” or “I don’t have time  
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53 to accommodate”. In-vivo coding was adopted as a first cycle coding method because it  
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55 captures “behaviors or processes which will explain to the analyst how the basic problem of  
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3 the actors is resolved or processed” (Strauss, 1987, p. 33) and helps preserve participants’  
4 voice. These first order concepts, which adhered “faithfully to informants’ terms” (Gioia et al.,  
5 2012, p. 20) offered general insights into the factors affecting the accommodation of MHCs.  
6  
7  
8 Second, using principles of axial coding (Strauss and Corbin, 1998) we sought to “determine  
9 which codes in the research are the dominant ones and... to reorganize the data set” (Boeije,  
10 2010, p. 109). In this second order theme analysis we identified relationships between and  
11 among first order codes and we considered whether the emerging themes help us explain  
12 different approaches to MHC accommodation. This process enabled us to group first order  
13 concepts into second order themes. In this phase we were still guided by the data, as opposed  
14 to a priori hypotheses. In the third stage, second order themes were gathered in aggregate  
15 dimensions (Gioia et al., 2012), which we labelled either by “capturing the content at a higher  
16 level of abstraction or by referring to existing literature that describes similar notions”  
17 (Andriopoulos & Lewis, 2009, 701).  
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33 We depict this process in Figure One, which identifies four HRM approaches, which  
34 we label inclusive, paternalist, transactional and prejudicial and which determine how MHCs  
35 are accommodated in organizations.  
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42 FIGURE 1 ABOUT HERE.  
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46 Additionally, we use a form of axial coding (Strauss and Corbin, 1988) to identify five themes  
47 that cut across our second-order themes: (1) *perspective on MHCs*; (2) *balance of organisation*  
48 *versus employee interests underpinning accommodation*; (3) *level of employee involvement in*  
49 *determining accommodation*; (4) *mode of organisation-employee communication*; (5) *levels of*  
50 *adjustment/ accommodation made*. To create these five cross-cutting themes, we adopted  
51 principles of constant comparison, comparing empirical themes from one transcript to another  
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3 and our emerging second-order themes. For example, looking at statements about HR  
4 managers' viewpoints towards accommodation led us to categorize the second-order themes of  
5 "tailored employee support," "accommodation," "contingent," and "limited accommodation"  
6 into the cross cutting theme "levels of Adjustment/ Accommodation made." Some of the  
7 second-order themes relate to more than one cross-cutting theme (or axial code). For example,  
8 our findings suggest that "scepticism of MHCs" relates to both "perspectives on MHCs" and  
9 "levels of adjustment / accommodations made." We believe that this form of data presentation  
10 best reflects the accounts of our participants and our inductive findings.  
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## 25 Findings

### 26 *Organizational Approaches to MHC Accommodation*

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28 Our analysis identifies four distinct approaches to accommodating MHCs in  
29 organizations that differ qualitatively from each other on several dimensions that we describe  
30 more fully in table 1, below. Each of these four approaches is distinguished from the others by  
31 its distinctive combination of attributes on five dimensions: (i) the organization's perspective  
32 on MHCs, (ii) the balance of organization versus employee interests underpinning  
33 accommodation, (iii) the level of employee involvement in determining accommodations, (iv)  
34 the mode of organization-employee communication, and (v) the levels of  
35 adjustment/accommodation made. Broadly, we see these approaches as points on a continuum  
36 of supportiveness in relation to employees' MHCs. We perceive that organizations generally  
37 exhibit a central tendency in their approach to accommodating employee MHCs that reflects  
38 its policy, activities, disclosure, and accommodation climate, albeit with some individual  
39 variation. To a substantial extent, HR managers are the central actor in determining the  
40 "approach" a given organization takes to MHC accommodation. Notably, an organization's  
41 approach to MHC accommodation is a relatively stable organizational attribute, rather than  
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3 varying on a case-by-case basis. While HR managers drew on examples and insights from  
4 across their careers, and thus their evidence generally related to a number of organizational  
5 settings, the central tendency in our data suggest that by far the most common approaches to  
6 MHC accommodation are transactional and paternalist approaches, with inclusive and  
7 prejudicial approaches being very much less common in our data. Drawing from our findings  
8 we propose that an organization's approach to accommodating MHCs shapes the nature and  
9 severity of MHC stigmas that arise in workplaces.

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21 TABLE 1 ABOUT HERE.  
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#### 24 Transactional HRM Approaches

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26 *A Transactional HRM approach is “based on employers’ expectations for short-term*  
27 *economic exchange, involving a narrow range of work-related mutual obligations” (Zhu,*  
28 *Zhang & Shen, 2012). In the context of MHCs, we find transactional HRM approaches are*  
29 *characterized by limited disclosure on a “need to know” basis: the HR managers we*  
30 *interviewed who adopted this approach prioritized business interests and were therefore*  
31 *concerned with the impact the employee’s MHC would have on their team, their supervisor or*  
32 *the business as a whole.*

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43 *I've equally seen where the business has said, look, we've got this ongoing issue with this*  
44 *individual around mental health, and I just can't have this person in my team any longer,*  
45 *because it's causing too much pressure on the rest of the team. Their absence, erratic*  
46 *behaviour is just too much, and we're going to risk losing other members of the team. In*  
47 *that particular situation it got very complex very quickly - the individual had come back*  
48 *on a return-to-work plan, but reduced hours and reduced days, and was still behaving*  
49 *quite erratically. The expert advice that we were getting from the medical specialists was*  
50 *this individual should continue on this return-to-work plan. The tension between the line*  
51 *manager and the team and this particular individual became so great that that individual*  
52 *ended up going on long-term absence and didn't follow that return-to-work plan, so we*  
53 *ended up agreeing an exit. (P2)*

