FACTORS THAT INFLUENCE EMPLOYEE PARTICIPATION IN WORKPLACE MENTAL WELLBEING INITIATIVES: THE ROLE OF LEADERSHIP

A thesis submitted in partial fulfilment of the requirements for the
Degree of Master of Commerce in Management

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2021

Abstract

This study examines the factors that influence employee participation in workplace mental wellbeing initiatives. Extant research consistently shows that employee participation rates are low, typically between 1–50 percent. However, there is limited research explaining why this is the case, due, in part, to the underrepresentation of employees' perspectives, an overreliance on quantitative approaches to identify barriers to participation, and a resulting lack of qualitative research that provides in-depth insight into the factors that both impede or enhance participation. To address these gaps in the literature, a qualitative case study was conducted at a large local government organisation in New Zealand. Data was collected from organisational records and semi-structured interviews with 19 employees, five managers, and the company's Employee Assistance Programme (EAP) provider. The thematic analysis identified six factors that influence employee participation: 1) leadership, 2) organisational context, 3) perceived value, 4) remaining silent, 5) work pressures and expectations, and 6) initiative specific factors. This study proposes that three key leadership behaviours of *obstructing, accommodating,* and *promoting* have a significant and direct influence on employee participation, and also indirectly moderate how employees experience each of the other factors. The study demonstrates that employee participation is heavily influenced by how leaders shape the organisational culture and their ability to foster a work environment that is characterised by high levels of trust and psychological safety. This study makes a meaningful contribution to the literature on mental wellbeing by highlighting the dynamic interplay between a range of individual and organisational factors that can both positively or negatively influence participation. Importantly, this thesis provides practical recommendations for organisations seeking to enhance sustained employee participation in workplace mental wellbeing initiatives.

Keywords: Workplace mental wellbeing initiatives, employee participation, case study, leadership, organisational culture

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Acknowledgements

First, I would like to thank my supervisors Dr. Russell Wordsworth and Dr. Sarah Wright. You have taught me so much, whether it was correctly using a damned apostrophe or avoiding the orphaned 'this'. Your wisdom, time, patience, and guidance has been invaluable to me, and I am sincerely grateful for everything you have contributed to this thesis.

My sincerest gratitude goes to the organisation who enabled me to do this study. A special thanks to the participants who bravely shared their stories with me. Your vulnerability and authenticity made this study possible, and I hope I have given you a voice.

To my parents Helen and Rich, for sending me news articles that I might find relevant, for helping me find the word I couldn't think of, for the whiteboard sessions, and for bringing me an elaborate cheese board after I had hit four hours on a Zoom call just to make me laugh. Thank you for the constant support and encouragement. I couldn't have done this without you.

To my brother Matt – thank you for teaching me how to survive my master's by sharing how you battled through yours (and won). You shielded me from learning things the hard way. Thanks for giving me straight feedback in your *oh-so-academic* language, "sentence is too wordy bruh."

To Harley – thank you for always supporting and encouraging me to be the best version of myself. Thank you also for dragging me out for a walk up the Harry 'Elf', a West Coast roadie, or a dreamy Canopy Camping escape to make sure I kept my own mental wellbeing in check. I'm glad we could share the experience of studying for our master's together, and there's a very real possibility that we are turning into quite the power couple.

To my classmates, whether you were fiercely cat-walking in killer stilettos in the office, miming R18 fishbowl cards, or having lunch with me in our secret spot on campus, I felt like I was part of an awesome group of people (despite sometimes being one of two students in management classes). To my friends and wider family, thank you for convincingly feigning interest whenever I talked about my ontological, epistemological, and axiological assumptions - or whatever convoluted stage of my thesis I was grappling with at the time.

Dedication

This thesis is dedicated to my beloved late uncle, Jeff, whose wit and wisdom I could never match. You showed me that you can be wildly successful even when you get an E in Economics. I will never forget the surprise of seeing him striding towards me on campus with his colleagues flanking him, looking like he worked for the Ministry of Magic. Jeff inspired me to work hard, aim high, and to celebrate by painting the town ‘a screaming shade of scarlet.’ But most importantly, he taught me that family always comes first.

For Jeff.

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Chapter One: Introduction

Background to the Research Problem

This thesis utilises a case study research design to examine the factors that influence employee participation in workplace mental wellbeing initiatives. Research on this topic is important because the state of mental health and wellbeing in New Zealand is deteriorating. In fact, it is considered so bad that it has been characterised as a crisis (Paterson et al., 2018; Russell, 2016). Nationally, one in five people suffer from mental illness or mental distress each year, and there is evidence this figure is increasing (Health Promotion Agency [HPA], 2018; Ministry of Health [MOH], 2018; Organisation for Economic Co-operation and Development [OECD], 2018; Paterson et al., 2018). Between 2016 and 2018, the proportion of individuals in New Zealand seen by a primary healthcare provider with a diagnosed mental health issue increased by 22 percent (MOH, 2018). In New Zealand, the number of people in mental health crisis (an emergency that poses a direct and immediate threat to one's physical or emotional wellbeing) increased fivefold from 2015 to 2018, from 52 crisis presentations a month to 245 (Mental Health Foundation [MHF], 2019; Rankin, 2018). In 2019, a staggering 685 people took their own lives, the highest annual number ever recorded in New Zealand (MHF, 2019). The 2018 national Government Inquiry into Mental Health and Addiction revealed that the financial burden of serious mental health issues costs New Zealand $12 billion every year, or 5 percent of gross domestic product (GDP) (Paterson et al., 2018). In the developed world, mental illness accounts for 15 percent of the total burden of disease (MOH, 2018). Mental illness or distress can also manifest in the workplace and lead to negative organisational outcomes such as absenteeism, presenteeism, and a loss of productivity (Evans-Lacko, 2016; Haddon, 2018; Hemp, 2004; Johns, 2010).

There are chronic and acute factors that have the potential to negatively affect an individual's mental health and wellbeing. In New Zealand, one chronic factor includes the persistent stigmatisation of mental health and the national culture surrounding mental health and illness (Paterson et al., 2018; Scarf et al., 2020). Braun (2008) found that New Zealand's national identity or persona is generally characterised as self-sufficient, stoic, and 'laid back', where the 'she'll be right' (everything will be okay) attitude can result in individuals' neglecting or ignoring mental distress, believing that it will go away on its own. Similarly, it has been

suggested that British colonisation may have also influenced New Zealanders to adopt a 'stiff upper lip.' A 'stiff upper lip' is the belief that psychological 'weaknesses,' or emotionally painful experiences are to be supressed, internalised, and endured alone so as to avoid burdening another with one's troubles (Andrew & Dulin, 2007; King, 2003). These tendencies to deal with mental distress alone have led to the belief that admitting to a mental health issue will be perceived as a weakness or that the affected individual will be shunned or ignored for being 'defective' (Cautin, 2011; Smith, 2019). These attitudes have resulted in the stigmatisation of mental health and the concerning number of suicides in New Zealand, which are particularly prevalent in male adolescents/young adults (McCool, 2017; MHF, 2019). Another chronic factor that can negatively affect an individual's mental health and wellbeing is New Zealand's health system which is considered to have an 'ambulance at the bottom of the cliff' response to mental illness (Paterson et al., 2018; Russell, 2016). Mental illness has historically been portrayed negatively and has exacerbated the enduring stigmatisation of those with mental illness, contributing to the low numbers of affected individuals seeking the help they need (Cautin, 2011; Corrigan et al., 2014; Gulliver et al., 2010; Penn & Martin, 1998). The MOH (2017) found that only 171,693 people in New Zealand accessed mental health services between June 2016-2017, only a fraction of those requiring mental health services (OECD, 2018). As a result, New Zealand has been characterised as having a health system that *reacts* to mental illness, often only when approaching or at a crisis point (Paterson et al., 2018).

In New Zealand, acute factors that have had the potential to negatively affect an individual's mental health and wellbeing include the earthquakes in Canterbury 2010 and Christchurch 2011, the Christchurch Mosque shootings in 2019, and most recently the global COVID-19 pandemic. The present study was undertaken during the COVID-19 pandemic and at the time of writing (July, 2021) there were 201 million diagnosed cases and nearly 4.3 million fatalities (World Health Organisation [WHO], 2020). The foreboding consequences of COVID-19 are expected to result in a global mental health crisis (WHO, 2020).

Encouragingly, recent developments suggest that Government agencies and health care providers in New Zealand are beginning to take a more proactive approach to *prevent* mental illness with early intervention and a greater emphasis on mental wellbeing. Mental wellbeing is often referred to as positive mental health or human flourishing (MHF, 2020; Nogues & Finucan, 2018; Paterson et al., 2018). While Government entities and health care providers carry most responsibility for supporting mental wellbeing, the workplace has also been

recognised as an important setting in which to promote mental health and wellbeing (Haddon, 2018; Szeto & Dobson, 2010). Working individuals spend a significant proportion of their lives at their places of employment. As such, exposure to mental wellbeing promotion may be greater and therefore more successful at work than in other community settings (Person et al., 2010).

Organisations that have attempted to improve health and safety in the workplace have historically focused their efforts on ensuring physical safety. However, the Health and Safety at Work Act 2015 obligates employers to consider both physical and psychological safety in the workplace (Employment New Zealand, 2020). Accordingly, organisations have started to promote mental wellbeing in the workplace through activities such as flexible working arrangements or Employee Assistance Programmes (EAP) (Kirk & Brown, 2003; Joyce et al., 2010). Organisations have also started offering workplace mental wellbeing initiatives, such as positive psychology seminars, stress management interventions, coaching and mentoring support, or yoga and mindfulness sessions. Beyond meeting health and safety obligations, organisations have a self-interest in maintaining a mentally thriving workforce (Hone et al., 2015; Keeman et al., 2017). Evidence suggests that mental wellbeing can benefit an employee's motivation and self-efficacy, positively impact others around them, and can improve organisational outcomes, such as reduced employee turnover and improved productivity (Grawitch & Ballard, 2016; Guerci et al., 2019).

Despite these potential benefits, employers often encounter a lack of employee participation in workplace mental wellbeing initiatives, with reported participation rates typically below 50 percent (Corrigan et al., 2014; Robroek et al., 2009). For example, Bolier et al. (2014) reported that only 32 percent of employees participated in an online mental wellbeing intervention, and 61 percent of those participants dropped out before completion. Nel and Spies (2007) reported that out of 65 employees invited to take part in a play and art therapy intervention for stress management, only 12 participated (18 percent). Robroek et al. (2009) found that workplace educational or counselling interventions had the lowest levels of initial participation. These rates never exceeded 47 percent, compared with fitness interventions which had initial participation levels of 53 percent and multi-component interventions which had even higher participation levels (64 percent). Studies such as these suggest a lack of employee help-seeking for mental wellbeing (Bamberger, 2009). McRee (2017) and Milot (2019) determined that

current perceptions of mental health and associated stigma negatively impact the utilisation of EAP in the developed world, noting that various studies across a range of industries put the overall percentage of employees utilising EAP between 1-5 percent. There is a lack of evidence explaining the reasons for this low participation in a range of workplace mental wellbeing initiatives (Corrigan et al., 2014). This study explores why there are such low participation rates using a case study approach.

While stigma around mental health has been identified as a possible reason for lack of employee participation in mental wellbeing initiatives (Butterworth, 2001; Haddon, 2018; Hanisch et al., 2016; Milot, 2019; Szeto & Dobson, 2010; Toth & Dewa, 2014), other possible barriers have been suggested in the literature. However, these have been insufficiently explored, particularly in the context of the workplace. Given the dearth of extant research on the barriers to participation in mental wellbeing initiatives, this study borrows from related literature on barriers to participation in broader workplace health promotion interventions (such as exercise, smoking cessation, or healthy living programmes) and community-based mental health services (Dillon et al., 2020; Little et al., 2019; Robroek et al. 2009). This literature identifies barriers that may also be relevant in the context of workplace mental wellbeing initiatives. Identified barriers include, time limitations, inconvenient locations, insufficient incentives, poor mental health literacy (understanding of mental health), the desire to handle mental wellbeing on one's own, beliefs about the ineffectiveness of such interventions, perceived cultural barriers, social comparison, irrelevance or lack of interest in interventions, and a perceived lack of support (Corrigan et al., 2014; Gulliver et al., 2010; Person et al., 2010; Spence, 2015). To date, these barriers have only been identified in workplace health promotion or community-based mental health services (Corrigan et al., 2014; Gulliver et al., 2010; Person et al., 2010). When discussed in relation to the workplace, they have merely been put forward as proposed barriers that 'might' affect employee participation in mental wellbeing initiatives (Spence, 2015). There is limited empirical research examining whether barriers to participation in mental wellbeing initiatives apply in the same way as they have shown to do in these other contexts. Ignoring this existing research may be counterproductive as it may result in similar findings that already exist (Corbin & Strauss, 2008). Instead, examining this related research may strengthen present understanding of how employees experience barriers and enablers to participation.

Employee perspectives and experiences have been historically underrepresented in the literature (Bright et al., 2012; Spence, 2015). Instead, most studies have focused on the perspectives of senior leaders or providers of wellbeing initiatives (Mellor & Webster, 2013; Quirk et al., 2018) or on the effectiveness of wellbeing interventions, without examining barriers or enablers to participation from either an employee or employer perspective (Graveling et al., 2008; Meyers et al., 2013). Corrigan et al. (2014) have noted that merely removing barriers, such as stigma around mental health, is insufficient on its own and has not been enough to increase participation in mental wellbeing activities. Hence it is important to consider factors that enable or encourage employee participation. However, to date, these have been comparatively underexplored in the literature (Gulliver et al., 2010; Person et al., 2010). For example, in Gulliver et al.'s (2010) systematic review, only three of the 22 examined studies addressed enablers. The literature on mental wellbeing or health promotion in the workplace has also tended to use quantitative methods which are unable to provide richly detailed explanations of low employee participation rates (Gulliver et al., 2010; Lakerveld et al., 2008; Linnan et al., 2010; Rongen et al., 2014). In contrast, this study adopts a qualitative case study design to provide a more emic explanation for the low rate of employee participation in workplace mental wellbeing initiatives and how employees personally experience barriers and enablers to participation. It responds to calls for qualitative research in order to gain in-depth and rich insights into employees' and managers' subjective account of mental wellbeing in the workplace (Armour, 2020; Gulliver et al., 2010; Hallaway, 2020; Skakon et al., 2010). In doing so, this study contributes to the literature in five ways.

First, it offers an explanation for why there is low employee participation in workplace mental wellbeing initiatives. Second, it highlights the significant role that leaders play in enhancing or curtailing employee participation, arguing that it is often the leader who influences whether an employee experiences a specific factor as a barrier or enabler. Third, the study highlights the importance of the organisational context within which employee participation occurs. The study also describes several aspects of the workplace context that are conducive to, and enable, employee participation. Fourth, the study identifies an important gap in Job Demands and Resources (JD-R) theory by evidencing that employees' job demands and expectations may be organisationally imposed or self-imposed. Fifth, the study identifies that individual factors that influence employee participation may be both barriers or enablers, depending on how those factors are experienced within a particular organisation. This study builds on extant research by offering a more complete picture of the dynamic interplay that exists between a range of

factors that influence employee participation. The study also offers practical insights for organisations seeking to enhance sustained employee participation in workplace mental wellbeing initiatives.

Research Questions and Study Design

This study addresses the following research questions:

1. Why is there a lack of employee participation in workplace mental wellbeing initiatives?
2. What factors act as barriers to employee participation in workplace mental wellbeing initiatives? Why are these barriers experienced as problematic for the individual or the organisation?
3. What factors enable and increase sustained employee participation in workplace mental wellbeing initiatives? How are these factors perceived to encourage and enhance participation?

A qualitative research design, consistent with an interpretive ontology and epistemology, was deemed most appropriate to address the research questions. The researcher conducted semi-structured interviews with 23 staff members at a local government organisation in New Zealand, including five managers and 18 employees. The researcher also interviewed the organisation's EAP provider. Of the 24 total interviews, there were eight male and 16 female participants. The interviews were transcribed verbatim and analysed using thematic analysis. The thematic analysis identified six key factors that influence employee participation in workplace mental wellbeing initiatives.

Thesis Outline

This thesis is divided into five chapters.

Chapter One has presented the background to the research problem and outlined the research questions and study design.

Chapter Two critically reviews the literature on mental wellbeing, mental health, and mental illness, defining the key terms used in the study. It also examines mental wellbeing in an organisational context. The chapter then discusses participation levels in workplace mental wellbeing initiatives, wider health promotion initiatives in the workplace, and community-

based mental health services. This chapter also identifies current gaps in the literature which justify the need for this study.

Chapter Three presents the research methodology, outlining and justifying the chosen research design. The chapter discusses philosophical considerations, research design, and the methods selected for data collection and analysis.

Chapter Four presents the findings of the thematic analysis, describing the six key factors that were found to influence employee participation in workplace mental wellbeing initiatives. The chapter incorporates vivid and compelling quotes from interview participants to illustrate each of these factors and how they inhibit or enable employee participation.

Chapter Five discusses the findings and how they relate to existing literature. The chapter outlines theoretical implications and presents new insights obtained from this research. The chapter identifies the study's limitations and provides suggestions for future research, before concluding with the practical implications of the research.

Chapter Two: Literature Review

Introduction

The following chapter reviews relevant literature on mental wellbeing, mental health, and mental illness. The review begins by defining the key constructs used in this study. It then examines the social constructions of mental wellbeing, mental health, and mental illness and explores how attitudes around these constructs have changed over time. The focus of the review then shifts to mental wellbeing in an organisational context and employee participation in workplace mental wellbeing initiatives. The review concludes with a discussion of the gaps in the extant literature and how the present study aims to address these.

Key Concepts

Mental wellbeing, mental health, and mental illness are difficult to clearly define as they are relatively broad concepts and often applied in different contexts (Center for Disease Control and Prevention [CDC], 2018; Dodge et al., 2012; van Agteren et al., 2021). However, for the purposes of this study, the following working definitions are utilised.

Mental Wellbeing

For the purposes of this study, mental wellbeing, also known as 'positive mental health' and 'flourishing', is "more than the absence of mental illness and it is more than feeling happy. Someone with positive mental health and high wellbeing is feeling good, functioning well, has satisfaction with life, is developing as a person, and has strong relationships" (MHF, 2020a, para. 2). Mental wellbeing is about self-realisation or fulfilling one's potential, rather than the treatment of mental illness. Slade (2010) noted that the scientific field of positive psychology is devoted to the promotion of wellbeing, because positive psychology focuses on harnessing an individual's strengths as opposed to dwelling on problems or deficits. It is believed that such practices will enable the individual to thrive and create a meaningful life. Positive psychology has gained greater scholarly attention over the past few years as it places emphasis on 'positive mental health' and breaks away from the pessimistic 'disease model' and the associated prejudice around mental illness (Froh, 2004; Keyes & Annas, 2009; Slade, 2010). This positive lens of promoting mental wellbeing and flourishing, rather than continuing to emphasise the negative side of mental illness, is at the heart of this study.

Wellbeing

Wellbeing can be understood as how people feel, how they function, and how they evaluate their lives overall (New Economics Foundation [NEF], 2012). As the CDC explained, "wellbeing includes the presence of positive emotions and moods (e.g., contentment, happiness), the absence of negative emotions (e.g., depression, anxiety), satisfaction with life, fulfillment and positive functioning" (2018, para. 13). For the purposes of this study, wellbeing can be defined as the state of being happy, healthy, or prosperous (Merriam-Webster, n.d.-b). Mental wellbeing is just one aspect of the multifaceted construct of wellbeing, which includes dimensions of physical, spiritual, and social wellbeing (Dodge et al., 2012; Hone et al., 2014; Huppert, 2014). Physical wellbeing goes beyond the absence of disease. Instead, it refers to a healthy lifestyle and improving the functioning of one's body (Scheier & Carver, 1992). Physical wellbeing is connected to mental wellbeing in a reciprocal relationship, with physical wellbeing positively influencing mental wellbeing and vice versa (Dodge et al., 2012). Spiritual wellbeing relates to one's value systems. It involves having an insightful connection with the self and others, and often considers the meaning of life (Seaward, 1991). Social wellbeing is concerned with personal relationships and perceptions of social integration, contribution, and acceptance (Keyes, 1998).

Scholars have adopted Aristotle's conceptualisations of 'hedonic enjoyment' and 'eudaimonia' to explain the two perspectives of wellbeing (Kahneman et al., 1999; Waterman, 1993). Hedonic wellbeing focuses on achieving happiness by obtaining pleasure and avoiding pain (Di Fabio & Palazzeschi, 2015; Kahneman et al., 1999). Eudaimonic wellbeing focuses on pursuing one's full potential and self-realisation. It sees the pursuit of personal growth, mastery, and personal excellence as a way to improve wellbeing (Di Fabio & Palazzeschi, 2015; Joshanloo, 2016; Waterman, 1993). This study draws on research that considers a combination of both the hedonic and eudaimonic perspectives of wellbeing to be more appropriate. Such research believes that wellbeing is a multidimensional phenomenon that includes both feeling good (hedonism) and functioning well (eudemonia) (Aked et al., 2008; Fisher, 2014; Keeman et al., 2017). This broad conceptualisation of wellbeing enables this study to examine a wider range of wellbeing initiatives.

In New Zealand, a culturally contextual wellbeing model is also utilised, called Te Whare Tapa Whā. Māori health advocate Sir Mason Durie developed this wellbeing model. The model represents health and wellbeing as a wharenui (a Māori meeting house) with four walls (MHF,

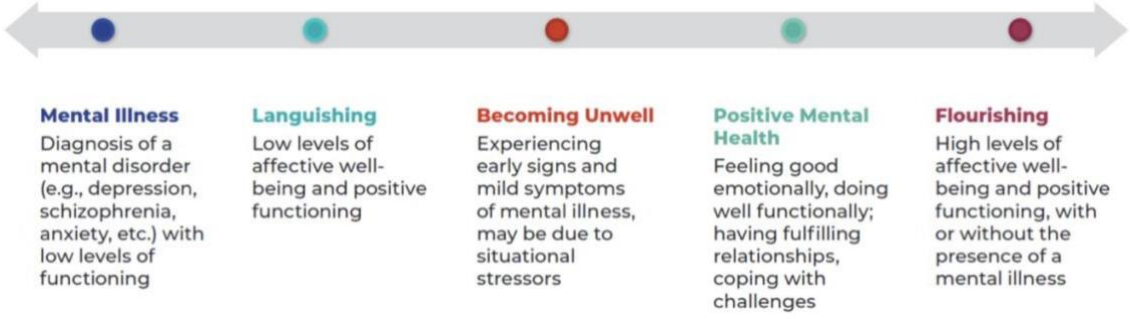
2020b). These four walls are taha wairua (spiritual wellbeing), taha hinengaro (mental and emotional wellbeing), taha tinana (physical wellbeing), and taha whānau (family and social wellbeing). Given that the present study was conducted in New Zealand, it was important to consider how each wellbeing dimension is recognised and understood culturally in order to establish potentially significant cultural factors that influence employee participation in workplace mental wellbeing initiatives. While each dimension of wellbeing is inevitably interrelated, this study is primarily concerned with exploring the factors that influence employee participation in workplace *mental* wellbeing initiatives, and therefore deliberately excludes the other dimensions of broader wellbeing. This study does not examine factors that influence employee participation in physical, family, social, or spiritual wellbeing initiatives in detail because they are separate constructs with potentially different barriers and enablers to participation (Newton, 2007). Instead, this study focuses on mental and emotional wellbeing, or taha hinengaro, an individual's "… mind, heart, conscience, thoughts and feelings" (MHF, 2020b, para. 3). Despite this specific focus, it is recognised that many of the mental wellbeing initiatives discussed in this study may also improve physical wellbeing (e.g., yoga, running groups, boot camps), social wellbeing (e.g., social clubs, team activities), and spiritual wellbeing (e.g., meditation, and mindfulness).

Mental Health

In simple terms, mental health refers to the overall condition of one's mental or emotional state (Merriam-Webster, n.d.-a). Every individual's mental health exists somewhere on the continuum illustrated in Figure 1. This continuum has mental illness and languishing at one end and flourishing at the other (Cowen, 1991; Keyes, 2002; MHF, 2020a).

Figure 1

The Mental Health Continuum



Source: Every Moment Counts (n.d.).

An individual's mental health is the foundation of their thinking, emotions, behaviour, communication, learning, and self-esteem (American Psychiatric Association [APA], 2018). For the purposes of this study, mental health refers to "a state of wellbeing in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (World Health Organisation, 2018, para. 3). An individual's mental health is also important for maintaining healthy relationships and undertaking daily activities like work or school. It also helps an individual to build resilience to cope with adversity and adapt to change (APA, 2018).

Mental Illness

In contrast to flourishing, mental illness (or mental disorder) is located beyond the languishing end of the continuum (see Figure 1). For the purposes of this study, mental illness refers to "health conditions involving changes in emotion, thinking, or behaviour (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities" (APA, 2018, para. 1). The term 'mental illness' encompasses a wide range of mental disorders, such as clinical depression, anxiety disorder, Schizophrenia and Obsessive-Compulsive Disorder (OCD). One in five US adults experience some form of mental illness in their lifetime (National Institute of Mental Health [NIMH], 2021). Institutions which work with individuals suffering from mental illness have worked hard to remove the negative stigma often associated with these conditions. "Mental illness is nothing to be ashamed of! It is a medical condition, just like heart disease or diabetes" with support and treatment options available (APA, 2018, para. 8). Given that mental illnesses are so common and can impair an individual's ability to function at work, it was important for the present study to explore factors that influence employee participation in workplace mental wellbeing initiatives regardless of whether the employees had experienced or been diagnosed with a mental illness. This inclusive approach to the study design aimed to gain insight into how employers can encourage all employees, including those with a mental illness, to move along the mental health continuum towards flourishing.

Workplace Mental Wellbeing Initiatives

Workplace mental wellbeing initiatives are referred to in a variety of ways in the literature, including workplace wellbeing programmes (Spence, 2015), workplace interventions that promote mental wellbeing (Graveling et al., 2008), and worksite wellness programmes (Person

et al., 2010). For the purposes of this study, "workplace mental wellbeing initiative" or any derivative (i.e., wellbeing initiative) will henceforth be used to refer to any programme, intervention, or activity delivered in the workplace that promotes employee mental wellbeing and/or prevents employee mental ill-health (Graveling et al., 2008; Spence, 2015). When the workplace focuses on the mental wellbeing dimension, they may aim to prevent mental ill-health by offering initiatives that help employees cope with work-related stress or trauma, using services such as EAP counselling services, outplacement support, or critical incident de-briefing. They may also seek to promote mental health and wellbeing by offering initiatives that support "flourishing psychological health." These initiatives may include activities such as coaching, meditation, yoga, or positive psychology seminars (Spence, 2015, p. 111).

Employee Participation in Mental Wellbeing Initiatives

Defining employee participation in mental wellbeing initiatives is challenging because participation depends on factors such as the organisational context and the manner in which the initiative or programme is implemented (Crump, 1996). However, for the purposes of this study, employee participation refers to employees actively and voluntarily attending and engaging in workplace mental wellbeing initiatives (Linnan et al., 2001). Following Glasgow et al.'s (1993) recommendation, this study does not include "intent" to participate because employees often report their intentions but fail to follow through with actual participation. Employee participation also does not include "passive" participation, where employees participate indirectly or involuntarily but do not actively engage in the activity (Linnan et al., 2001). As Glasgow et al. (1993) noted, the most common definition of participation is registering for a programme or attending a preliminary meeting. While it is considered important for facilitators or providers of initiatives to establish the initial number of people entering into a particular programme, given that employees frequently drop out of interventions before completion, it may be preferable for providers to establish more continuous measures of participation (Glasgow et al., 1993). These may include calculating the percentage of sessions attended (e.g., 50 percent or more) or the percentage of days doing the activity (e.g., exercising). Using such measures would enable organisations to establish potential dropout rates.

The Social Construction of Mental Wellbeing, Mental Health, and Mental Illness

Historically, mental illness has been negatively portrayed in Western societies, leading to prejudice and discrimination against affected individuals. Cautin (2011) noted that in America between 1860-1890 individuals with mental illnesses were "disregarded or punished for 'deviant behaviour' that was believed to be the result of demonic possession or sinful transgression" (p. 4). While most of these individuals were initially cared for in their homes, some were considered too disruptive or behaved violently and were subsequently institutionalised in asylums (Cautin, 2011). In these asylums, patients were frequently physically restrained, given electric shock treatments, and injected with sedatives. Many were treated inhumanely (Shorter & Healy, 2007). Some of these controversial treatments have been used up until recently. For instance, at the time of writing, the Royal Commission of Inquiry into Abuse in Care was investigating what happened at the Child and Adolescent Unit at Lake Alice Psychiatric Hospital in the 1970's (Abuse in Care Royal Commission of Inquiry, 2021). Survivors of the abuse reported experiencing electric shocks, unmodified electroconvulsive therapy (ECT) (the administration of ECT without the prior administration of a muscle relaxant), paraldehyde injections (used to treat convulsions, seizures and fits, also used as a sedative or to induce sleep), sexual abuse, rape, drug abuse, physical abuse, psychological abuse, solitary confinement, and even torture by both patients and staff. While ECT is still used today, overall utilisation rates remain somewhat low, possibly due to the controversy surrounding the treatment (Fisher et al., 2017). Even as recently as the 1970's, individuals with mental disorders were sent to asylums due to 'ignorance' around mental illness and the belief that individuals with mental illnesses were 'defective' and 'incurable' (Smith, 2019). Historically, asylums have been associated with despair and hopelessness (Cautin, 2011). As Goffman (1968) noted, asylums have been referred to as 'madhouses', for 'lunatics' and people with 'sick behaviour'. This long-standing ignorance of mental illness has led affected individuals to feel shunned and/or embarrassed about their mental illness and has resulted in extreme stigma and fear surrounding mental health issues (Smith, 2019).

Fear of being stigmatised, discriminated against, or judged by others, often mean that affected individuals delay seeking help and treatment (Corrigan et al., 2014; Paterson et al., 2018). Rondinone (2019) noted that some of the discriminative terms and negative connotations of the mentally ill are still in use today, with the 'deranged mental patient' a popular Halloween costume or horror movie villain. These negative connotations and harmful stereotypes of the

mentally ill reinforce the stigma around mental health, causing negative attitudes towards mental illness and demarcating it from other more 'accepted' medical conditions (Domino, 1983; Rondinone, 2019). Stigmatising comments such as 'psycho', 'mad', or 'bonkers' have also become common in everyday language, such that they frequently go unnoticed (Shattell, 2009; Steele, 2012). Those suffering from mental illness often consider the fear of stigma or prejudice to be just as distressing as the symptoms of their mental health condition (Corrigan et al., 2014; HRD, 2014). In 2013, two of three people with mental health problems reported that they did not seek treatment due to fear of stigmatisation, discrimination, or judgement from others (The Canadian Medical Association [CMA], 2013). Corrigan et al. (2014) found that the stigma surrounding mental illness in its various manifestations (i.e., anticipated, enacted/experienced, or internalised) acts as a barrier: those who need help often do not ask for it. In a systematic review and meta-analysis of workplace psychological interventions, Carolan et al. (2017) found that only 15-43 percent of the working population seek help for mental health problems. Studies such as these provide the justification for the current study's exploration of the reasons for low help-seeking behaviours and the lack of participation in workplace mental wellbeing initiatives.

The literature suggests that changes in society over recent decades indicate a readiness to break away from the stigma surrounding mental illness to mitigate low help-seeking behaviours. In recent years, the social construction of mental health and wellbeing has instead shifted towards flourishing, moving "from repairing what is broken to nurturing what is best" (Meyers, 2013, p. 618). For example, to reduce stigma around mental illness, treatment for those with mental disorders in the UK in the 1960s transitioned from asylums to hospitals. Furthermore, mental health issues became more visible to the public in a "taboo ridden society" (Smith, 2019, para. 14). By the 1990's, it was no longer deemed acceptable for people with mental illness to be institutionalised in asylums and/or confined for prolonged periods of time. The increase of professionals working in psychiatry also began to alleviate the stigma, as well as the fear and misunderstanding around mental health and illness. However, despite these efforts, the stigma around mental health and illness has continued, partially as a result of the (popular) media's negative portrayal of mental illness and the representation of individuals suffering from these conditions (Corrigan et al., 2013; Smith, 2019). For example, Domino (1983) found substantial negative changes in participants' attitudes toward mental health professionals, mental hospitals and facilities, and mentally ill patients after viewing the 1975 film *One Flew Over the Cuckoo's Nest*, a drama about a psychiatric hospital with a nurse who abused her patients, forced them

to take medication, and treated them with electro-convulsion therapy. Vivid imagery in (tabloid) newspapers, television shows, and magazines that negatively portray and stereotype mental illness in order to "sell" emotive stories also reinforce perceptions of sufferers of mental disorders as 'dangerous' and 'unpredictable' (Benbow, 2007; Corrigan et al., 2014).