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57 As such, accommodations under a transactional HRM take a more pragmatic approach,  
58 placing emphasis on policy, business requirements, and compliance with legislation.  
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3 Communication between the employer and the employee focuses on defining boundaries to  
4 obligations to support employees as well as setting expectations in terms of what  
5 accommodations can be provided from the business and the employee's performance.  
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10 *some line managers think about the impact that has on the overall team's ability*  
11 *to deliver, they worry about precedents, they worry about productivity, they worry*  
12 *about cost (P26)*  
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14  
15 *...for me it's about having a conversation with the individual and seeing what they*  
16 *want to try and achieve, then it's about setting the expectations on both parties of*  
17 *what does performance and success look like (P25)*  
18

19 Crucially, we found that in transactional HRM approaches, accommodation is contingent  
20 on the perceived value and contribution of the employee to the organisation:  
21

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23  
24 *If take myself back to say the early 2000s ... I would absolutely say that my bias and my*  
25 *inexperience meant that for more valuable employees, I took the time to work out how*  
26 *the hell I was going to make it happen and I'd jump through hoops because they were*  
27 *good employees and worth having back, and I can picture another example actually at*  
28 *the time, she was a pain, you know, she was never consistently on time for work, phones*  
29 *weren't answered, mail wasn't delivered, things like that, it was just so frustrating and*  
30 *so when she had an absence and wanted to return to work, we were like, no, this is all*  
31 *we are going to offer you. (P21)*  
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37 In transactional approaches to MHC accommodation, stigmatization stems from  
38 concerns about the impact an employee's MHC might have on the business. Because  
39 transactional HRM approaches are concerned with maintaining business operability, they draw  
40 attention to the potentially reduced performance of employees with MHCs thus reinforcing  
41 MHC stigmatization:  
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49 *getting them to understand the impact that they're having and the way that they need to*  
50 *try and change their approach to fit in better or to work better with people is also*  
51 *challenging (P31)*  
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53

#### 54 Paternalist HRM Approaches

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56  
57 *Paternalist HRM* approaches have long been identified in relation to the support and  
58 management of stigmatized groups (see Colella & Stone, 2005), and typically entail  
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3 sympathetic but infantilizing, pitying, and disempowering processes towards MHC visibility  
4 and disclosure often attributed to a duty of care to: “*help your people look after themselves*”  
5  
6 (P3). We find that like inclusive approaches, the paternalist approach favors a care-based  
7  
8 approach in which challenges for employees in carrying out their role are responded to, albeit  
9  
10 in ways that leave relatively little room for employee agency. This is frequently illustrated  
11  
12 through examples of HR managers deferring trust to the individual’s treating psychologist or  
13  
14 psychiatrist when deciding the reasonable accommodations to be provided, sometimes  
15  
16 bypassing the individual’s assessment of their own mental health:  
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22 *...person [with an MHC] wanted to return more days a week than what she was*  
23 *being provided clearance for, so we were very strict with only allowing her to work*  
24 *to the degree that her medical professionals had signed off on. We reduced her*  
25 *scope of work significantly (P3).*  
26  
27

28  
29 In trying to establish a duty of care, the following example illustrates how the HR  
30  
31 manager felt she was in a better position than the employee to determine whether  
32  
33 accommodations could be provided and what they should be:  
34  
35

36 *I was called down because their supervisor was with them in an office and she was*  
37 *upset... So I started having a conversation and over a number of weeks I got her to*  
38 *trust me ... and she had pre-existing psychological ill health and the workplace was*  
39 *damaging her, and so I actually said to her here’s my business card, I want you to*  
40 *give that to your psychologist when you see them this week because I want them to*  
41 *call me to have a conversation about how we help you. In that case I took a massive*  
42 *risk that I didn’t mention to the CEO at the time, the psychologist rang me and*  
43 *ranted at me about how he’s not telling me anything, I went good, be quiet then*  
44 *because I need to tell you some stuff, and I told them about the workplace and about*  
45 *the work that she was about to have to be trained to do in that workplace and he*  
46 *interjected and said, “oh my god, she can’t work there, that will kill her” and I went*  
47 *“well thank you very much, that’s my point, how do we get her out of here?” And I*  
48 *came to an agreement with her and with him that I would terminate her because*  
49 *she needed unemployment benefits and if she resigned she wouldn’t get it and she*  
50 *didn’t have the time or the headspace to look for another job (P20).*  
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56 The quotes above illustrate that even if it appears that an employer is looking after their  
57  
58 staff living with MHCs, paternalist approaches can be distinctly double-edged for employees,  
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60 because in some cases individuals can be denied agency through approaches that assume

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3 knowledge regarding their wants and needs. The same quotes also illustrate the shortcomings  
4  
5 of the legislative framework that underpins accommodation of MHCs in Australia, which  
6  
7 assumes the treating practitioner to be the voice of the employee. Nevertheless, the same  
8  
9 legislative framework demands that accommodations are made. In the case of the paternalist  
10  
11 HRM approach, the accommodations made could be quite directive involving a combination  
12  
13 of well-meaning micromanagement and unintentional infantilization of the employee  
14  
15 experiencing the MHC:  
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18  
19 *This person that came back from... let's say mental illness was somebody I was*  
20 *managing. So, this person used to get very tired and they also used to forget things. So,*  
21 *we just talked about strategies – about how we would manage it so, about keeping lists,*  
22 *about updating me when they'd done things, and about making sure that they did reduced*  
23 *hours for the period and didn't feel tempted to work at home in the evening. (P1)*  
24  
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26  
27 In paternalist HRM approaches, the tendency to stigmatize stems from kind but pitying  
28  
29 orientations towards MHC visibility and disclosure. Accommodation of MHCs in paternalistic  
30  
31 approaches involves active demonstration that the organization is discharging its duty of care  
32  
33 towards employees, which although well-intended, is often somewhat at the expense of deep  
34  
35 engagement with, or understanding of, employees' MHCs and their particular needs. While  
36  
37 paternalistic approaches are superficially accepting and accommodating, they preserve an  
38  
39 active “othering” of employees with MHCs within the workplace that is ultimately, if  
40  
41 unintendedly, diminishing:  
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44  
45 *Look, I'd say there's certainly a stigma around mental illness and I don't think that comes*  
46 *as a surprise to you when I make that comment. [Interviewer: No]. Again it's because*  
47 *it's the unknown and it's been something that's been so unspoken of for such a long time,*  
48 *people are still tiptoeing very carefully around someone whose might be struggling with*  
49 *mental illness and I think it really comes from the inability of the how do I help this*  
50 *person or how do I speak to this person? (P23)*  
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### 54 55 Inclusive HRM Approaches