These harmful media portrayals still occur today. For example, Scarf et al. (2020) found that participants showed an increase in prejudice towards those with mental illness after watching the 2019 film *The Joker*, a psychological thriller about a mentally troubled man with a violent and nihilistic alter-ego: The Joker. Kenny et al. (2018) developed a Prejudice Toward People with Mental Illness (PPMI) scale, which 80 participants completed before and after viewing *The Joker*. Scarf et al. (2020) found that the mean PPMI increased from SD 2.99 (0.66) to 3.20 (0.78). This increase in prejudice may exacerbate the suffering of individuals with mental illness, and potentially increase self-stigma, an internalised stigma that individuals adopt when they experience discrimination in society. This stigma eats away at an individual's self-esteem and self-efficacy (Corrigan et al., 2014; Krajewski et al., 2013; MHF, 2021b). Self-stigma causes feelings of disgrace, shame, embarrassment, and self-loathing (Corrigan et al, 2014; Scarf et al., 2020; Toth & Dewa, 2014). These feelings can be more disabling than the mental illness itself because the individual may come to see their mental illness as a defining aspect of their core identity as opposed to just one feature of their lives (Mayer, 2020; MHF, 2021b; Penn & Martin, 1998).

The stigma and self-stigma associated with mental illness is also present in the workplace and can prevent employees from disclosing mental illness or distress at work, reaching out for job opportunities, or participating in workplace mental wellbeing initiatives (Haddon, 2018; Milot, 2019; Toth & Dewa, 2014). As Heenan (2006) noted, an individual may choose not to participate in workplace mental wellbeing initiatives due to fear of revealing that they are not coping mentally. They may believe that doing so may potentially limit their career opportunities or that participating in such programmes will result in negative career consequences (Toth & Dewa, 2014). Employees may also fear having details of their mental illness being noted in company records, that they will be given special treatment by their colleagues or managers, or that being treated favourably will be held against them in the future (Hanisch et al., 2016; Heenan, 2006). To prevent singling out individuals with a mental illness, the literature suggests that from the 2000's onwards, the focus shifted to promoting positive mental health for every individual, not just those with mental illness, through the promotion of

mental wellbeing (Froh, 2004; Smith, 2019). This focus aims to create a more inclusive approach to promoting mental wellbeing for all employees in the workplace, regardless of whether employees have experienced or been diagnosed with a mental illness.

One example of this societal shift towards more inclusive wellbeing promotion occurred in 2008 when the New Economics Foundation (NEF), on behalf of the Foresight Commission in the UK, developed *The Five Ways to Wellbeing* (Appendix A) (MHF, 2021a). This wellbeing model is a set of five evidence-based actions that anyone can use, whether or not they have a mental illness. If done regularly, these actions can improve an individual's wellbeing and foster personal growth (Aked et al., 2008). This model is now internationally recognised and focuses on the social relationships (connect), physical activity (be active), awareness (take notice), learning (keep learning), and giving (give). These actions are the wellbeing equivalent of the "five fruit and vegetables a day" rule (Aked et al., 2008; All Right, 2021). They are simple acts that every individual can do daily to feel good, build resilience, increase wellbeing, and reduce the risk of developing mental health issues (Aked et al., 2008). Research suggests that flourishing is higher in New Zealand workers who participate in *The Five Ways to Wellbeing* (Hone et al., 2015). This wellbeing model prevents singling out individuals with mental illnesses and aims to reduce the stigma or judgement associated with participating, therefore normalising these wellbeing activities. This widely recognised wellbeing model informs the present study by identifying a wider range of workplace mental wellbeing initiatives that can be included in the study that fall under each of the five themes presented above.

Another example that demonstrates society's readiness to promote wellbeing for every individual is the New Zealand Labour Government's first-ever wellbeing budget. In 2019, they injected $1.2 billion into mental health programmes in a response to the *Government Inquiry into Mental Health and Addiction* (Government of New Zealand, 2019; Paterson et al., 2018). This inquiry included mental health problems across the complete spectrum, from minor mental distress to enduring psychiatric illness (Paterson et al., 2018). Covering the full spectrum of mental health indicates that mental wellbeing is important for everybody. This view differs from earlier government strategies or workplace programmes that exclusively target individuals with mental illnesses, which may reinforce their feelings of ostracisation or shame (MHF, 2021b). The present study adopts this inclusive approach by advising what workplace mental wellbeing initiatives may cover the complete spectrum of mental health in order to assist every individual to move towards flourishing. For instance, initiatives for minor

mental distress may include yoga or mindfulness lessons, and initiatives for more enduring mental illnesses may include EAP counselling, coaching, or mentoring.

Today, mental health advocates and spokespeople are helping to change societal attitudes around mental health and wellbeing. New Zealand rugby legend Sir John Kirwan is a mental health advocate who has contributed to changing public perceptions and attitudes towards mental health issues in New Zealand since the Government's National Depression Initiative, *Depression.org*, developed in 2006 (Health Navigator, 2020). In 2020, Sir John Kirwan released a mental wellbeing app called *Mentemia*, intended to be for "everybody every day." The app encourages users to do simple daily activities that support their mental wellbeing (Campbell, 2020). These activities include breath training to control stress, daily mood tracking, or choosing to engage in small acts of kindness, such as reconnecting with an old friend or making someone laugh (Mentemia, 2020). Various other wellness apps have also increased in popularity over the last ten years, including *Calm* and *Headspace*, mindfulness and guided meditation apps aimed at improving sleep and reducing stress and anxiety (Wortham, 2021). These are just a few of many examples that suggest a change and readiness to promote and normalise mental wellbeing as a form of self-realisation. However, these examples of apparent readiness are slight when compared with the long-standing stigma and negative perceptions around mental health. Thus, it is not surprising that participation rates in such wellbeing activities remain low.

Mental Wellbeing in Organisations

After decades of workplace health and safety overlooking psychological health, organisations have begun to make efforts to normalise and promote mental wellbeing in the workplace. In 2013, the Canadian Mental Health Commission developed The National Standard of Canada for Psychological Health and Safety in the Workplace, the first standard in the world to offer guidelines designed to create psychologically safe work environments (Canadian Medical Association, 2019). Employers are increasingly recognising that poor mental health, including minor periods of mental distress, can negatively impact an employee's job performance and wider organisational outcomes (Sonnentag, 2015). It is in an organisation's best interest to support and promote employee mental wellbeing in the workplace because work affects wellbeing and wellbeing is important for organisational success (Hone et al., 2015; Keeman et al., 2017). Employee wellbeing has become increasingly salient since the Coronavirus

(COVID-19) pandemic, which has left employees grappling with rapid and significant change, uncertainty, anxiety, and fear (Usher et al., 2020). Some employees have been forced to adjust to working remotely, making it increasingly difficult to separate work and home life (Carnevale & Hatak, 2020). Consequently, employees may have encountered challenging work and family conflicts such as home-schooling children or caring for elderly relatives. Those living alone are at a greater risk of experiencing feelings of isolation, loneliness, a lack of purpose, and other associated negative effects on wellbeing as a result of the pandemic (Carnevale & Hatak, 2020). Economic concerns, COVID-19 fatigue in the news, and frequent reminders of death also exacerbate these challenges and further threaten employee wellbeing (Sinclair et al., 2020).

Historically, employers have tended to focus on reducing employee ill-health, such as reducing stress and burnout, as opposed to increasing employee wellbeing (Hone et al., 2015). Sonnentag and Frese (2012) compiled empirical evidence from 70 longitudinal papers and found a positive relationship between job stress and negative psychological wellbeing. Furthermore, studies have found that high levels of stress cause absenteeism (Jensen et al., 2019). In 2018, New Zealand lost 7.4 million working days due to sickness absence, costing the country's economy $1.79 billion, with mental wellbeing/stress listed as the fifth most common driver of absence (BusinessNZ, 2019). In recent years there has been an increase in employees taking 'mental health days' where stress leave is negotiated with employers (Employment New Zealand, 2020). Stress and burnout can also increase organisational turnover. As Haddon (2018) noted, approximately 25 percent of employees suffering from burnout will eventually leave their jobs. In 2020, after nearly a year of coping with the COVID-19 pandemic, the workplace absenteeism cost associated with mental health-related absences in the UK reached £14 billion GBP (nearly $27 billion NZD) with absences due to mental health challenges increasing by 10 percent since 2019 (Capper, 2021).

Of growing concern to employers is the rise in presenteeism, where employees attend work despite a medical or mental illness which should keep them away from work (Evans-Lacko & Knapp, 2016; Halbesleben et al., 2014). The *Health and Well-Being at Work Survey Report* published by the Chartered Institute of Personnel and Development (CIPD) revealed that 89 percent of respondents had witnessed presenteeism in their workplace over the last year and that a further 27 percent believed that this number was increasing (CIPD, 2020). Presenteeism can be motivated by extrinsic pressures as well as intrinsic motives (Sinclair et al., 2020).

Employees often attend work while unwell due to extrinsic pressures such as high workloads, staffing challenges, and strict absence policies (Johns, 2010; Miraglia & Johns, 2016). Intrinsic motives that influence employee presenteeism include affective commitment (Miraglia & Johns, 2016), employees' perceiving their work to be a public service (Jensen et al., 2019), and employees genuinely, intrinsically caring about the outcome of their work on their employer and customers (Sinclair et al., 2020). As Halbesleben et al. (2014) noted, individuals suffering from mental health issues feel pressured to continue to attend work because they are not visibly injured or unwell. Employees may fear disciplinary action by their managers or fear job consequences, such as missing out on a promotion as a result of taking time off (McKevitt et al., 1998). Employees may also fear that others will interpret their absence as illegitimate or unjustified. They may also perceive pressures from colleagues or managers to attend work (Grinyer & Singleton, 2000). This fear can generate feelings of guilt for employees who take sick leave, making them feel obliged to attend work while mentally unwell. As a result, individuals with mental health issues are "at work, but out of it"; mentally 'absent', distracted, unable to focus, and/or less productive (Hemp, 2004, para. 1). One study estimated that the organisational cost of presenteeism related to mental health issues is five to ten times greater than the costs of absenteeism (Evans-Lacko & Knapp, 2016). This is because presenteeism prevents an employee from taking the necessary time off to recover, potentially exacerbating their mental illness or distress, or leading to other problems such as fatigue, irritability, decreased motivation, poor concentration, additional time required to accomplish tasks, and increased accidents or errors in the workplace due to impaired function (Halbesleben et al., 2014; Johns, 2010).

Employers are beginning to understand the various negative consequences of employee mental ill-health described above, and as a result are beginning to understand that a mentally healthy workforce leads to positive organisational outcomes (Dimoff & Kelloway, 2017; Grawitch & Ballard, 2016; Keeman et al., 2017). High mental wellbeing benefits the individual, as they experience increased motivation, self-efficacy, and feel that they are developing professionally in meaningful work (Di Fabio, 2017; Yeoman et al., 2019). When the workplace promotes employee mental wellbeing, the organisation acts as an incubator for learning and developing, allowing employees to achieve their inherent desire for self-realisation and flourishing (Yeoman et al., 2019). Employees that are able to thrive mentally also positively impact those around them. Their positive mood impacts group dynamics, making employees more able to work in peaceful and productive collaborations and boosting workplace morale (Di Fabio et

al., 2016; Lewis, 2016). In addition, when employees feel that they are valued and supported mentally by their managers, manager-subordinate relationships improve, increasing employee commitment and performance at work (Fernet et al., 2015, Inceoglu et al., 2018). Wider organisational outcomes are also improved, as employees feel adequately challenged and can cope with their workloads, turnover is decreased, costs associated with absenteeism and presenteeism are reduced, and the organisation's productivity is increased (Grawitch & Ballard, 2016; Guerci et al., 2019). Organisations that offer workplace programmes for physical and psychological health have observed increases in employee self-esteem, job satisfaction, and organisational commitment (Dimoff & Kelloway, 2017). For example, the introduction of an employee counselling programme at a UK post office led to a 60 percent decrease in absenteeism and a considerable increase in employee life satisfaction (Allison et al., 1989).

As organisations have become increasingly aware of the positive organisational outcomes of protecting and supporting employee mental health, employers have started to do more to promote and build employees' mental wellbeing in the workplace (Sonnentag, 2015). Employers have attempted to improve staff engagement to enhance employees' experiences of dedication, energy, growth, and thriving at work (Schaufeli & Bakker, 2004; Spreitzer et al., 2005). Another way employers have sought to promote mental wellbeing is by negotiating flexible working arrangements, through flexitime, working from home, and job-sharing schemes (Dimoff & Kelloway, 2019; Russell et al., 2009). These flexible work arrangements have been found to be effective in improving employee mental ill-health by minimising work pressures and balancing work-life conflicts, benefitting both the employer and the employee (Hornung et al., 2008). Thomson (2008) found that flexible working arrangements in an organisation in the UK resulted in a 27 percent reduction in employee turnover, a 50 percent reduction in sickness absence, and an increase in employee satisfaction, from 60 percent to 89 percent. While these workplace benefits are important and recommended strategies for supporting employee mental wellbeing, they are not initiatives, and will therefore not be discussed in further detail as they extend beyond the scope of the study. Alongside these workplace benefits, organisations have started offering corporate wellness programmes designed to encourage healthier lifestyle choices for employees, such as healthy eating, smoking cessation, weight loss, or exercise programmes (Kohll, 2018; Linnan et al., 2001; Person et al., 2010) and initiatives that promote employee mental wellbeing (Bolier et al., 2013; Graveling et al., 2008; Spence, 2015). As Sutton et al. (2016) noted, many organisations

consider these wellbeing programmes as central to employee engagement and performance strategies.

One of the most adopted workplace wellbeing programmes worldwide is EAP, a programme which helps employees experiencing work or personal-related challenges (Kirk & Brown, 2003). As McLeod (2010) noted, EAP counselling has been found to be effective in improving psychological outcomes, reducing sickness absence, and improving employee attitudes towards work. However, a lack of utilisation of EAP hinders its effectiveness. McRee (2017) and Milot (2019) determined that current perceptions of mental health and the associated stigma have negatively impacted upon EAP utilisation. Various studies across a range of industries puts the overall percentage of employees utilising EAP between 1-5 percent. According to Attridge et al. (2013), while 98 percent of medium to large organisations in the United States offer EAP to their staff, only 4 percent use it each year. Significantly, McRee (2017) noted that the estimated mental ill-health rates are much greater than the EAP utilisation rates. Dimoff and Kelloway (2019) supported this argument, noting that one in five adults in North America experience a mental health problem every year, meaning that EAP is "grossly underutilised" (p. 5). Robroek et al.'s (2009) systematic review found that workplace educational or counselling interventions had the lowest levels of initial participation (they never exceeded 47 percent), compared with fitness interventions which had initial participation levels of 53 percent and multi-component interventions of 64 percent. These results suggest that employees were less likely to seek help for mental struggles (Bamberger, 2009). These findings are concerning, as the HRD explained, "EAPs are designed to promote positive organisational behaviour, enhance employee wellbeing, and improve workplace productivity. It is a confidential service that is free of charge to employees… it is difficult to understand why the usage rates can be so low" (2014, para. 3).

Alongside EAP's, in more recent years, workplaces have begun to incorporate elements of positive psychology into workplace wellbeing initiatives, which may include self-help activities such as counting blessings, using gratitude journals, or practising mindfulness (Winslow et al., 2017). Meyers et al.'s (2013) systematic review found that workplace positive psychology interventions are a promising tool in improving employee wellbeing and performance as well as reducing stress, burnout, and to a lesser extent, depression and anxiety. Bolier et al. (2013) also conducted a systematic review of positive psychology initiatives delivered in the workplace via the internet. Using a pre-test/post-test method and effect sizes

(Cohen's d) to measure the effectiveness of these interventions, Bolier et al. found a small effect on subjective wellbeing d = 0.34 (95% CI [0.22, 0.45], p<.01) and psychological wellbeing d = 0.20 (95% CI [0.09, 0.30], p<.01). These findings suggest that web-based initiatives were somewhat beneficial to employee mental wellbeing. Aikens et al. (2014) found that an online mindfulness programme resulted in reduced stress and increased resilience, vigour, and engagement compared to the control group. It short, the programme was effective at enhancing mental wellbeing. Seligman et al. (2005) found positive effects from writing about positive events each day up to six months after the intervention. However, as participation in this intervention was voluntary, it is conceivable that participants were more invested than others in improving their mental wellbeing.

More recently, some organisations have begun to adopt somewhat unconventional or non-traditional workplace mental wellbeing initiatives such as onsite meditation rooms, mindfulness training, massage therapy, and art and play therapy to support employee wellbeing (Aikens et al., 2014; Dimoff & Kelloway, 2019; Huet & Holttum, 2016). Aikens et al. (2014) conducted a mindfulness programme in an organisation and found that those who participated experienced significant decreases in perceived stress. They also experienced increased mindfulness, personal resilience, and vigour. Huet and Holttum (2016) used art therapy to manage work-related stress with 20 employees across four health and social care sites. Of those who participated, 65 percent found the process to be psychologically beneficial. However, as this study had a small sample size and the participants chose to participate, the results may not have adequately reflected the efficacy of the intervention. Nel and Spies' (2007) mixed method's study investigated the use of play and art in the workplace as a stress management initiative. Corporate employees were interviewed before and after the interventions. Findings indicated that both types of therapy positively impacted participants' mental wellbeing, improving every participant's stress levels, and educating them about how to identify and control stressors more effectively. In 2017, UnitedHealthcare conducted a "Wellness Check-up" survey with 609 full-time employees across the US and found that almost 60 percent of respondents with access to a workplace wellness programme felt that the initiative had positively impacted their health and wellbeing (Kohll, 2017). A Harvard Business Review survey of 465 full-time employees found that those who had participated in their workplace's health, wellness, or fitness programme experienced greater satisfaction with the offered initiatives, considered their health to have improved, their productivity to have increased, and felt that their attitude toward their employer was more positive (McManamy, 2016).

While the above outcomes are encouraging, they are contingent upon employees actively engaging in the wellbeing initiatives on offer. Dimoff and Kelloway (2019) and Linnan et al. (2008) noted that despite an increase in the available options, very few employees utilise wellbeing-related resources to their full potential, if they use them at all. In fact, participation rates are typically below 50 percent and often significantly lower (Corrigan et al., 2014; Robroek et al., 2009). Nel and Spies (2007) reported that only 18 percent of employees participated in a stress management wellbeing initiative. While Nel and Spies felt this was an ideal sample (12 employees) to facilitate group interaction, this small sample size reaffirms the lack of employee participation. Carolan et al. (2017) noted that adherence and engagement were the two biggest difficulties with implementing an Internet-based wellbeing intervention. They are also important determinants of intervention effectiveness. As Kohll explains, "A wellness program is nothing without employee participation. Employers are usually left scratching their heads as to why some employees take full advantage of the wellness program while others do not" (2017, para. 1).

Given the limited research on workplace mental wellbeing initiatives, this study borrows from related literature on participation rates in broader workplace health promotion interventions (such as exercise, smoking cessation, or healthy living programmes) or community-based mental health services (Dillon et al., 2020; Little et al., 2019; Robroek et al. 2009). As Linnan et al. (2001) noted, participation rates in workplace health promotion interventions have historically been low and improvements have not been reported for some ten years. For instance, Person et al. (2010) reported an overall participation rate of 10.4 percent in a healthy living programme. McLellan et al. (2009) investigated workplace sociocultural attributes and participation in health assessments. They found an overall participation rate of 23 percent (the actual rate varied widely - from 10 percent to 86 percent). Robroek et al.'s (2009) systematic review of determinants of participation in workplace health promotion interventions found that the median participation level in 23 studies was 33 percent (the rates varied greatly, from 10 percent to 64 percent).

Another issue related to participation is the tendency for employees to drop out of initiatives before completing the programmes. In Bolier et al.'s (2014) study, baseline participation rates for an online workplace mental wellbeing intervention were 32 percent. Of these participants, 61 percent failed to complete the programme. In another study, Person et al. (2010) reported an initial participation rate of 50 percent in a healthy living programme. By the second session,

participation had dropped to 22 percent, 14 percent in the third session, 4 percent in the fourth session, and 1 percent in the fifth session. No employees participated in any more than five of the 10 offered sessions. The study's participants listed insufficient incentives, inconvenient locations, and time limitations as the top reasons that prevented them from participating or completing the initiatives (Person et al., 2010). The literature suggests that adherence to self-help interventions tends to be particularly low. This low adherence has been attributed to the fact that messaging tends to be universal and not tailored to the diverse needs of individual users (Boiler et al., 2013; Schueller, 2010). As Winslow et al. (2017) noted, individual differences and contextual factors such as tenure, may impact intervention participation rates and subsequently, a programme's effectiveness. For example, some employees may be personally motivated to improve their mental wellbeing by utilising initiatives while others are less inclined. Similarly, newer employees may feel less burnt out than more tenured employees, perhaps perceiving less need to improve their mental wellbeing by utilising workplace wellbeing initiatives. Weiss et al. (2016) found that interventions that were delivered on an individual face-to-face basis had a stronger impact compared to self-help or group interventions. Conversely, Carolan et al. (2017) found that adherence was highest in Internet-based interventions because there was increased accessibility, flexibility, and anonymity. These different results suggest that organisations have not yet determined the most effective ways to support employee mental wellbeing, as employees have diverse needs and preferences around mental wellbeing. These conclusions also suggest that there are current gaps in knowledge, which the present study aims to address.

Gaps in Literature and Project Justification

The literature review has identified several areas that have been underexplored. There is limited empirical research which has examined the reasons for low employee participation rates, or more specifically, barriers and enablers to employee participation in workplace mental wellbeing initiatives. Hence, as mentioned previously, this study borrows from a wider range of related health promotion and mental health help-seeking literature, as it may identify barriers that also apply in the context of workplace mental wellbeing initiatives (Dillon et al., 2020; Little et al., 2019; Robroek et al. 2009). Additionally, Corbin and Strauss (2008) argue that ignoring related information can be counterproductive as it may lead to results that have already been found in previous research. For instance, previous studies have identified mental health stigma as a significant reason for lack of employee participation in workplace health promotion

and mental wellbeing initiatives (Butterworth, 2001; Hanisch et al., 2016; Milot, 2019; Szeto & Dobson, 2010; Toth & Dewa, 2014). Mellor and Webster (2013) identified other barriers/challenges in implementing a workplace health and wellbeing approach, such as integrating various systems into a coherent whole, finding an appropriate balance between occupational and employee lifestyle risks, managers' readiness to focus on employee wellbeing, managers' ability to monitor employees' health-related needs, and a target-driven organisational culture. However, these challenges were in relation to the implementation of initiatives and did not focus specifically on employee participation in these initiatives. Further, the study focused on the managers' views, not on the employees' views.

While other possible barriers have been suggested in the literature, they have been insufficiently explored in the context of the workplace. For instance, poor mental health literacy (understanding of mental health) and the desire to handle mental wellbeing on one's own have been identified as barriers to mental health help-seeking in the community (Corrigan et al., 2014; Gulliver et al., 2010). Studies have also identified beliefs around the ineffectiveness of interventions, perceived cultural barriers, the irrelevance of interventions, and a perceived lack of support as barriers to participation in community-based mental health services (Corrigan et al., 2014). Other studies have identified confidentiality and trust, concerns about the characteristics of the provider of mental health services, knowledge of mental health services, fear or stress regarding seeking help, a lack of accessibility, a difficulty or unwillingness to express emotion, not wanting to burden anyone, and seeking help elsewhere as barriers to seeking help for mental health issues for young people (Gulliver et al., 2010). Dillon et al. (2020) examined facilitators and barriers to participation in community mental wellbeing programmes for vision impaired elderly. They found that a lack of awareness of available programmes, difficulties accessing the services, and a lack of insight into their own mental health issues were barriers to participation. Another study noted that the framing or labelling of mental wellbeing interventions may also be a potential barrier to participation in workplace wellbeing initiatives (Slade, 2010). To date, these barriers have been identified in workplace health promotion (i.e., exercise) or community-based mental health services (not workplace mental wellbeing initiatives) or have merely been put forward as *proposed* barriers that *might* affect employee participation in mental wellbeing initiatives. There is a lack of empirical research that examines whether, and more importantly how, such barriers might influence employee participation in workplace mental wellbeing initiatives.

One identified barrier to participation in workplace fitness initiatives was that the content of the fitness programmes did not cater for diverse population characteristics (Robroek et al., 2009). Person et al. (2010) found that the most commonly reported barriers to participation in a healthy living programme were "insufficient incentives, inconvenient locations, time limitations, not interested in topics presented, undefined reasons, schedule, marketing, health beliefs, and not interested in the program" (p. 149). Spence (2015) proposed service-needs misalignment (little relevance or interest to employees), time and work pressures, and limited access to resources as barriers to employee participation in WorkWell programmes (health and wellbeing programmes that focus on health promotion as well as illness prevention). Spence also proposed 'change readiness' as a potential cause of low participation, suggesting that some employees may not feel psychologically ready to commit to personal change. For instance, while many smokers recognise that smoking is unhealthy and harmful, they are not always ready to invest the effort to quit and instead, remain in a state of contemplation or ambivalence unless provided with opportunities and incentives to their improve behaviour. In contrast, some individuals may not be interested in health promotion programmes because they do not perceive a need to improve their health (Gulliver et al., 2010). Others may believe that their health and wellbeing is their own responsibility, not their employers' responsibility (Spence, 2015).

Investigating participation in workplace exercise initiatives, Little et al. (2019) found that employees may perceive organisational wellbeing initiatives as 'box-ticking' and 'half-hearted' attempts at improving employee wellbeing, without genuine concern or compassion. Such perceptions led employees to actively disengage in the initiatives. These employees perceived manager's intentions as disingenuous and believed that the initiatives were only in place so that the organisation could appear to be benevolent. In a similar vein, Carmichael et al. (2016) found that the most commonly reported reasons for employers to introduce wellbeing programmes were economic, with the primary intention to increase employee productivity and reduce absenteeism as opposed to sincerely supporting employee wellbeing. Similarly, Spence (2015) noted that WorkWell programmes can be perceived by employees as a tool to enhance an employer's brand or to give the impression that the organisation is a good place to work. Spence also noted that since the HR function has shifted away from employee welfare and professional development toward strategic goals and worker performance, promoting WorkWell initiatives may be perceived by employees as fulfilling a strategic agenda as opposed to genuinely attempting to look after employees' health and wellbeing.

Rossing and Jones (2015) conducted a case study of workplace exercise initiatives and found that social comparison and competitiveness were barriers to participation. Further, Linnan et al. (2001) found that larger social or contextual factors, such as social comparison, may be barriers to participation in workplace health promotion programmes, even for employees who are highly motivated to participate. Social comparison in physical exercise may apply to mental wellbeing initiatives as employees may feel that they are not mentally coping as well as others. In the context of play related mental wellbeing initiatives, competitiveness may also be a barrier. As Ward-Wimmer (2003) noted, play becomes more competitive in adulthood and is associated with winning, losing, and even cheating. Robroek et al. (2009) and Glasgow et al. (1993) found that men were less likely to participate in workplace health promotion activities. This finding could also apply in the context of workplace mental wellbeing. Men are typically less willing to show weakness or speak about emotions and thus may be less likely to participate in mental wellbeing activities (McKelley & Rochlen, 2007). There is limited research that examines whether barriers to participation in mental wellbeing initiatives apply in the same way as they have been shown to do in workplace health promotion initiatives or community-based mental health services. Drawing on a similar field of knowledge may provide important insights into factors that influence employee participation in workplace mental wellbeing initiatives.

Another significant gap in the literature is that employee perspectives and experiences have been historically underrepresented in extant literature (Bright et al., 2012; Spence, 2015). Bright et al. (2012) noted that "literature enumerating employee attitudes and barriers to participation in [wellness] programs is sparse" (p. 531). Mellor and Webster's (2013) study is a case in point: they only interviewed managers about the implementation of a health and wellbeing approach and did not report employees' perspectives. Similarly, Russell et al. (2016) also emphasised the managers' perspectives, interviewing 13 managers and only eight employees. When research has typically focused on employees, it has tended to examine employees' characteristics (Joslin et al., 2006), superficially compare participants and non-participants in terms of demographic and lifestyle factors (Breslow et al., 1990), or examine the benefits of employee participation (Nohammer et al., 2011). Edwards and Marcus (2018) suggested that future research should use qualitative interviews in order to uncover employees' narratives of wellbeing initiatives in the workplace and how they can enhance an individual's quality of life and productivity.

Another gap identified in the literature is that very few studies have examined barriers or enablers to employee participation in workplace mental wellbeing initiatives. While many studies in the literature examined the effectiveness or efficacy of workplace wellbeing initiatives, they did not examine employee barriers and enablers that may influence participation (van Agteren et al., 2021). Graveling et al. (2008) conducted a review of workplace interventions for mental wellbeing and found that none of the 66 studies they investigated systematically addressed barriers or enablers to participation, for either employers or employees. Similarly, in a systematic review of 51 studies utilising workplace positive psychology interventions, no studies reported employee barriers or enablers to participation (Meyers et al., 2013). Robroek et al. (2009) noted that 80 percent of the studies in their review failed to report determinants of non-participation (i.e., barriers) and that this information would be beneficial for understanding selective participation. As Seligman et al. (2005) argued, the effectiveness of interventions may only be measured based on voluntary participation. Few studies addressed how to effectively reach individuals that may be particularly resistant to participating in mental wellbeing interventions. Spence (2015) also found that WorkWell initiatives are typically not rigorously evaluated, which suggests that employers do not typically consider challenges and successes associated with the implementation of wellbeing initiatives. Similarly, McCarthy et al. (2011) reported that 46 percent of 319 surveyed HR professionals did not attempt to assess the impact of their wellness initiatives, meaning they had no knowledge of barriers and enablers to participation.

Another prominent gap in the literature is that enablers (sometimes referred to as facilitators) that would encourage employee participation in mental wellbeing initiatives were comparatively underexplored in existing research. Corrigan et al. (2014) argued that merely removing barriers, such as stigma, is insufficient on its own: it has not been enough to increase participation in mental wellbeing activities. They contend that scholars must also consider enablers. Gulliver et al.'s (2010) systematic review found that of 22 studies on perceived barriers and facilitators to mental health help-seeking in young people reviewed, only three qualitative studies reported enablers to help-seeking. Significantly, none of the quantitative studies mentioned enablers. Person et al. (2010) focused exclusively on barriers to participation in a workplace health promotion programme about nutrition and other health-related subjects: they did not mention potential enablers. While Dillon et al. (2020), Gulliver et al. (2010), and Quirk et al. (2018) addressed enablers, the former two studies were not in the context of the workplace. Furthermore, the latter only focused on the managers' enablers, not those of the

employees whom the interventions were designed for. Dillon et al. (2020) found that interview participants tended to discuss barriers more than facilitators. Of the 12 themes identified in their study, eight were barriers and only four were facilitators. Similarly, Mellor and Webster (2013) focused more on the challenges or barriers in implementing a workplace health and wellbeing programme than they discussed enablers. As mentioned previously, Spence (2015) proposed several possible factors that may positively influence employee participation, such as alignment with employees' needs, changing organisational norms, addressing change readiness issues, motive transparency, and genuine commitment to systemic change. However, Spence (2015) noted that these are merely developing hypotheses and should be examined in future research to provide evidence-based knowledge of whether they actually influence employee participation rates.

Armour (2020) noted that future research needs to investigate eudaimonic wellbeing, exploring the individual's subjective experience of pursuing personal excellence. It has been underexplored in the literature, particularly when compared to hedonic wellbeing, which is generally focused on surviving, not thriving. As previously discussed, the current study considers both hedonic and eudaimonic wellbeing, positive psychology, and human flourishing to establish if this positive view of mental wellbeing still has a persistent stigma associated with it in the workplace, and more specifically, whether it hinders participation, or if there are other barriers that are not currently understood.