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57 *Inclusive HRM* approaches are characterized by empathy towards MHCs leading to  
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59 highly engaged, flexible, respectful, and supportive organizational climates (Borghouts-van de  
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3 Pas & Freese, 2017). Where an inclusive HRM approach pertained, it was associated with a  
4  
5 recognition of a wider organizational purpose:  
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8 *particularly from a HR perspective I don't care what you earn or what your role is I want*  
9 *you to be a healthy individual; healthy individuals are productive no matter what their*  
10 *role is and it's something we should do as a community and as a society. (P28)*  
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13  
14 Beginning with empathy, an inclusive HRM approach is characterized by higher levels  
15  
16 of MHC disclosure and accommodation, with the needs of the employee underpinning the  
17  
18 design of the return-to-work program. In our findings, inclusive HRM approaches are  
19  
20 distinguished by an ongoing dialogue between the employee and the organization that  
21  
22 ultimately leads to tailored accommodation:  
23

24  
25 *We had a person with a personal MHC and through working with them and their*  
26 *psychologist we realized they were quite mathematically minded. There was an emerging*  
27 *business need where we could use their skills, so we took them off their day job and*  
28 *navigated them to project based work. We created a schedule which didn't consume a*  
29 *role but supported the business through projects and we created meaningful work so they*  
30 *could feel their status being recognized. That program lasted 12 months and slowly we*  
31 *increased their hours and even changed contracts (P18)*  
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34  
35 Inclusive HRM approaches encourage visibility and promote active discussion of MHCs.  
36  
37 In our findings, this was demonstrated through the design and delivery of training sessions  
38  
39 which proactively address mental health issues. The purpose was to allow line managers to  
40  
41 develop “the right language” (P16) and overcome any discomfort they might experience when  
42  
43 discussing MHCs.  
44

45  
46 *(Interviewer: What type of training do you provide?) I think for mental health, there*  
47 *needs to be a level of basic level of understanding, what it is, how broad it is, and how*  
48 *many people it impacts... and what our responsibilities as an employer are. Then ...*  
49 *training them to have more of a coaching approach, where they're asking a lot more*  
50 *questions rather than just talking at people. If they have some core questions that they*  
51 *feel comfortable they could ask, those questions will then enable them to gather the*  
52 *information from the other party without having to have all the information themselves.*  
53 *(P5)*  
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3 We found that inclusive approaches entail organizations de-emphasizing the origins of  
4 employee MHCs in favor of playing an active and engaged role in addressing them. Therefore,  
5 we suggest they lead to comparatively low levels of MHC stigmatization because they involve  
6 employees, support their wellbeing independent of the nature or cause of an employee's MHC:  
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13 *Saying hey, what do you need? Do you need more time off work so maybe a temporary*  
14 *reduction in hours for a little while so, if they can only manage three days a week every*  
15 *second day say, then can we accommodate that? That's the kind of conversations and*  
16 *considerations that we provide to people with mental health returning to the workforce.*  
17 *(P13)*  
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19

20 Furthermore, in seeking to destigmatize MHCs, we find that a key element of inclusive  
21 approaches to MHC accommodation is a de-emphasis, at least temporarily, of the importance  
22 of job performance. In that sense, inclusive approaches to accommodating MHCs entail a  
23 willingness to overlook the disruptiveness of MHCs described in prior research (Beatty,  
24 2018), in favor of emphasizing the importance of employee wellbeing: *"What I've*  
25 *experienced is that [company name] is trying to take a more unbiased approach and sort of*  
26 *park things like performance issues and all of that in the face of adversity"* (P18).  
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### 39 Prejudicial HRM approaches

40 A *Prejudicial HRM* approach is characterized by a "bare minimum" compliance orientation in  
41 which contested duties and ambiguous obligations are exploited to reduce organizational  
42 exposure to perceived adverse impacts of accommodation. Our data suggests that prejudicial  
43 HRM approaches are characterized by the "othering" of employees with MHCs, skepticism  
44 about the veracity of MHCs, rejection of the viability of MHC accommodation, and low levels  
45 of managerial support:  
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54 *[Name] is just not wanting to come back to work. The employer is saying, what the bloody*  
55 *hell is [name] doing, is he just having holidays on the beach? Does anybody want to go*  
56 *over and take photographs of him? (P10).*  
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*... if the person has been difficult to manage in that supervisor's mind, the manager may not be motivated to bring that person back into the workplace, because it's seen as well, it's one less thing that I have to deal with (P30).*

We find that, surprisingly, prejudicial HRM approaches are often relatively unconcerned with performance effects of MHCs, borne of a broad rejection for responsibility for MHCs and the anticipation that any adverse impacts of MHCs on work performance will be addressed by employees themselves. This finding is consistent with prior research that shows that disabled employees typically anticipate possible performance concerns by working harder for longer hours (Colella & Bruyere, 2011):

*the role of the employee is to return to work as quickly as possible and to work with all the providers and the specialists to rehabilitate as quickly as possible and to accept any work that comes their way from the employer to help them return to work. But that takes a particular mindset, particularly when you're damaged psychologically (P10).*

Additionally, it might reflect the fact that prejudicial HRM approaches to MHCs typically result in employees' exit from organizations, thus limiting the performance consequences of MHCs for the organization.