The final gap identified in the literature is that most studies on mental wellbeing in the workplace utilised quantitative approaches, using methods like structured questionnaires with closed item scale responses, pre and post-tests of intervention effectiveness, and systematic reviews (Gulliver et al., 2010; Lakerveld et al., 2008; Linnan et al., 2010; Rongen et al., 2014). The lack of extant theory on the barriers and enablers to participation suggest that a qualitative approach is appropriate for this study, as it allows us to explore *why* there is low participation. Various studies (Armour, 2020; Hallaway, 2020; Skakon et al., 2010) suggest that future research should take an exploratory, qualitative approach, like a case study approach, to gain a richer understanding of employees and managers subjective account of mental wellbeing in the workplace. Very little use has been made of the case study method in the literature on employee participation in mental wellbeing initiatives. While Quirk et al. (2018) utilised a case study, it failed to address the perspectives of the employees' perspectives on perceived barriers and enablers to participation: it focused solely on employers. Similarly, Dillon et al. (2020)

conducted a case study on barriers and facilitators to participation in mental wellbeing programmes for vision impaired elderly. However, this was not in the context of the workplace. This context means that most of the identified barriers and facilitators are unique to the vision loss context and not applicable to this study. Using a systematic review, Gulliver (2010) has argued that future studies should employ qualitative methods as qualitative data may provide deeper insights than quantitative methods. The gaps in the literature highlight the need for further research to explore in-depth employees' barriers and enablers to participation in workplace mental wellbeing initiatives in order to identify ways that might facilitate and encourage sustained participation. The identification of these gaps in the literature led to the development of the present study and informed the research questions.

Summary

This review has examined the existing literature on mental wellbeing, mental health, and mental illness, defined these key constructs, and outlined how attitudes around them have changed over time. The literature on mental wellbeing in the workplace suggests that employers are increasingly aware of the benefits of having a mentally thriving workforce as well as the consequences of having staff who are exhibiting signs of poor mental health, which is particularly relevant during the COVID-19 pandemic. The review found that historically there have been very low rates of employee participation in workplace mental wellbeing initiatives. It also identified several current gaps in the literature. These gaps include an underrepresentation of employees' perspectives, a lack of qualitative, in-depth, and exploratory research, and a lack of emphasis on enablers that can enhance sustained employee participation. The review has identified opportunities for the present study to address these gaps and has informed the study's methodology, which is outlined in the following chapter.

Chapter Three: Methodology

Introduction

The previous chapter has shown that there is a lack of existing research which examines specific barriers and enabling factors that influence employee participation in workplace mental wellbeing initiatives. Furthermore, most studies in this area employ a quantitative approach. In response to these findings, I decided that a qualitative and abductive approach was the most appropriate for this study. This chapter presents the rationale for this choice of methodology and the specific use of a case study design. The chapter commences with a discussion of the ontological, epistemological, axiological, and methodological assumptions that underpin this study. The chapter then explains the research design, the data collection process, and how the material was analysed. The chapter also includes a discussion of the steps that were taken to ensure the findings' trustworthiness. The chapter concludes by outlining the study's ethical considerations.

Philosophical Considerations

In any research project, it is crucial to ensure that the research questions, the research paradigm, and the research design all align. In order to choose an appropriate methodology, the researcher must first consider which approach is most suitable to address the research questions (Corbin & Strauss, 2008). The aims, purpose, and context of the research, as well as the researcher's ontological and epistemological assumptions about the world and the nature of knowledge inform this choice (Denzin & Lincoln, 2011). A comprehensive examination of the philosophical assumptions that underpin the study is presented below.

Ontology is concerned with the nature of reality or what the researcher considers to be 'real' (Creswell & Poth, 2016; Guba & Lincoln, 1994). Two ontological positions, realism (objectivism) and relativism (subjectivism), are typically conceptualised as existing on opposite ends of a continuum. At one end of the continuum, the realist ontology assumes that a single objective reality exists and that this reality is independent of human thought or perception (Bisman, 2010). The realist ontology sees reality as a concrete structure that can be viewed 'as it is', considered external to the subject, and seen as if through a one-way mirror (Chua, 1986; Guba & Lincoln, 1994). On the other end of the continuum, relativism assumes that there are multiple realities and that these are socially constructed (Tashakkori et al., 1998).

This ontological position is not concerned with single truths, absolute facts, or universal meaning. It embraces the idea that multiple realities can exist in the minds of individuals because reality is socially constructed and developed intersubjectively based on an individual's unique ideas and perceptions of the world (Llewellyn, 2007). Relativism assumes that, "reality is subjective, relativistic or self-referential, and non-material, and is therefore internally experienced, interpreted and constructed by the mind" (Bisman, 2010, p. 5). This view accepts multiple realities and believes that all realities are equally valid (Llewellyn, 2007).

Epistemology concerns the nature of knowledge and what is considered acceptable knowledge or 'truth' (Chua, 1986). A realist ontology is generally aligned with a positivist epistemology which suggests that acceptable knowledge is objective, with concrete facts that can be identified with precision and certitude. In short, this ontology believes that reality is unable to be influenced by a researcher's values and biases (Crotty, 1998; Guba & Lincoln, 1994). In contrast, a relativist ontology is more likely to be aligned with an interpretivist or constructivist epistemology which considers acceptable knowledge as subjectively created by the researcher and those they research (Guba & Lincoln, 1994). Interpretivist or constructivist epistemologies view the relationship between the knower and the known as inseparable (Tashakkori et al., 1998). Similarly, the investigator and the object of investigation are inextricably and interactively linked. In short, the researcher and research subjects co-create the findings as the research progresses (Guba & Lincoln, 1994). Researchers operating within this paradigm acknowledge that there is no universal meaning because no one can fully understand the intricacies of someone else's mental world. For the interpretative scientist, this is considered acceptable knowledge (Llewellyn, 2007).

Axiology is concerned with values and how the researcher's values, ethics, and moral conduct influence the research process (Guba & Lincoln, 2002). The realist ontology and epistemology consider research to be value-free because the researcher reports findings in an unemotional way, writing in distant third person language. The researcher believes that their personal subjectivity does not enter into the research process (Tashakkori et al., 1998). In stark contrast, the relativist ontology and epistemology consider research to be value-bound because the researcher cannot entirely divorce themselves from their own values, norms, or biases. Thus, the researcher's values, as well as those of the participants, may impact the research outcomes (Creswell & Poth, 2016; Llewellyn, 2007; Tashakkori et al., 1998). I accept that this research

is value-bound and freely acknowledge my personal values and beliefs and consider how they may impact on the research.

Taking into account my personal philosophical stance, this study adopts an interpretivist research paradigm. While interpretivism and constructivism are closely related paradigms and the terms are often used interchangeably, there are subtle differences between the two. Without disregarding the significance of these differences, for the pragmatic researcher they are considered minor. Both paradigms, "share the goal of understanding the complex world of lived experience from the point of view of those who live it" (Schwandt, 1994, p. 221). They seek to interpret the meanings that different actors construct of the social world. The interpretivist paradigm aligns most closely with my own ontological beliefs about the social world. Accordingly, the two paradigms are henceforth referred to under the umbrella term 'interpretivism'.

In this study, I adopted a relativist or subjective ontology, due to my belief that there are multiple, socially constructed realities and that individuals interpret the world differently. It followed that I would adopt an interpretivist epistemology, considering acceptable knowledge to be subjective and created via the interactive relationship between the researcher and the subject of investigation. I also acknowledge and accept that this study is therefore value-bound, as I bring my own values and potential biases to the research process. While these values possibly impact the study's outcomes, I explain below the steps I took to ensure the validity of the findings.

Methodology refers to "the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes" (Crotty, 1998, p. 3). The choice of methodology should be informed by the research questions as well as one's ontological and epistemological assumptions and beliefs. The research methods (the actual tools, processes, and techniques utilised in collecting and analysing data) are subsequently informed by the chosen methodology (Walliman, 2017). Positivist studies generally employ quantitative, objective research methods such as surveys, questionnaires, and experiments while interpretivist studies tend to favour qualitative research methods such as interviews, observations, and focus groups (Creswell, 2017).

Scholars recommend using a qualitative approach to answer 'why', 'how', and less commonly 'what' research questions (Yin, 2017). This means it is an obvious choice for this study. As explained in Chapter One, this study seeks to understand 'why' there is low participation in workplace mental wellbeing initiatives, what factors positively or negatively influence employee participation, why those factors are experienced as problematic, or how they are perceived to enhance or encourage participation. These questions have not been adequately addressed in previous studies on workplace mental wellbeing initiatives. Furthermore, existing research on similar topics has predominantly employed quantitative approaches meaning that they do not provide detailed insight into why or how certain factors impede or enhance participation. In contrast, qualitative techniques like interviews produce large amounts of qualitative data and provide the researcher with an opportunity to create a richly detailed account of the data (Braun & Clarke, 2006). Qualitative research is also appropriate when attempting to understand social processes in their specific context (Hartley, 2004) and to study phenomena in a natural setting (Denzin & Lincoln, 2011). It is for these reasons that I chose to use an abductive qualitative case study design with multiple forms of data collection including an analysis of existing organisational documentation and in-depth semi-structured interviews, with systematic and concurrent data collection and analysis (Creswell & Poth, 2016). A case study research design was considered most suitable for eliciting from respondents the desired richness of detail and therefore the most appropriate for addressing the research questions.

I also considered the following research strategies in order to determine the most suitable methodology for this study: grounded theory, ethnography, narrative research, phenomenology, and case study. A case study approach was deemed to be most appropriate for this research compared to the other qualitative methodologies for several reasons. First, the use of grounded theory was discounted due to the fact that a lack of employee participation in mental wellbeing initiatives is not an entirely new phenomenon. Furthermore, previous studies examining employee participation in mental wellbeing initiatives (or broader health promotion initiatives or community-based mental health services) provide some indication of the potential barriers to participation (Corrigan et al., 2014; Gulliver et al., 2010; Little et al., 2019; Person et al., 2010; Robroek et al., 2009). The research was also not entirely inductive as it began with a thorough review of the current academic literature. When the review revealed gaps, this study borrowed from related literature so as to not ignore existing knowledge and present findings that are already known (Corbin & Strauss, 2008; Vincze, 2012). This research also moved beyond an inductive logic and adopted abduction by iteratively moving back and forth between

data and theory to make creative inferences and double-check these with further data (Charmaz, 2009; Timmermans & Tavory, 2012).

Second, a case study approach was considered more appropriate than an ethnographic one because the focus of the present study was not to provide a scientific description of individuals or a wider culture's customs, habits, and mutual differences. The focus was instead to provide thick descriptions and narratives of individuals' subjective interpretations of their experiences with mental wellbeing initiatives (Creswell, 2017). Third, narrative research was discounted due to the fact that it, "is best for capturing the detailed stories or life experiences of a single life or the lives of a small number of individuals" (Creswell, 2007, p. 55). Narrative research also generally provides an account of a specific event or action (or series of events or actions) and considers them in relation to the chronological order in which they happened (Creswell, 2007). I would be unable to answer the research questions about why there is low participation in workplace mental wellbeing initiatives if I only sought information from one or two individuals. Furthermore, promoting mental wellbeing in the workplace is an ongoing process, not a single event: chronology is thus not applicable.

Finally, a case study approach was considered more appropriate than a phenomenological one because "phenomenologists focus on describing what all participants have in common as they experience a phenomenon (e.g., grief is universally experienced)" (Creswell, 2007, p. 58). However, as individuals experience mental wellbeing differently I did not want to 'reduce' individual experiences to a universal essence or common understanding (Moustakas, 1994; van Manen, 2016). Instead, I wanted to identify a range of factors that influence employee participation in workplace mental wellbeing initiatives. Additionally, as van Manen (2016) notes, an interpretive approach to phenomenology would make 'epoche' or 'bracketing' (where researchers' put aside their personal experiences, as much as possible, in order to gain a fresh perspective of the phenomenon being investigated) an 'impossibility' because the investigator has an active role in interpretive research and cannot entirely separate themselves from the subject of investigation (Llewellyn, 2007; Tashakkori et al., 1998).

While a quantitative approach was also considered, survey research using closed item questions and scale responses would not answer the 'why' or 'how' aspects of the research questions and would thus not fill the aforementioned gaps in the literature. Additionally, quantitative data collection methods such as structured questionnaires would not provide sufficient depth or the

richness of insights required (Coughlan et al., 2009). There was also a strong call in the literature for future research to consider a more exploratory, qualitative approach (Armour, 2020; Gulliver, 2010; Hallaway, 2020; Skakon et al., 2010). As Gephart (2004) notes, qualitative studies can 'rehumanise' research, an important consideration for mental wellbeing research. However, I undertook some quantitative data collection and analysis as part of the case study to understand current levels of employee awareness and participation in existing mental wellbeing initiatives in the chosen organisation.

Case Study Research

Creswell and Poth (2016) define case study research in the following manner:

> Case study research is a qualitative approach in which the investigator explores a bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information (e.g., observations, interviews, audio-visual material, and documents and reports), and reports a case description and case-based themes. (p. 73)

Case study research is appropriate for those seeking to understand and illuminate human behaviours or social processes, and in particular how they are influenced by the organisational and environmental context in which they operate (Hartley, 2004). In case study research, the researcher often provides details such as a description of the case(s) and the individual or organisation's day-by-day activities. The researcher may focus on several specific issues or analyse themes (Creswell & Poth, 2016; Stake, 1995).

As Stake (1995) recommends, those researchers who use a case study approach should provide 'thick descriptions' of human behaviour using vignettes or 'episodes' of storytelling. Thick descriptions allow for the reader to determine the transferability of findings: whether they could transfer the findings to their own case (Lincoln & Guba, 1985). In case study research the data collection and data analysis occur concurrently in an iterative process (unlike experiments or surveys), allowing theory development to be grounded in empirical evidence (Creswell & Poth, 2016; Hartley, 2004). The researcher can also strengthen confidence in the findings by enfolding extant literature with the emergent concepts and theories: this practice will increase the validity and generalisability of the findings (Eisenhardt, 1989). Interweaving the literature

with the findings often validates the choice of themes presented in the analysis and ensures the narrative's credibility (Nowell et al., 2017). Additionally, engaging with the literature has the potential to enhance the analysis because it sensitises the researcher to subtle features of the data (Tuckett, 2005).

Selecting the Case

A researcher must consider several factors when selecting cases (Eisenhardt, 1989). As Yin (2003) notes, the research questions should lead to an appropriate unit(s) of analysis being selected. I considered whether to focus on a single case or multiple cases (Stake, 1995). It was imperative that I determined the population to be examined and the boundaries of the investigation because doing so would enable me to control for extraneous variation and clarify the potential generalisability of the findings (Eisenhardt, 1989). I decided to focus on one case study (one organisation) only. A single case study allowed me to spend an extended period of time in one organisation and enabled me to uncover valuable and in-depth contextual information (Hartley, 2004). While I considered a multiple-case design utilising two organisations, I discounted this possibility for several reasons.

First, as Stake (2013) writes, the inevitability of comparing two cases may distract a researcher from meeting their research objectives, which in this case involves exploring why there is low employee participation and investigating possible barriers and enablers to participation. In cross-case comparisons, it is difficult to control variance and to select 'comparable cases' to begin with, making the findings less rigorous (Blatter, 2008). Second, a multiple-case design may dilute the overall analysis because studying more than one case may mean that a researcher is not able to provide sufficient data or the data may not be detailed enough (Creswell & Poth, 2016). Additionally, a multiple-case design would have required a greater volume of data to develop valid and reliable findings from each case: this approach was not feasible given the limited timeframe and resources. Finally, because interpretive researchers do not intend to develop generalisable findings (Guba, 1981) and case studies tend to focus on offering potentially transferable findings (Lincoln & Guba, 1985), I wanted to focus on particularisation. Stake (1995) opposes generalisations in case study research and argues that "the real business of case study [research] is particularization, not generalization" (p. 8). Stake contends that the main reason for studying a singular case is to provide an individualised

description of that particular case. Hence, a single case study design was deemed most appropriate.

After discounting a multiple case study design, I needed to decide whether to conduct an instrumental case study, or an intrinsic case study (Stake, 1995). As Grandy (2010) explains, both are the study of a case (e.g., an individual, group, or organisation). However, an instrumental case study aims to offer insight into a particular issue, draw conclusions that may apply to another case, or build theory: "In instrumental case research the case facilitates understanding of something else" (Grandy, 2010, p. 474). Whereas in intrinsic case study research, "the case itself is of primary interest in the exploration. The exploration is driven by a desire to know more about the uniqueness of the case rather than to build theory or how the case represents other cases" (p. 500). I was interested in a particular issue: low employee participation in mental wellbeing initiatives and possible barriers and enablers to participation. In short, the case's uniqueness was not of particular interest in this study. Therefore, I selected an instrumental case study design to illustrate this issue through one bounded case (Creswell & Poth, 2016). I used an embedded case study design to examine a specific aspect of the case (employee participation in workplace mental wellbeing initiatives), as opposed to a holistic design which analyses the entire case (Yin, 2003).