We find that the prejudicial HRM approach is associated with high levels of MHC stigmatization. A prejudicial HRM approach accepts and encourages non-disclosure of MHCs underpinned by a trivialization of MHCs and a disregard for their relevance to the organization. Perhaps the most striking example of how a prejudicial HRM approach can lead to MHC stigmatization can be seen in the example below:

*[In a previous role], an employee was struggling with quite severe mental health issues, anxiety depression, she'd been working there for a number of years; she felt very beaten down, unvalidated, underinvested in. She had this curious habit of when she was overwhelmed in the workplace, instead of putting her hand up and saying, "I need a break" or "I need to step out" or "I need some time off", she would fake a bee sting. She would find somewhere in the office or in the foyer and she would fake a bee sting, and as a result of the bee string, she would say, "I'll go into anaphylactic shock". So, then we had to engage in the exercise of an EpiPen - her being stabbed with an EpiPen and calling an ambulance, writing up an incident report, et cetera. I presume that the reason that she*

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*was doing this was because she felt it was easier to go through the theatre of an event where there's a physical act with a physical response and the response is her being taken from the site that creates anxiety, i.e. the workplace, as opposed to dealing with the more complex question of, well, I've got mental health challenges in this place. (P6).*

## Discussion

Inclusive and prejudicial HRM approaches were relatively uncommon among our participating HR managers experiences. Much more common were transactional and paternalistic approaches to accommodating MHCs. While these approaches are both notable improvements on prejudicial forms of MHC accommodation, it was striking that each entailed its own distinctive stigmatization processes.

Building on our inductive analysis, we propose two new sub-types of stigma that extend theorization of structural MHC stigma (Pryor & Reeder, 2011; Sheehan et al., 2017). Our findings suggest that in addition to the direct interpersonal stigma (see, Jones et al., 1984) and structural stigma (see, Sheehan et al., 2017) created by prejudicial approaches to MHC accommodation, both transactional and paternalistic approaches to accommodating employee MHCs can unintentionally stigmatize employees and MHCs more broadly. From this analysis we refine the typology of stigma (Pryor & Reeder, 2011), extend theorization of workplace mental health stigma (Elraz, 2018), and theorize the process of MHC stigmatization. We extend work on structural stigma which can be defined as “public and private sector policies that unintentionally restrict the opportunities of the minority group” (Sheehan et al., 2017: 51). To do this we propose two new sub-types of structural stigma, which we define as follows:

*Business-based structural stigma occurs when human resource interventions and associated managerial activities are bounded by a dominant business logic that inhibits employees experiencing MHCs from engagement in, and agency about, their job and its demands, leading to processes that stigmatize either the employee and/or mental health at the level of the organization and inadvertently restrict opportunities.*

*Care-based structural stigma occurs when human resource interventions and associated managerial activities are bounded by a dominant care logic that inhibits employees experiencing MHCs from engagement in and agency about, their job and its demands, leading*

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3 *to processes that stigmatize either the employee and/or mental health at the level of the*  
4 *organization and inadvertently restrict opportunities.*  
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9 We propose that these constructs better reflect the types of stigma experienced by  
10 employees living with MHCs than the broader constructs identified in prior research about  
11 structural stigma (e.g. Pryor & Reeder, 2011; Sheehan et al., 2017) and highlight the role of  
12 HRM approaches in shaping the process of MHC stigmatization. We theorize that the  
13 cumulative approaches taken by HR, and other, managers in relation to employee MHCs shape  
14 the type of MHC stigmatization that arises in an organizational setting. Specifically,  
15 transactional approaches are likely to generate business-based stigma, and that paternalist  
16 approaches to MHC accommodation are likely to generate care-based stigmas.  
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28 In the case of business-based stigma, the organization takes a transactional approach to  
29 MHC accommodation whereby the degree of accommodation provided varies due to the  
30 employee's perceived value to the business and their capacity to contribute. This approach to  
31 accommodation therefore tends to lead to employees experiencing a loss of engagement in, and  
32 agency about, their job and its demands. In our data we found examples whereby managers  
33 inadvertently either downplayed the employee's MHC (well enough to work) or removed the  
34 employee from parts or all their role (insufficient capacity to contribute).  
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45 In the case of care-based stigma, the organization takes a paternalist approach to MHC  
46 accommodation whereby a higher degree of accommodation tends to be provided to  
47 employees. This approach tends to be motivated by sympathy, the perceived need for support,  
48 and an assumption that there is a substantial need for accommodation. The paternalist approach  
49 therefore also tends to lead to employees experiencing a loss of engagement in, and agency  
50 about, their job and its demands. In our data we found examples whereby managers assumed  
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3 what was best for an employee or excluded employees from conversations about their own  
4 well-being and accommodations.  
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8 Our findings also suggest that approaches to accommodation can reinforce patterns of  
9 stigma over time. Organizations that took an inclusive approach to accommodation appeared  
10 to reinforce a low-stigma cycle, where low levels of stigma encouraged disclosure, which  
11 enabled managers to develop comfort in talking abouts MHCs which in turn encourage  
12 disclosure and so on and so forth. In contrast, transactional or paternalist approaches to  
13 accommodation (the central tendency in our data) appeared to unintentionally contribute to a  
14 negative stigma cycle, where higher levels of stigma discouraged disclosure and reduced  
15 managerial comfort with MHCs. The approach an organization takes to accommodating MHCs  
16 therefore has wide reaching consequences beyond the individual employee's experiences. For  
17 example, managers' responses to a specific employee's MHC influence the overall  
18 organizational climate in relation to other employees who witness how a given employee's  
19 MHC was responded to, further reinforcing the stigmatizing effects.  
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36 While we describe care-based and business-based stigmas in relation to MHCs, we  
37 propose that these forms of structural stigma potentially apply in other contexts in which a  
38 stigmatized attribute (gender, race, sexuality, disability) is navigated organizationally.  
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#### 44 ***Practical implications for HRM***