Taking the above into account, I selected a local government organisation in New Zealand for investigation. It was important that I selected a large organisation for two reasons. First, researchers need to select a case that offers maximum opportunity for information to be gathered to meet the research objectives (Bleijenbergh, 2010). Second, I wanted to select a large case in order to protect the participants' confidentiality. Using a large organisation minimises the risk that a participant may be identifiable by their statements (Kaiser, 2009). At the time of writing, the organisation had a total of 420 employees including fixed term, permanent, and casual employees. The high number of staff members reduces the possibility of participants being recognised or traced by others reading interview excerpts included in this thesis. It would have been harder to ensure confidentiality in a smaller organisation.

Selecting a local government organisation also increased the possibility of transferability of the findings, as Lapsley and Pallot (2000) describe below:

> With local government consisting of a large number of similar organisations (in terms of function, duties, legal imperatives, financing and activities), there is potential for organisations to not only reflect their external environment but to seek institutional isomorphism by mimetic processes. (p. 218)

At the time of writing, New Zealand had 78 local government organisations, consisting of local, regional, and unitary councils (Local Government New Zealand, 2021). There is potential for local authorities in New Zealand to seek legitimisation by resembling each other with regards to organisational procedures and responses to external initiatives (Lapsley & Pallot, 2000). This possibility could apply in the way these organisations provide mental wellbeing initiatives to their staff and thus potentially increase the transferability of this study's findings to other local authorities.

While the selected organisation was an obvious choice for me, it was also partly a matter of convenience, because I had completed a management consulting internship with the company in 2019 and had a well-established relationship with the HR Manager. Having some familiarity with the company also meant that I was aware of the organisation's wellbeing strategy. Developed in 2018, the organisation's wellbeing strategy aimed to build on existing initiatives such as EAP and the social club, as well as develop new initiatives such as a wellbeing intranet site and wellbeing events. I was also aware that the overall success measures of the organisation's wellbeing strategy included, "increased participation in wellbeing promotion activities at all sites, improved feedback in all-staff survey results, leaders at all levels seeing and supporting the benefits of wellbeing at work, and wellbeing programmes included in business unit plans and championed throughout [the] organisation." Thus, I already knew that employees were offered various wellbeing initiatives and that the organisation was actively trying to increase employee participation in these programmes. These features meant it was possible to study this organisation and ultimately answer my research questions. It also provided me with assurance that I would not be selecting a case that did not offer staff wellbeing initiatives.

My established relationship with the HR Manager meant that gaining access to the research site was rather straightforward. I sent an initial email inquiry to the organisation. The HR Manager and CEO responded with enthusiasm stating that they were happy for their staff members to participate in the research. They both felt that the topic of employee mental

wellbeing was valuable, which was not surprising given that the COVID-19 pandemic was potentially impacting on the mental wellbeing of their staff. At the time of the study, the organisation was experiencing pandemic-related stress. As a result of the nationwide lockdown (implemented on the 25th of March, 2020), the organisation's staff were forced to work remotely. All of the staff had to adjust to working from home: many were experiencing technological challenges and work-family conflicts such as home-schooling children or looking after elderly relatives (Sinclair et al., 2020; Usher et al., 2020). Being away from colleagues and their usual work environment also meant that some employees felt isolated. The economic strain caused by the initial lockdown and the social distancing requirements put pressure on the organisation's budget, which meant that some employees were concerned about their job security which ultimately exacerbated their feelings of stress and anxiety. Thus, there were significant challenges potentially impacting staff on top of their day-by-day activities.

The organisation's day-by-day activities include managing the following services for the community: (a) water supply, (b) roading and public transport services, (c) waste collection and disposal, (d) avoidance and mitigation of natural hazards, (e) regulatory services such as animal registration or control, and (f) community infrastructure such as libraries, museums, playgrounds, parks and reserves, cemeteries, and recreational facilities. The organisation also regularly consults with the community on financial planning and decision-making, and seeks feedback on any subject. Internal contextual conditions that emerged during the analysis became of particular interest when exploring the factors that influence employee participation in mental wellbeing initiatives. For instance, the organisation was going through significant refurbishments which meant that staff were re-located to temporary office accommodation, often far away from their main office building. Due to the resignations of several senior managers, a significant management restructure was also taking place. At the beginning of 2021, a new Chief Executive was appointed. This change in leadership was met with mixed feelings of both uncertainty and excitement in staff, with some expressing concern about the potential for significant change in the organisational culture. The organisation was also facing additional uncertainty around local government reforms and what this might mean for the organisation. Further, staff in the organisation were experiencing the added pressure of increased workloads due to 2020 being a Long-Term Plan (LTP) year. As analysis progressed, it became clear that these contextual conditions were highly pertinent to the chosen phenomena of study as they influenced employee participation in workplace mental wellbeing initiatives.

Research Process

In case study research, it is typical to collect and analyse multiple sources of information (e.g., observations, documents and reports, interviews, and audio-visual material) to develop an in-depth understanding of the phenomenon within the case (Creswell & Poth, 2016). The multiple sources of evidence should be triangulated to ensure the study's reliability, validity, and credibility (Lincoln & Guba, 1985). This process is also believed to strengthen the grounding of theory (Eisenhardt, 1989). This study analysed multiple sources of information, including organisational documents and semi-structured interviews over a six-month period. During the period of study, I also took detailed field notes to enrich the document analysis and interviews. I recorded both factual information such as dates, times, settings, behaviours and actions, and reflective information such as my thoughts, ideas, questions, or concerns (Schwandt, 2015). Very early on in the data collection process it became evident that a factor that influences employee participation could be *both* a barrier or an enabler, depending on how it is managed and experienced by individuals within a particular organisation. I thus developed revised research questions which are outlined below:

1. Why is there a lack of employee participation in workplace mental wellbeing initiatives? What factors positively or negatively influence employee participation in workplace mental wellbeing initiatives?
2. Why are these factors experienced as problematic, or how are they perceived to encourage and enhance employee participation?

Following Eisenhardt (1989) and Hartley's (2004) suggestions, I remained sensitive to any potential opportunistic forms of data collection, such as chance conversations by the coffee machine or reception desk. This practice introduces the researcher to emergent themes or unique case features. As Stake (1995) notes, "Most researchers find that they do their best work by being thoroughly prepared to concentrate on a few things, yet ready for unanticipated happenings that reveal the nature of the case" (p. 55). Similarly, Corbin and Strauss (2008) note that qualitative researchers appreciate serendipity and discovery.

Data Collection

To understand the overall organisational context, I began by analysing existing organisational documents. This documentation included policies, the company's purpose and vision, existing

staff survey data, action plans, the organisation's wellbeing strategy, wellbeing newsletters, an annual wellbeing report from the organisation's EAP providers, and other sources that became relevant as the research progressed. As McCarthy et al. (2011) and Spence (2015) note, organisations do not typically evaluate their workplace health and wellbeing programmes in terms of their impact or effectiveness. This proved to be true at the case organisation. While the organisation had over 25 activities designed to support staff mental wellbeing (including but not limited to the provision of EAP, a wellbeing committee, social groups, fitness groups, online wellbeing resources, and coaching and mentoring support), it had no historical data on employee awareness or engagement with these activities. Thus, in order to inform the primary data collection process for this study, the organisation agreed to administer a company-wide survey to establish the current levels of employee awareness and participation in its mental wellbeing initiatives. Eighty-six employees took part in the survey. Participants were asked to indicate the extent of their awareness of the organisation's wellbeing initiatives. As shown in Table 1, the findings showed reasonable levels of awareness.

Table 1

Employee Awareness Levels of Existing Mental Wellbeing Initiatives

Please indicate the extent to which you are aware of the following wellbeing initiatives at your workplace:				
Wellbeing Initiative	I am not aware of this initiative	I have heard about the initiative but do not know what it involves	I am aware of the initiative and have a reasonable idea of what it involves	I am very aware of the initiative and am clear on what it involves
Employee Assistance Programme (EAP)	3%	10%	37%	51%
Peer Support Programme	12%	16%	40%	32%
Wellbeing Committee	12%	29%	30%	29%
Wellbeing Newsletter	5%	18%	40%	37%
Change Newsletter	44%	27%	22%	7%
Making a Difference (MAD) Committee	0%	1%	37%	62%
Social Club	0%	4%	33%	63%
Running Club	47%	29%	12%	12%
Yoga Sessions	16%	30%	32%	22%
Fitness Boot Camps	56%	25%	5%	14%
Book Club	86%	10%	3%	1%
Staff Te Reo Lessons	8%	19%	33%	40%
Staff Corporate Challenge	3%	15%	30%	52%
Sports Challenge	11%	19%	42%	27%
Planting Days	38%	30%	21%	11%
Wellbeing Survey	18%	25%	30%	27%
The Five Ways to Wellbeing Resource	33%	26%	21%	21%
Intranet to Promote Wellness Resources	19%	26%	32%	23%
Coaching and Mentoring Support	29%	37%	14%	21%
All Staff Engagement Survey	4%	10%	27%	59%
Our Voice Working Group	4%	19%	32%	45%
Lunchtime Presentations	8%	32%	30%	30%
Team Activities (i.e. celebrate sporting events	26%	25%	25%	25%
Annual Hot Bun Easter Event	15%	8%	33%	43%
Wellbeing Book Review	50%	24%	10%	17%

Even though the survey found that staff had reasonable levels of awareness, participation levels in these initiatives were generally low (see Table 2).

Table 2

Employee Participation Levels in Existing Mental Wellbeing Initiatives

Please indicate the extent to which you have participated in the following wellbeing initiatives at your workplace:					
Wellbeing Initiative	Never	Rarely (in less than 25% of the chances when I could have)	Sometimes (in about 50% of the chances when I could have)	Frequently (in about 75% of the chances when I could have)	Always (every time)
Employee Assistance Programme (EAP)	45%	34%	13%	6%	3%
Peer Support Programme	86%	7%	1%	3%	3%
Wellbeing Committee	77%	3%	4%	7%	8%
Wellbeing Newsletter	28%	13%	17%	24%	18%
Change Newsletter	66%	18%	4%	4%	7%
Making A Difference (MAD) Committee	21%	17%	31%	18%	13%
Social Club	34%	28%	14%	13%	11%
Running Club	89%	3%	3%	1%	4%
Yoga Sessions	77%	13%	3%	4%	3%
Fitness Boot Camps	92%	3%	1%	1%	3%
Book Club	96%	1%	3%	0%	0%
Staff Te Reo Lessons	56%	18%	14%	7%	4%
Staff Corporate Challenge	56%	15%	6%	11%	11%
Sports Challenge	92%	3%	0%	1%	4%
Planting Days	92%	7%	0%	0%	1%
Wellbeing Survey	32%	10%	23%	11%	24%
The Five Ways to Wellbeing Resource	42%	23%	13%	7%	15%
Intranet to Promote Wellness Resources	34%	32%	18%	7%	8%
Coaching and Mentoring Support	69%	20%	7%	3%	1%
All Staff Engagement Survey	15%	10%	10%	8%	56%
Our Voice Working Group	41%	20%	15%	4%	20%
Lunchtime Presentations	46%	15%	14%	13%	11%
Team Activities (i.e. celebrate sporting events)	39%	17%	20%	14%	10%
Annual Hot Bun Easter Event	30%	10%	11%	17%	32%
Wellbeing Book Review	83%	7%	1%	3%	6%

The EAP utilisation rate seemed slightly higher than expected, compared to average utilisation percentages reported in extant research. However, in interviewing the organisation's EAP provider, it was revealed that participation rates for the EAP were higher than usual at the time of study due to an increase in employees utilising the counselling service following the COVID-19 pandemic:

> *"What we've seen, is that more people are using … the therapeutic counselling. I've certainly seen a surge of more people wanting to use the service because in actual fact, their basic resilience is lower than what it was before, so their emotional tank is full."* (EAP provider)

Further, participation in the EAP also included engagement with the workplace chaplain who regularly visits the workplace, hence the slightly higher than typical utilisation rates. The workplace chaplain is contracted through the organisation's EAP and is available for confidential discussions about any subject an employee wishes to discuss: from stress management, conflict resolution, to marriage or grief counselling. As the low participation rates in wellbeing initiatives in the case organisation were consistent with extant literature, I wanted to speak with staff personally to explore the reasons behind this lack of utilisation.

Research Sample

Apart from being a current employee at the chosen organisation, there was no selection criteria that interview participants were required to meet in order to be involved in this study. Every employee in the organisation was invited to participate to allow the whole population to be included in the sample if they so desired. In this study, I chose to use volunteer sampling because it is the most appropriate sampling method for researching sensitive topics such as mental wellbeing. It is necessary to ensure that participants are willing to speak about the subject (Jupp, 2006). With volunteer sampling, there is the possibility of self-selection bias, whereby the participants that volunteer are not equivalent to those who do not (Olsen, 2008). However, I spoke with participants with vastly different opinions and experiences with mental wellbeing in the workplace. While some were keenly interested in mental wellbeing, others were actively resistant or against the concept. The range of perspectives assured me that participants did not all display similar characteristics (i.e., all being interested in wellbeing). This reassured me that the sample was more likely to be representative of a wider population (Jupp, 2006). Volunteer sampling can also be problematic in the sense that it is difficult to determine if participants are typical of the wider group to which the findings are to be generalised (Jupp, 2006). As Palinkas (2015) notes, in some circumstances it is impossible to identify a sample that may be representative of a wider population at the study's outset. This was the case in the present study. As mental wellbeing is personal, subjective, and internally experienced, it was impossible for me to identify a range of participants with differing perspectives and experiences of mental wellbeing until they volunteered to share those perspectives with me in an interview setting. However, as previously mentioned, interpretivist scientists typically avoid making generalisations (Guba, 1981). Furthermore, as case studies tend to focus merely on offering potential transferable findings (Lincoln & Guba, 1985) or particularisations (Stake, 1995), this issue was of less concern.

I purposefully sought the participation of both managers and employees at the chosen organisation. I conducted interviews with several managers to gain an initial understanding of the organisation's strategy and intent around supporting employee mental wellbeing, as well as any organisational factors that may be impeding employee participation in mental wellbeing initiatives. I then interviewed employees in order to explore their subjective and personal experiences of factors that influence their participation. This was particularly important as employees' perspectives had been underrepresented in extant literature. The Executive

Assistant (EA) at the organisation approached various managers across a range of departments and suggested that they contact me via email if they were interested in being interviewed. Five managers (two women and three men), contacted me via email to arrange interviews. These initial interviews highlighted the important role of the EAP provider at the organisation. The EA contacted this person and provided them with my email address. The EAP provider approached me via email to arrange an interview time.

Following interviews with managers and the EAP representative, the organisation sent an email inviting all of its staff members to participate in the study. The invitation (Appendix B) provided an email address which staff could use to contact me. Participant involvement in the study was entirely voluntary and confidential. The organisation did not know which employees ultimately contacted me and agreed to be interviewed. This initial invitation resulted in seven participants. The EA sent a second company-wide email on my behalf to prompt further participants to contact me if they so desired. This second email led to a further 11 participants. The total number of participants was not determined a priori but instead, was established when theoretical saturation signalled that the findings were sufficiently comprehensive and the interviews revealed no new information. While no new barriers and enablers were being identified after approximately 17 interviews, I continued to interview employees because important contextual factors that affected employee participation in mental wellbeing initiatives were still being uncovered. A total of 24 individuals participated formally in the interview stage of the study before the data reached the point of theoretical saturation. The sample included five managers (two women and three men), one EAP provider (a male), and 18 employees (14 women and four men). While I would have liked a few more male employee participants to balance out the gender of participants, this sample was representative of the organisation's general workforce. At the time of the study, the organisation was made up of 246 women, 163 men, one intersex or indeterminate employee, and seven employees of an unspecified gender. Therefore, I felt that the sample was an accurate reflection of the gender mix of the organisation. The sample also focused on illuminating the perspectives of employees which was important to me because, as mentioned above, their perspectives are frequently unreported in extant literature. Table 3 provides descriptive summaries for each of the study's participants.