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47 Our findings show that how organizations accommodate MHCs plays an important role  
48 in processes of MHC stigmatization, and we therefore propose that HRM has a key role to play  
49 in MHC de-stigmatization. HRM interventions can address processes of stigmatization by  
50 encouraging the development of more empathetic and supportive accommodation  
51 environments, by encouraging a two-way dialogue between employees and their line managers,  
52 equipping managers with the right language in relation to MHCs, and in relation to individual  
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3 employee MHCs. Importantly, our findings suggest that improving knowledge regarding  
4 MHCs and improving procedures for MHC accommodation are likely to be somewhat limited  
5 in their impacts and that a broader cultural change approach will likely be more successful.  
6  
7 Research has shown that anti-stigma campaigns are highly context dependent in that the  
8 effectiveness of MHC de-stigmatization measures vary across organizational settings, such that  
9 what works in one environment might be less effective in a different organization, and that thus  
10 there is a need to tailor MHC de-stigmatization programmes to fit particular organizational  
11 conditions (Szeto & Dobson, 2010).  
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22 At the level of the organizational climate, stigma arises when individuals are “othered”;  
23 therefore, creating a more inclusive climate could possibly be supported through programs that  
24 promote mental health for all employees, rather than targeting exclusively those with MHCs.  
25 Whole-of-organization initiatives eliminate the need for individuals to disclose MHCs, thus  
26 helping raise awareness, understanding and acceptance of MHCs. While there have been few  
27 evaluations of MHC de-stigmatizing programs, training that raises awareness of MHCs, their  
28 symptoms and effects, and offers practical advice and case studies of effective responses has  
29 been found to have positive outcomes (Szeto & Dobson, 2010). Such programs would shift the  
30 organizational default from dealing with “exceptions” from mental wellness to promoting all  
31 employees’ mental health. A second level of intervention lies with improving the capacity  
32 among line- and HR-managers to have challenging conversations regarding MHCs. Our  
33 findings show how challenging and uncomfortable managers find navigating MHCs among  
34 employees in the workplace, and thus training that increases managers’ ability to conduct  
35 conversations about MHCs would aid de-stigmatization. At the individual level, we find that  
36 HR managers frequently invoke the distinction between work-related and unrelated MHCs as  
37 part of how they justify their approach to managing employees with MHCs. HR managers, we  
38 find, often highlight legal and financial obligations to employees that suffer from work-related  
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3 MHCs. At the same time, we propose that the transactional perspective entailed in invoking  
4 the distinction between work-related and unrelated MHCs is more likely to promote  
5 concealment and poor-quality MHC accommodations, ultimately reinforcing stigmatization.  
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7 Thus, we suggest avoiding a sharp distinction between work-related and work-unrelated  
8 MHCs.  
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### 14 15 ***Limitations and future research*** 16

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18 Several avenues for impactful research stem from the limitations to our study. First, one  
19 important limitation of our research is that it is probable that because our interviewees  
20 volunteered to participate in the study, they are more responsive to MHCs than non-  
21 participating organizations. This sample selection issue might mean that our findings are more  
22 accommodating of MHCs than would be true for a representative sample. More generally, it is  
23 important to recognize that all respondents are likely to present themselves and their  
24 organizations in the best possible light. That said, our findings suggest that a wide variety of  
25 approaches exist across organizations, and we don't find evidence of clustering of data  
26 entailing inclusive MHC accommodation. This suggests to us that respondents were relatively  
27 candid and open in their responses and that the core thrust of our findings is likely robust to  
28 alternative sampling. Second, future research could enrich our findings by encompassing  
29 perspectives beyond HR managers by including line managers, employees with MHCs, and  
30 their co-workers to both validate our findings and illuminate how MHC accommodation could  
31 be improved to generate an inclusive culture. Extending research encompassing managers and  
32 employees would also illuminate relationships between structural stigma and self-stigma.  
33  
34 Third, our focus lies with the accommodation and support of employees with MHCs and we  
35 have only a limited insight into the broader team and organizational performance impacts of  
36 alternative ways of accommodating MHCs in the workplace. Fourth, our focus has been with  
37 the nature and process of how a single potentially stigmatized attribute – having an MHC – is  
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3 navigated organizationally. However, multiple potentially stigmatizing attributes often  
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5 coincide at the individual level, suggesting fruitful future research regarding the  
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7 intersectionality of multiple stigmatizing identities. Fifth, the new theoretical constructs we  
8  
9 identify – care-based and business-based stigma – have potential application in contexts other  
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11 than MHCs in organizations, and future research could explore and validate these constructs in  
12  
13 relation to other stigmatized phenomena. Sixth, our data collection immediately preceded the  
14  
15 profound impacts on work, employment, economy and society that were provoked by the  
16  
17 COVID-19 pandemic (Authors, 2020). Research is emerging that is documenting the  
18  
19 significant impacts of COVID-19 on MHCs both in wider society and within workplaces  
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21 (Giorgi et al., 2020; Rajkumar, 2020). Further research that examined how extreme events like  
22  
23 COVID-19 affect how organizations, managers, and employees navigate MHCs would be  
24  
25 extremely valuable.  
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### 30 31 **Conclusion** 32

33  
34 Responding to the relative absence of HRM research that examines how MHCs are  
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36 accommodated in workplaces, this study has provided new empirical evidence of the  
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38 experiences of HR managers navigating the complexities of employees' MHCs. Our findings  
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40 indicate that organizations accommodate MHCs in different ways, and that different  
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42 approaches to MHC accommodation have significant implications for MHC stigmatization.  
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44 Specifically, we identify two new forms of structural stigma, which we respectively label  
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46 business-based and care-based stigma, that stem from transactional and paternalist HRM  
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48 approaches to accommodating MHCs. We explore the implications of our analysis for de-  
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50 stigmatizing MHCs in workplaces and for future HRM research that advances understanding  
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52 of how organizations can better support employees with MHCs.  
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3 **Data Availability Statement:** Due to the nature of this research, participants of this study did  
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5 not agree for their data to be shared publicly, so supporting data is not available.  
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FIGURE ONE