Table 3

Summary of Participants

Participant Pseudonym	Role	Gender
Kristen	Manager	Female
Fred	Manager	Male
Asher	Manager	Male
Jeremy	Manager	Male
Claire	Manager	Female
George	EAP Provider	Male
Ann	Employee	Female
Lucas	Employee	Male
Marcia	Employee	Female
Hazel	Employee	Female
Noah	Employee	Male
Elise	Employee	Female
Pauline	Employee	Female
Leah	Employee	Female
Alice	Employee	Female
Alexander	Employee	Male
Juliette	Employee	Female
Blossom	Employee	Female
Sophie	Employee	Female
May	Employee	Female
Annelise	Employee	Female
Isabel	Employee	Female
Clara	Employee	Female
Oliver	Employee	Male

Primary Data Collection

While semi-structured interviews seek to address several predetermined questions or topics, the questions evolve during the course of the interview (Barlow, 2010). Semi-structured interviews are suitable for comparing participants' experiences. Follow-up questions can be used to help to clarify and understand participants' unique individual experiences. Hutchinson et al. (1994) provide seven possible benefits for participants partaking in qualitative interviews: interviews (a) provide a form of catharsis and offer participants a sense of relief as a result of expressing their feelings; (b) facilitate feelings of self-acknowledgement and validation of their experiences; (c) offer a sense of purpose by talking through experiences that may be shared in order to help others; (d) increase self-awareness and provide participants with new

perspectives; (e) offer a sense of empowerment from being heard; (f) promote healing due to the potential therapeutic nature of interviews; and (g) provide the voiceless or disenfranchised with a voice and the chance to share their stories or experiences. I chose to use semi-structured interviews to explore in rich detail employees' reasons for participating or not participating in workplace mental wellbeing initiatives.

As interviews may address complex, sensitive, or personal aspects of a participant's experiences, they have the potential to arouse powerful emotions for participants and potentially cause them psychological harm or emotional distress (Corbin & Morse, 2003). For this reason, I followed Corbin and Morse's (2003) guidelines which are designed to mitigate the risk of psychological harm to participants. I built trust and rapport with the participant during the tentative phase of the interview in several ways. I made casual conversation to relax the participant and set the tone for the interview. I briefly explained the Information Sheet and Consent Form (Appendix C and D) and invited participants to ask any questions that they had. I also invited participants to choose their own pseudonym, a technique which has been found to build rapport, increase psychological meaning to the participant, and reassure the participant of their confidentiality (Allen & Wiles, 2016).

Interviews with Managers

In order to establish a general overview of the organisation's strategy, intentions, and approach to supporting employee wellbeing, I conducted several 'orientation interviews' with key managers. Hartley (2004) contends that orientation interviews are useful for gaining an initial understanding of an organisation's history and current functioning. To give the interview some direction, I asked every manager three broad 'grand tour' questions. These questions were designed to provide participants with the opportunity to share their thoughts or stories with no constraints (Corbin & Morse, 2003). The 'grand tour' questions are provided below:

- *There have been various challenges over recent years that can have a negative impact on how we feel and one's mental wellbeing, such as earthquakes, mass shootings, and the COVID-19 pandemic. While the responsibility of supporting mental wellbeing does not fall entirely on the workplace, can you tell me a bit about your organisation's overall strategy or intention with supporting employee mental wellbeing?*

- *From a managerial perspective, can you tell me a bit about how things in the organisation might be impeding employee participation in these initiatives?*
- *Can you tell me a bit about how things in the organisation could enhance or encourage employee participation in these initiatives?*

Interviews with Employees

After the initial orientation interviews with managers, I conducted interviews with employees to hear first-hand what factors influence their participation in workplace mental wellbeing initiatives. I also asked every employee three 'grand tour' questions to allow them to share their experiences and stories with no restrictions (Corbin & Morse, 2003). These questions are provided below:

- *There have been various challenges over recent years that can have a negative impact on how we feel and one's mental wellbeing, such as earthquakes, mass shootings, and the COVID-19 pandemic. While the responsibility of supporting mental wellbeing does not fall entirely on the workplace, can you tell me a bit about how your workplace supports your mental wellbeing?*
- *Have you participated in any of the wellbeing initiatives offered by your workplace? If so, can you tell me a bit about what influenced your decision to participate, how you experienced it, and what highlights or challenges you may have experienced? If not, can you tell me a bit about what influenced your decision not to participate, have you experienced any barriers that impeded your participation?*
- *What factors would enable or encourage you to participate in any of these wellbeing initiatives in the future?*

I also prepared several follow up questions for both sets of interviews to serve as 'back up prompts' in case the interviewee required further prompting for the interview to advance (Appendix E). These back up questions were seldom used because the grand tour questions were sufficient in generating rich data. Anticipating that the sensitive topic may have been challenging for participants to talk about with a stranger, on reflection, I was surprised at how willing they were to share with me their very personal, intimate stories and experiences related to their mental wellbeing, physical health, and relationships. On reflection, the process was consistent with the possible benefits of interviews that Hutchinson et al. (1994) identify,

outlined previously. At the conclusion of the interviews, I invited participants to reflect on their experience of the interview and asked whether they had found the interview helpful or meaningful. All of the participants responded positively. Most participants felt the interview was cathartic or an outlet where they could speak candidly and honestly to a neutral researcher and know that their story had been heard. They appreciated the opportunity to voice their thoughts or think deeply about a subject that they had not previously considered in great detail. Some participants found it beneficial to vent their frustrations and be listened to: Jeremy (one of the managers) confessed, "you've let me talk, basically." Likewise, May (an employee) said, "I feel like I've just done a big whinge", and Marcia (another employee) revealed that it was "quite good to chat about [wellbeing]." For others, the interview provided an opportunity to think more about their mental wellbeing, their teams' mental wellbeing, or the organisation as a whole. For instance, Kristen (a manager) felt that the interview reminded her "of the options that there are out there" that she should make sure that her team was aware of. Similarly, Claire (another manager) saw the research as "an opportunity to … revitalise the whole [wellbeing] strategy and start thinking about … how [to] get this [wellbeing] more embedded." Marcia (an employee) was also thankful for the opportunity to speak about something that she is "passionate about." Sophie (an employee) was really happy that "somebody is looking at this [topic]." Blossom (another employee) agreed. She was grateful that someone was "advocating" for the employees and taking the time to come to the organisation to listen to employees' experiences in the interviews, saying, "thank you for coming out here."

Concurrent data collection and analysis informed subsequent interviews and allowed me to follow up on emergent themes and concepts for clarification (Creswell & Poth, 2016). While the interviews still included the same 'grand tour' questions in order to allow participants the freedom to share their stories and experiences without constrictions, the interview protocol was adapted for subsequent interviews as data collection and analysis progressed to further explore emergent themes and concepts. For example, an emergent concept that was not evident in existing literature was that some employees perceived peer pressure from colleagues to behave in a certain way and not have, as Pauline (an employee) put it, "too much fun at work" by engaging in wellbeing activities. This perception acted as a barrier to participation. *Perceived peer pressure* thus became a new code. In subsequent interviews, I incorporated follow up questions to examine emergent concepts such as this. However, I was careful to ask these questions after the participants had concluded their stories so as to prevent any intrusion which

may have altered the course of the interview (Corbin & Morse, 2003). For the emergent theme of perceived peer pressure, follow up questions included:

- *You mentioned peer pressure earlier, can you tell me a little bit more about what you mean by that?*
- *Can you tell me more about how you feel you should behave at work?*
- *How does this feeling of peer pressure influence your decision to participate in wellbeing initiatives?*
- *Can you think of an example of a time where you felt that you could not engage in wellbeing activities due to peer pressure?*

I asked these questions to unpack the emerging theme and understand in greater depth how and why this perceived peer pressure influenced participation in wellbeing initiatives.

Transcription

The 24 interviews resulted in 343 pages of transcribed text (excluding pages of general conversation before and after the interview itself). Interviews ranged from 17 minutes to one hour and 17 minutes long, with the average interview lasting approximately 51 minutes. All participants consented to the interview being audio recorded with the exception of one employee who did not feel comfortable sharing his/her experiences on record. This participant did, however, consent to hand-written notes being taken throughout the interview. The recordings were transcribed verbatim as soon as possible after each interview to ensure accurate data analysis. To ensure participants' confidentiality, I used the software programme Otter.ai. The automatically generated transcripts were edited by listening to the recordings and manually screening the transcripts for errors. Handwritten notes were also recorded during interviews. These were incorporated into the transcripts as memos to enrich the data beyond merely written text. These notes enabled me to capture emotions and non-verbal cues such as facial expressions, eye contact, body language, and gestures (Kowal & O'Connell, 2004). These handwritten memos were useful to permanently capture fleeting conversational behaviour for later analysis. Every participant was emailed their transcript. Participants were given one week to review and amend their transcript before it was included in the data analysis phase. Two participants chose to edit their transcripts, one making only minor grammatical changes and the other choosing to "soften" the content of their transcript after becoming

unexpectedly emotional and vocal in the interview and regretting how they came across. The remaining participants consented to the original transcripts being used in the data analysis phase.

Data Analysis

I chose to use thematic analysis as it coheres with the abductive qualitative methodology. Thematic analysis is not exclusive to any one research method but is widely used across many fields, disciplines, epistemologies, and for various research questions (Braun & Clarke, 2006; Lapadat, 2010). Braun and Clarke (2006) define thematic analysis as "a method for identifying, analysing, and reporting patterns (themes) within data" (p. 79). Boyatzis (1998) explains that thematic analysis may be used to visualise the data, find relationships, analyse findings, systematically observe a case, and quantify qualitative data. It is suitable for organising large sets of qualitative data. Furthermore, thematic analysis is flexible because the researcher can identify themes and their prevalence in a range of ways, giving the researcher the potential to produce an account of the data in rich detail (Braun & Clarke, 2006).

A theme captures something that the researcher considers important in relation to the research questions (Boyatzis, 1998). A researcher may deem a theme to be significant without necessarily depending on quantifiable measures such as how frequently the theme is mentioned or how many sentences were dedicated to the particular theme. The researcher makes a judgement about whether a theme may be important in answering the research questions (Braun & Clarke, 2006). Identifying themes can be a deductive process, where the researcher draws on existing theoretical constructs to develop first-order codes. However, this deductive approach can be too rigid and prematurely close the investigator off to novel findings (Lapadat, 2010). An inductive approach is more commonly used in thematic analysis. Here themes are grounded in the data and emerge as the researcher notices patterns and constantly cycles back through the data to revise codes in order to build a complex, exploratory analysis (Lapadat, 2010). This study used an abductive approach. Charmaz (2009) positions abduction as secondary to induction whereby "we engage in imaginative thinking about intriguing findings and then return to the field to check our conjectures" (pp. 137–138). Abductive logic ensures that creative inferences are checked against new data (Timmermans & Tavory, 2012). As such, abduction aligns with the recommendation to move back and forth between

data and theory in an iterative and reflective process (Charmaz, 2009; Nowell et al., 2017; Timmermans & Tavory, 2012).

Good thematic analysis makes its theoretical framework transparent to the reader (Braun & Clarke, 2006). A researcher must make a decision on what 'level' themes will be identified at: a semantic (explicit) level consistent with the realist method or a latent (interpretative) level consistent with the constructionist method (Boyatzis, 1998). A semantic analysis focusses only on the explicit, surface meanings of data. In other words, a researcher does not look beyond what a participant has said or written for any further meanings. In contrast, a latent analysis goes beyond the surface meaning of the language and delves into the underlying ideas and the participants' assumptions (Braun & Clarke, 2006). I used a constructionist, latent approach to thematic analysis as it most coheres with my epistemological assumptions and thus is the most appropriate approach for my data analysis. The analytical strategy used in thematic analysis is coding. Here the researcher examines the text (i.e., interview transcripts, documents, field notes, or research memos), identifies concepts, themes, or relationships, and marks similar passages with a code to categorise them (Lapadat, 2010). King (2004) defines a code as "a label attached to a section of text to index it as relating to a theme or issue in the data which the researcher has identified as important to his or her interpretation" (p. 257). A 'good code' is able to capture the qualitative richness of the chosen phenomenon (Boyatzis, 1998).

In this study, analysis proceeded along the guidelines established by Braun and Clarke (2006). I began data analysis by familiarising myself with the data set by repeatedly listening, reading, and manually editing the transcripts that were automatically (but imperfectly) generated by the software programme Otter.ai. Once the transcripts were edited to accurately reflect the interviews, I then read the transcripts in an 'active' way; searching for meanings and patterns, taking initial notes and memos, and marking ideas for possible codes. Open coding, the initial interpretive process where raw data is first analysed and categorised (Price, 2010), then commenced on printed hard copies of transcripts with colour coded pens. Once the quantity of data became unmanageable in hard copy, I continued this process on an electronic copy of the file in Microsoft Word. I was careful to code as many themes and patterns as possible in case they became relevant later in the analysis. I included the surrounding context of the codes and did not 'smooth out' or disregard potential inconsistencies or codes which did not seem immediately relevant (King, 2004). I did not develop codes to fit with any pre-existing frame or preconceptions that I held: instead, codes were data-driven (Braun & Clarke, 2006;

Charmaz, 2009). This initial coding resulted in a total of 89 codes of various strength and significance.

I then began diagramming or visually grouping related open codes together. Constructing and re-constructing diagrams allowed me to consider a broader range of ideas and develop more detailed complex diagrams under a key idea, category, or concept. Following this, I began the process of data reduction: "a form of analysis that sharpens, sorts, focuses, discards, and organises data in such a way that 'final' conclusions can be drawn and verified" (Miles & Huberman, 1994, p. 11). Using coding trees, I was able to refining the data into several core conceptual categories (see Chapter Four). Open coding was followed by a process of axial coding; where categories were related or crosscut to one another in order to determine relationships between the codes (Wick, 2010). I found it useful to conduct hierarchical coding, the process of organising codes from general to specific using as many vertical levels as needed (Richards & Richards, 1995), visually with the use of coding trees. Hierarchical coding helped me to analyse the data at different levels of specificity: from broad higher order codes which provided an overview, to more detailed lower order codes which revealed the fine-grained distinctions to be made (King, 2004). The iterative process of moving between transcripts, codes, memos, diagrams, coding trees, and my own conceptual thinking led to the development of 11 themes. I then reviewed these themes and grouped them into higher-level categories, resulting in six key categories of factors that influence employee participation in workplace mental wellbeing initiatives. I then selected vivid and compelling quotes from participants in order to illustrate these categories and how they influence employee participation.

Ensuring the Finding's Trustworthiness

It is essential to conduct research in a rigorous and methodical manner in order to procure meaningful and trustworthy results (Nowell et al., 2017). While assessing the quality of quantitative data (through measures of validity and reliability) is relatively straightforward, evaluating the quality or 'rigour' of qualitative data is more complex. Guba (1981) and Guba and Lincoln (1982, 1985) developed the concept of 'trustworthiness,' which takes the place of the widely used concepts of validity and reliability in quantitative research, to assess the rigour of qualitative research. I assessed the quality of research using the concept of trustworthiness. Trustworthiness is typically divided into four elements: credibility, transferability, dependability, and confirmability. These elements are discussed in further detail below to

provide the reader with confidence in the study's trustworthiness. I also ensured I met Tracy's (2010) 'qualitative quality' criteria which are: (a) worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence.

Credibility concerns the 'fit' between a participant's perspectives and the researcher's interpretations of them (Nowell et al., 2017). Credibility corresponds with the quantitative/positivist researcher's criterion of internal validity, whereby the study measures what it actually intended to (Shenton, 2004). Credibility is the qualitative/interpretivist researcher's equivalent. As Merriam (1998) notes, credibility addresses how congruent the findings are with the participant's reality. The research is considered credible when co-researchers or readers (i.e., participants) can recognise the experience described in the study and consider it to be a vivid and faithful representation of their views (Beck, 1993; Guba & Lincoln, 1989; Tracy, 2010). I ensured the study's credibility in several ways. First, I adopted appropriate and well-established research methods for the phenomena under investigation (Shenton, 2004; Yin, 1994). Second, I used member checking; I sought feedback and validation of the findings from participants. Guba and Lincoln (1989) consider this practice to be "the single most critical technique for establishing credibility" (p. 239). Third, I ensured credibility by engaging in regular peer debriefing and sought frequent advice from my supervisors. Credibility is increased when more than one researcher analyses the data (Lincoln & Guba, 1985; Shenton, 2004). Fourth, I sought to ensure the study's credibility by keeping a reflexive journal to track how ideas and thoughts developed over the research process (Nowell et al., 2017). Finally, I examined the study's findings against those in the previous literature to evaluate the congruency of findings with existing research (Shenton, 2004; Silverman, 2004).

Transferability is achieved when the reader can determine whether they could transfer the research's findings to their own site (Lincoln & Guba, 1985). Transferability corresponds with the quantitative/positivist researcher's criterion of external validity or generalisability; where the findings of one study can be applied to another situation (Merriam, 1998). As Charmaz (2005) notes, good naturalistic studies have "findings [that] can be extrapolated beyond the immediate confines of the site, both theoretically and practically" (p. 528). While achieving resonance through transferability is a process performed by the reader, it is the researcher's responsibility to provide thick descriptions of the fieldwork context to enable the reader to make such an assessment (Lincoln & Guba, 1985; Nowell et al., 2017; Tracy, 2010).