Data Coding Structure

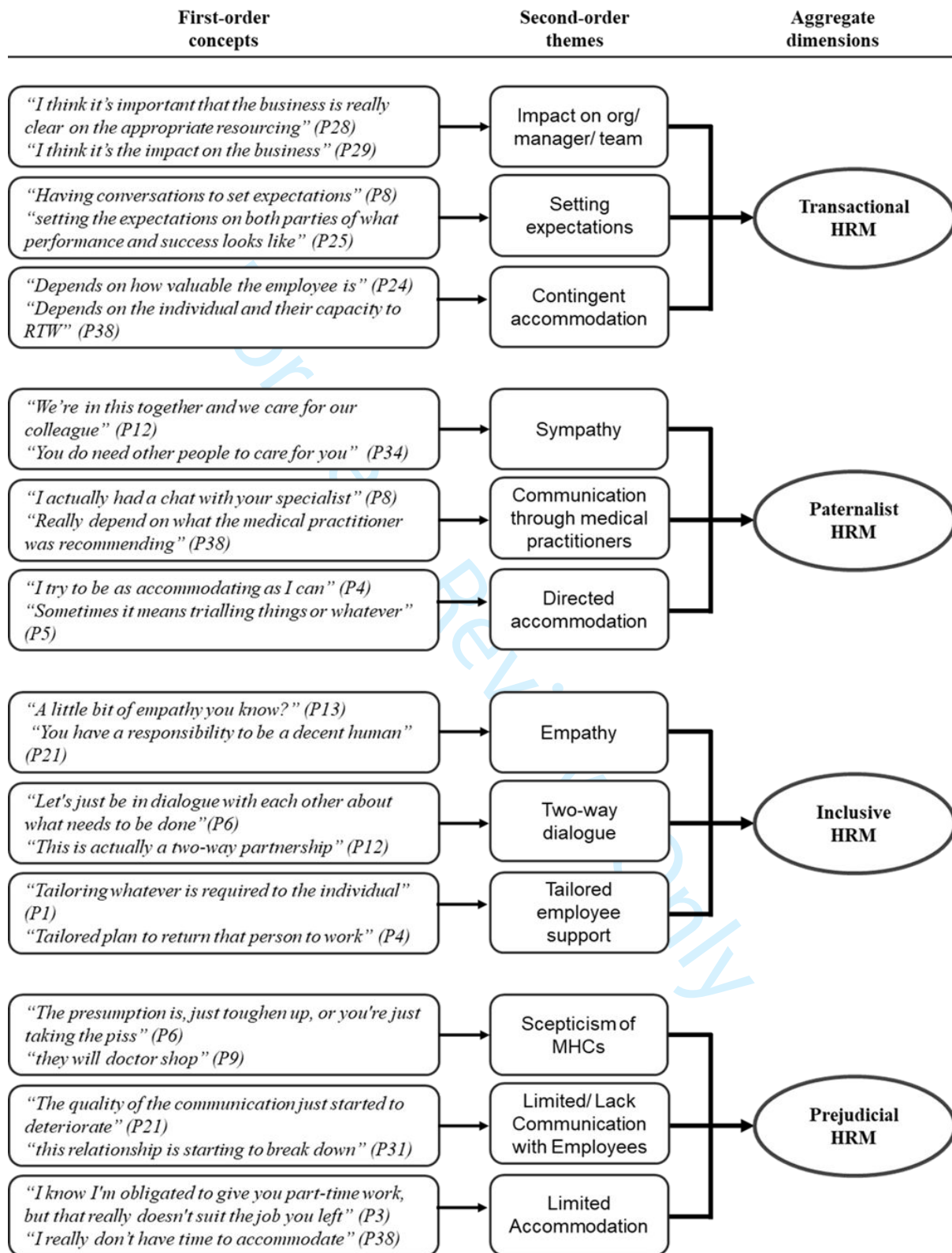


TABLE ONE

Characterising Organizational MHC Accommodation Climates

Perspective on MHCs	Balance of Organisation versus Employee Interests underpinning Accommodation	Level of Employee Involvement in Determining Accommodation	Mode of Organisation- Employee Communication	Levels of Adjustment/ Accommodation Made	
<p><u>Pragmatic</u></p> <p><i>I think you draw the line on a case-by-case basis and I think it comes down to what the reasonable modifications are, or what the job is. (P35)</i></p>	<p><u>Both, Emphasis on Organisational Interests</u></p> <p><i>We don't need to be able to solve all the problems, we just need to be able to know where to ... find that support and to also know where the lines are from a business point of view, because it can be easy to want to do everything for the employee but sometimes you can't. (P37)</i></p>	<p><u>High (emphasis on capacity determination)</u></p> <p><i>That's where the communication comes in and setting expectations. You can't just accommodate every single thing. That's where you need to talk to them and say, look, these are the business requirements, this is how much we can accommodate and then have that conversation. ... If someone is a high-performing person and diligent, they will understand that. They will not</i></p>	<p><u>Two-Way Dialogue, (emphasis on capacity)</u></p> <p><i>It would have to be a conversation around well what's your doctor saying you can do, what they are fit to do in their job, and then what reasonable adjustments you can make. (P12)</i></p>	<p><u>Contingent (on employee's value to the business)</u></p> <p><i>... if they were for want of a better term, a good employee, then certainly managers and supervisors I think are naturally going to be more willing to bend over and make changes and adjustments to enable them to be back at work. Whereas the employee that quite frankly they wish they could get a resignation from, they are not going to bend over as much for them. (P27)</i></p>	<p><u>Transactional HRM</u></p>

		<i>have unreasonable expectations. (P8)</i>			
<p><u>Sympathetic</u></p> <p><i>I guess it's also sometimes about helping your people look after themselves (P3)</i></p>	<p><u>Both, Emphasis on Employee Support</u></p> <p><i>In some cases, we've had to do evaluations with a psychologist or psychiatrist to understand if there were any impacts in the workplace that were affecting this person or making calls about their future employment (P36)</i></p>	<p><u>Moderate (emphasis on presumed needs)</u></p> <p><i>The person might want to come back quickly but then they mightn't be okay to come back, so you sort of need to look after them during that transition period (P34).</i></p>	<p><u>Emphasis on Organisation to Employee</u></p> <p><i>I think it's all about the communication, you know, why things are the way they are, and then following up with that as well that if things aren't working for them or aren't working for us then we sit down and continue to talk about it and see what we can resolve. (P17)</i></p>	<p><u>Substantial</u></p> <p><i>Part of the transition was that on his return to work he wouldn't need to manage the employees directly for a period of time, so ... we reviewed priorities and we actually put a hold on a few of the projects to reduce that mental load I guess (P19)</i></p>	<p><b><u>Paternalist HRM</u></b></p>
<p><u>Empathetic</u></p> <p><i>We are still training our managers to have the skill to be inclusive, to report things in the right way and to</i></p>	<p><u>Both, Emphasis on Employee Support</u></p> <p><i>I think you have to - within the confines of what the employee is comfortable to share -, you have to try and educate those around,</i></p>	<p><u>High</u></p> <p><i>I have always found though that there's hidden talents within employees when you start probing for other things they could do (P15)</i></p>	<p><u>Two-Way Dialogue</u></p> <p><i>...always treating a person as an employee irrespective of their reasons for being absent and the two-way communication around needs, wants,</i></p>	<p><u>High</u></p> <p><i>... so what we did is we actually allowed for them to have counselling sessions done during work hours but keeping the routine of coming to work</i></p>	<p><b><u>Inclusive HRM</u></b></p>

<p>communicate using the right language (P16).</p>	<p>to say, look, I appreciate this is having an impact on you. This is what we're doing, this is what the employee is doing, you might not realise it. This is what they're going through. I think [you just have to] come back to what your aims are as an employer, and what your values are. (P5)</p>		<p>the reality of being away from work and returning to work (P11).</p>	<p>every day doing what they're good at and feeling that they've accomplished... it was actually a really important part of their healing process for that particular episode (P23)</p>	
<p><u>Sceptical/Dismissive</u></p> <p>We have several people that go off on psychological illnesses the day they are put on a performance management or a performance improvement plan. People use it as a tool to avoid accountability” (P9).</p>	<p><u>Organisation Concern Dominant</u> E.g.</p> <p>When I see that glaze coming over [managers'] eyes I turn the conversation to the insurance premiums... As soon as I start to mention those they go okay, so what are we going to do? (P10)</p>	<p><u>Low</u></p> <p>I guarantee you the cases that will fall over will be when there's an unskilled manager who isn't really interested in enabling the person to return... they've already made up their mind (P33).</p>	<p><u>Limited, Directive</u></p> <p>If it's psychological I think line managers go, oh god they are going to be, it's going to hard. I think it's an education thing there, you mentioned it right at the very beginning. (P38)</p>	<p><u>Minimal</u></p> <p>I think if [an MHC] is declared, a manager will still avoid hiring that person which to me says everything (P33).</p>	<p><b><u>Prejudicial HRM</u></b></p>

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For Peer Review Only

**FIGURE ONE**  
**Data Coding Structure**

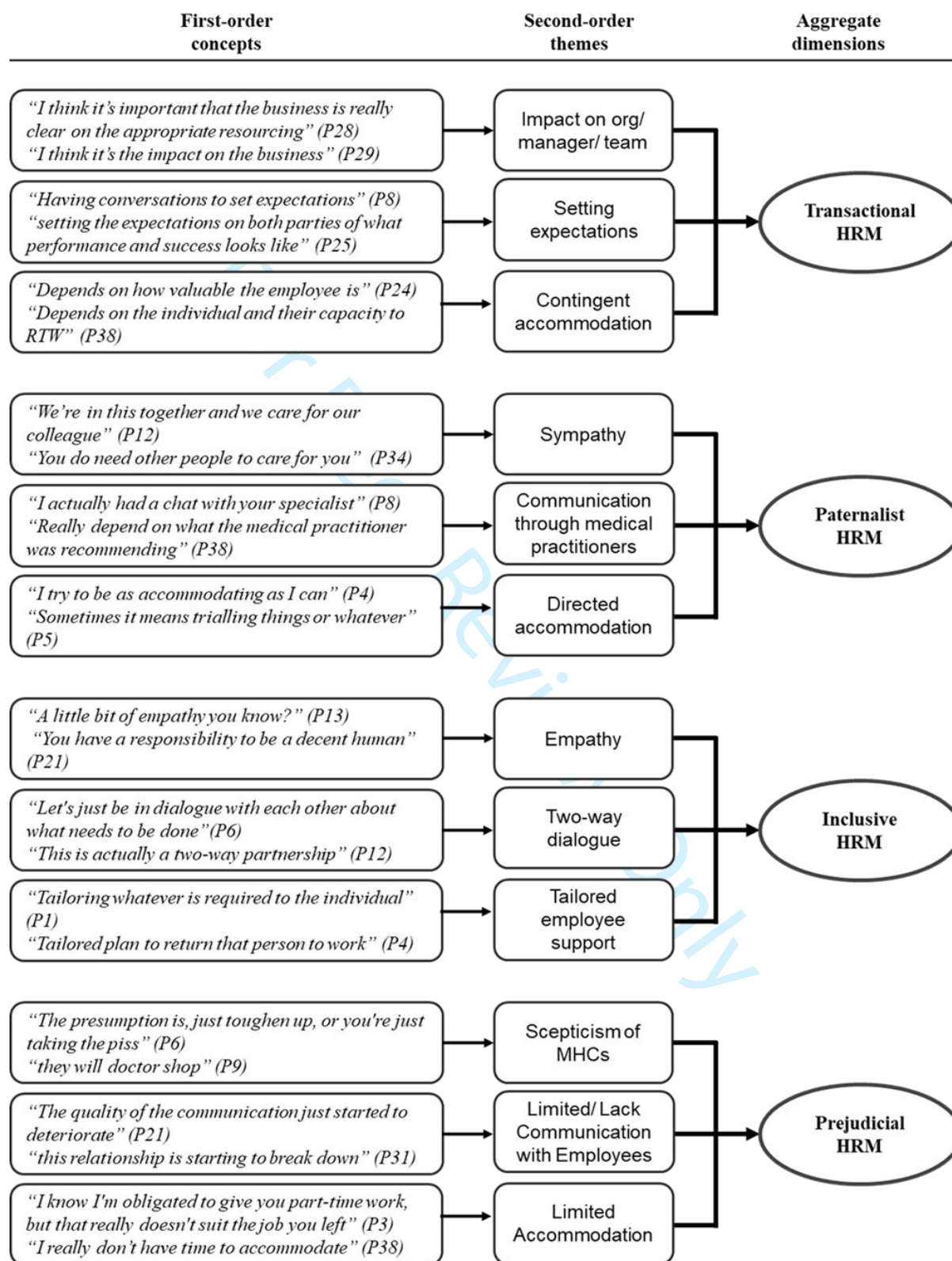


TABLE ONE

## Characterising Organizational MHC Accommodation Climates

Perspective on MHCs	Balance of Organisation versus Employee Interests underpinning Accommodation	Level of Employee Involvement in Determining Accommodation	Mode of Organisation- Employee Communication	Levels of Adjustment/ Accommodation Made	
<p><u>Pragmatic</u></p> <p><i>I think you draw the line on a case-by-case basis and I think it comes down to what the reasonable modifications are, or what the job is. (P35)</i></p>	<p><u>Both, Emphasis on Organisational Interests</u></p> <p><i>We don't need to be able to solve all the problems, we just need to be able to know where to ... find that support and to also know where the lines are from a business point of view, because it can be easy to want to do everything for the employee but sometimes you can't. (P37)</i></p>	<p><u>High (emphasis on capacity determination)</u></p> <p><i>That's where the communication comes in and setting expectations. You can't just accommodate every single thing. That's where you need to talk to them and say, look, these are the business requirements, this is how much we can accommodate and then have that conversation. ... If someone is a high-performing person and diligent, they will understand that. They will not</i></p>	<p><u>Two-Way Dialogue, (emphasis on capacity)</u></p> <p><i>It would have to be a conversation around well what's your doctor saying you can do, what they are fit to do in their job, and then what reasonable adjustments you can make. (P12)</i></p>	<p><u>Contingent (on employee's value to the business)</u></p> <p><i>... if they were for want of a better term, a good employee, then certainly managers and supervisors I think are naturally going to be more willing to bend over and make changes and adjustments to enable them to be back at work. Whereas the employee that quite frankly they wish they could get a resignation from, they are not going to bend over as much for them. (P27)</i></p>	<p><u>Transactional HRM</u></p>



		<i>have unreasonable expectations. (P8)</i>			
<p><u>Sympathetic</u></p> <p><i>I guess it's also sometimes about helping your people look after themselves (P3)</i></p>	<p><u>Both, Emphasis on Employee Support</u></p> <p><i>In some cases, we've had to do evaluations with a psychologist or psychiatrist to understand if there were any impacts in the workplace that were affecting this person or making calls about their future employment (P36)</i></p>	<p><u>Moderate (emphasis on presumed needs)</u></p> <p><i>The person might want to come back quickly but then they mightn't be okay to come back, so you sort of need to look after them during that transition period (P34).</i></p>	<p><u>Emphasis on Organisation to Employee</u></p> <p><i>I think it's all about the communication, you know, why things are the way they are, and then following up with that as well that if things aren't working for them or aren't working for us then we sit down and continue to talk about it and see what we can resolve. (P17)</i></p>	<p><u>Substantial</u></p> <p><i>Part of the transition was that on his return to work he wouldn't need to manage the employees directly for a period of time, so ... we reviewed priorities and we actually put a hold on a few of the projects to reduce that mental load I guess (P19)</i></p>	<p><b><u>Paternalist HRM</u></b></p>
<p><u>Empathetic</u></p> <p><i>We are still training our managers to have the skill to be inclusive, to report things in the right way and to</i></p>	<p><u>Both, Emphasis on Employee Support</u></p> <p><i>I think you have to - within the confines of what the employee is comfortable to share -, you have to try and educate those around,</i></p>	<p><u>High</u></p> <p><i>I have always found though that there's hidden talents within employees when you start probing for other things they could do (P15)</i></p>	<p><u>Two-Way Dialogue</u></p> <p><i>...always treating a person as an employee irrespective of their reasons for being absent and the two-way communication around needs, wants,</i></p>	<p><u>High</u></p> <p><i>... so what we did is we actually allowed for them to have counselling sessions done during work hours but keeping the routine of coming to work</i></p>	<p><b><u>Inclusive HRM</u></b></p>

<p>communicate using the right language (P16).</p>	<p>to say, look, I appreciate this is having an impact on you. This is what we're doing, this is what the employee is doing, you might not realise it. This is what they're going through. I think [you just have to] come back to what your aims are as an employer, and what your values are. (P5)</p>		<p>the reality of being away from work and returning to work (P11).</p>	<p>every day doing what they're good at and feeling that they've accomplished... it was actually a really important part of their healing process for that particular episode (P23)</p>	
<p><u>Sceptical/Dismissive</u></p> <p>We have several people that go off on psychological illnesses the day they are put on a performance management or a performance improvement plan. People use it as a tool to avoid accountability” (P9).</p>	<p><u>Organisation Concern Dominant</u></p> <p>E.g.</p> <p>When I see that glaze coming over [managers'] eyes I turn the conversation to the insurance premiums... As soon as I start to mention those they go okay, so what are we going to do? (P10)</p>	<p><u>Low</u></p> <p>I guarantee you the cases that will fall over will be when there's an unskilled manager who isn't really interested in enabling the person to return... they've already made up their mind (P33).</p>	<p><u>Limited, Directive</u></p> <p>If it's psychological I think line managers go, oh god they are going to be, it's going to hard. I think it's an education thing there, you mentioned it right at the very beginning. (P38)</p>	<p><u>Minimal</u></p> <p>I think if [an MHC] is declared, a manager will still avoid hiring that person which to me says everything (P33).</p>	<p><b><u>Prejudicial HRM</u></b></p>

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