Interpretivist researchers typically eschew generalisations, believing that human behaviour is context-bound, making it implausible to develop a generally applicable 'truth' (Guba, 1981). Thus, the qualitative researcher focuses on transferability and particularisation. As Shenton (2004) argues, examining similar studies using the same methods but carried out in different environments can actually provide a reader with valuable insights as they may offer results that differ slightly from one another. These differences do not make either study less trustworthy, they merely highlight multiple realities and therefore provide an overall picture of the phenomenon. In this study, I provide as much contextual information as possible while also protecting the organisation and research participants' anonymity. I also provide information about the study's boundaries. As Shenton (2004) suggests, information such as the number and location of organisations partaking in the study, the number of participants involved, the data collection methods used, and the time period in which the data was gathered is essential for evaluating transferability.

Dependability involves the researcher describing and documenting the research process in order to enable other researchers to repeat the study (Shenton, 2004). Dependability takes the place of reliability used in quantitative studies. It considers how consistently a chosen method measures something (Merriam, 1998). Dependability is difficult to achieve in qualitative research because of the changing nature of social phenomena (Shenton, 2004). However, following Guba and Lincoln's (1989) recommendations, I took steps to assure dependability by documenting an inquiry audit (Koch, 2006). An inquiry audit, also called an audit trail (Guba, 1981; Nowell et al., 2017), is a decision trail that the researcher documents, discussing how and why they made particular theoretical, methodological, and analytic decisions (Koch, 2006). An audit trail may include documents such as interview transcripts, or the researcher's reflective journal that provides a running account of the research process (Guba, 1981). An audit trail ensures that the research process has been logical and traceable so that a future researcher could arrive at the same (or comparable) conclusions given the same data, perspective, and situation (Koch, 2006). My two supervisors acted as 'external auditors' by examining the decision trail and ensuring it aligned with good practice (Guba, 1981). I employed 'overlapping methods' (i.e., document analysis, observations, and interviews) and triangulated the findings to increase the data's dependability (Guba, 1981; Shenton, 2004).

Confirmability is achieved when the researcher can demonstrate that the study's findings are data-driven and do not simply confirm the researcher's own preconceptions (Shenton, 2004).

Confirmability takes the place of objectivity; where the concept of 'truth' is independent from individual subjectivity (Chua, 1986; Bisman, 2010). In research, confirmability is achieved once credibility, transferability, and dependability have been realised (Guba & Lincoln, 1989). In this study, I took several steps to ensure confirmability as much as possible. I employed multiple data collection methods. These were triangulated, and 'audited' by my two supervisors to balance out any of my potential predispositions (Guba, 1981). As mentioned previously, my axiological position assumes and accepts that research is value-bound and my values, norms, and biases shaped the research outcomes. The reflective commentary that I kept throughout the process (the recorded notes about how interpretations were made) allowed me to stay sensitive to any potential biases and provide assurance that the findings do indeed reflect the participants' experiences, as opposed to my own preferences (Shenton, 2004). Confirmability is shown by always presenting the data behind claims: this practice guarantees that the interpretations and conclusions I made in this research do indeed come from the data, as opposed to having no empirical basis (Guba, 1981).

Ethical Considerations

The Human Ethics Committee (HEC) at the University of Canterbury considered and formally approved my research design on the 4th of September, 2020 (Appendix F). In order to obtain informed consent, participants were provided with an Information Sheet and Consent Form (Appendix C and D), both of which they were asked to review and sign before the interviews commenced. These documents provided participants with information about the study's purpose and what participation entailed. It also explained their rights and how the researcher would protect the data and ensure their anonymity. Participants were given the opportunity to ask any questions which were explained in full detail. I also obtained verbal consent before recording the interviews (audio only) on a mobile device. The audio recording was later used to aid data analysis. All but one participant agreed to this. At the beginning of the interview, participants were offered the opportunity to choose their own pseudonym in order to assure them of their confidentiality and help build rapport (Allen & Wiles, 2016). Allowing participants to choose their own pseudonym was very effective in creating conversational intimacy as they often chose a name that was personally meaningful to them in some way. Participants were also informed that they could withdraw from the study at any time without penalty, or withdraw any statements they had made during the interview, either at the time of the interview or when they were given their interview transcript to review. I edited all interview

transcripts as the participants requested. All data was stored safely on a password protected computer in a locked room at the University of Canterbury.

Given the sensitive topic of mental wellbeing, I took all possible precautions to ensure the study was conducted in an entirely ethical manner. The interview questions focused on the interviewee's participation in mental wellbeing initiatives. To avoid causing the participants mental or emotional distress, I did not ask them any personal questions about their mental wellbeing. I also had strategies in place to support the participant if they became distressed, such as offering to change the subject of conversation, terminating the interview, or providing them with mental wellbeing resources listed on the Information Sheet (Appendix C). Although one participant became tearful when s/he volunteered an upsetting personal story, s/he quickly composed his/herself and insisted on continuing with the interview. Although the strategies and resources were not used, it was important to have these available should they have been required. Participants were informed that they could refuse to answer any particular question or pause or terminate the interview at any point. I concluded the interviews with a debrief, asking participants if their involvement in the study had been helpful or meaningful to them. This debrief was designed to leave the participant in a positive frame of mind before they left the interview. I sent all participants a follow up email several days after the interview to thank them again for their involvement in the study and to ensure that the interview did not unsettle them in any way (Corbin & Morse, 2003). All of the participants responded positively.

Summary

This chapter has presented the rationale for employing an abductive qualitative research methodology in order to answer the research questions. It began by discussing the philosophical considerations of the study, including the ontological, epistemological, axiological, and methodological assumptions. The chapter then outlined the research design and justified the use of a qualitative case study methodology. The chapter presented the research methods, including methods for data collection and analysis. The chapter has provided a discussion of the steps taken to ensure the finding's trustworthiness. The chapter concluded with a discussion of the ethical considerations that guided the study. Having outlined the study's methodology, the following chapter presents the thematic analysis findings.

Chapter Four: Findings

Introduction

This chapter presents the study's findings which are the results of the thematic analysis of organisational documentation and 24 semi-structured interviews. The analysis identified six key factors that have the potential to directly or indirectly influence employee participation in workplace mental wellbeing initiatives. These are: 1) leadership, 2) organisational context, 3) perceived value, 4) remaining silent, 5) work pressures and expectations, and 6) initiative specific factors. The analysis revealed that these factors can act as either barriers or enablers to participation, depending on the situation. These factors and their properties are discussed throughout this chapter and are supported by compelling and vivid quotes that were selected to illustrate how and why each of these factors influence employee participation.

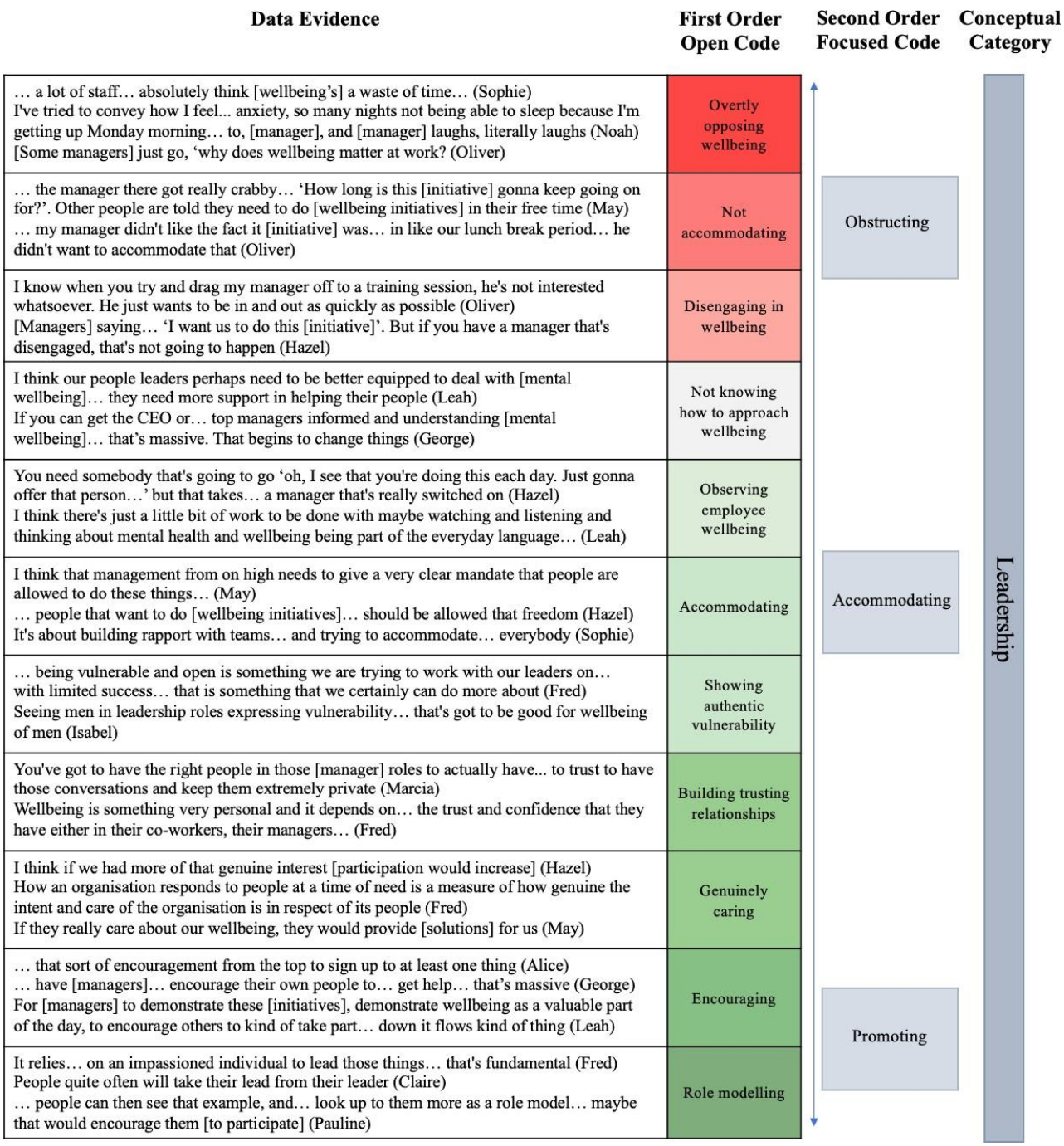
The chapter commences with a discussion of the theme that was the most evident in the data, *leadership*, explaining how the leader's behaviour can have a direct influence on employee participation. This theme is followed by the *organisational context*, highlighting how leaders can influence the overall culture and work environment which indirectly influences participation. The theme of *perceived value* of wellbeing initiatives is discussed in relation to employees' motivation to participate. The chapter then discusses the fourth theme, *remaining silent*. It highlights how individuals tend to treat mental wellbeing as a personal issue and avoid seeking out wellbeing resources for a range of reasons. Following this, the chapter discusses the theme of *work pressures and expectations* and how these can act as either objective or intrinsic barriers. The chapter concludes with a discussion of the final theme, *initiative specific factors*, outlining how the implementation, promotion, and coordination of wellbeing initiatives may impact participation.

Category One: Leadership

Leadership was the strongest theme to emerge from the data. The analysis revealed that managers' leadership behaviour can serve to either enhance or hinder employee participation in mental wellbeing initiatives. Leadership behaviour was thus conceptualised along a continuum featuring three key behaviours: *obstructing, accommodating,* and *promoting,* as depicted in Figure 2.

Figure 2

Coding Tree for Leadership Continuum



Obstructing

On one end of the continuum, managers can obstruct employee participation in varying degrees, negatively influencing participation. As depicted in Figure 2, *obstructing* is made up of three properties: *overtly opposing wellbeing*, *not accommodating* participation, and *disengaging in wellbeing*. Data from several participants suggested that managers can be overtly opposed to mental wellbeing initiatives, the most severe form of obstructing. Elise[1] (an employee) mentioned that her boss looks at wellbeing initiatives as "psychobabble" and "fluffy crap." Similarly, Hazel (an employee) described instances where managers dismissed wellbeing initiatives by saying "just get on with it! You don't need to have all that silly stuff [wellbeing initiatives] on the side!" Further, Jeremy (a manager) personally felt that some wellbeing initiatives such as walking meetings or gratitude were laughable, mentioning that they are "hard to take seriously" and that "this is not kindergarten." These comments suggest that leaders who are opposed, resistant, or dismissive of mental wellbeing initiatives are unwilling to accommodate employee participation and/or actively deter employees from participating. The data also suggests that these opposing attitudes may even be putting barriers up for employees. It appeared that underlying the managers' opposing attitudes around mental health and wellbeing was the stigma associated with mental health. Noah (an employee) whose manager "literally laughed" when he tried to confide in them about his work-related anxiety, described how shame and "fear… of [the manager's] judgement" discouraged him from participating in wellbeing initiatives such as EAP. Noah mentioned that "you don't want to seem to be weak. You don't want the managers and everyone looking at you and saying, what's he going there for? What's wrong? Is he a bloody idiot?" Several other participants felt the same way, mentioning feeling "scared", "nervous", and "reluctant" to reveal that they were experiencing mental challenges by engaging in wellbeing initiatives. Some participants felt "embarrassed" for seeing value in an activity which their manager appeared to disregard. As a result, they avoided participating or asking their manager to participate to protect themselves from possibly feeling stigmatised or judged.

The next property of obstructing is *not accommodating* participation, a slightly less severe form of obstructing behaviour. Some participants, including Oliver (an employee), described feeling that it was "unfair" how their manager "didn't want to accommodate [participation in wellbeing initiatives]" because facilitating participation was a disruption or inconvenience to business-

[1] All names are pseudonyms to protect participants' confidentiality.

as-usual. Similarly, May (an employee), mentioned how participation is "very much led by your manager" and described how a colleague "wanted to come in an hour early and finish early so [x][2] could do a run in the afternoon… and [x's] manager wouldn't let [x] at all… they just didn't want that flexibility." May also described an instance where a manager "got really crabby" with an [initiative] champion because the initiative was disrupting their teams' breaks, so the manager asked, "how long is this [initiative] gonna keep going on for?" May stated that some managers do not allow employees to participate during work time and are instead "told they need to do some of that stuff [wellbeing initiatives] in their free time." In cases such as these, it appears that some managers fail to see the value of the initiative from the perspective of the employee, instead focusing on the effort required to shuffle schedules around to facilitate employee participation. In some cases, employees were even explicitly told by their managers that they could not engage in wellbeing activities at work, and thus, they acted as a barrier to participation.

The next property of obstructing is *disengaging in wellbeing*. The data indicates that some managers are perceived as having little motivation to improve their knowledge around mental health and wellbeing through training or education. Oliver (an employee) felt that there is a need to get managers interested in wellbeing, but commented that "when you try and drag my manager off to a training session, [x's] not interested whatsoever, [x] just wants to be in and out as quickly as possible." Other participants such as Sophie (an employee) agreed, stating that some managers "sit there and say nothing" instead of getting engaged in wellbeing-related training. When employees perceive their manager to be uninterested or disengaged in this training and education, they ask themselves, "do they [managers] care?" It appears that this sense of doubt can lead employees to feel that they are not supported on an emotional level, which holds them back from engaging in mental wellbeing initiatives.

As shown in Figure 2, *not knowing how to approach wellbeing* is a feature of obstructing or accommodating. For instance, managers may inadvertently obstruct employee participation because they lack the ability to recognise that an employee is mentally struggling and could benefit from participation in a wellbeing initiative. As Oliver describes below:

[2] [x] is used to replace gender specific pronouns where necessary to protect participants' confidentiality.

> *"… someone should have picked up on something and asked me if I was okay. And no one ever did… I survived, you know, I'm strong, I'm out, but there's a lot of people that don't survive and the more people that are aware of signs and signals… someone might be saved… that's what I wanted for a long time, was someone to save me… Managers need to be trained to actually look after their staff properly, rather than just managing staff, they need to manage their wellbeing too… just to see if they are okay."* (Oliver, an employee)

Many participants shared this view, believing that managers need training around mental health and wellbeing. Leah (an employee) mentioned that managers "need some support" in learning how to look after employee mental wellbeing, commenting that although managers "say that they want to take care of their people… they don't know how to take care of their people, short of 'oh, by the way, here's the [EAP] card, go away and talk to them'." While not knowing how to approach wellbeing is not a deliberate form of obstructing, one explanatory driver of this obstructive behaviour is managers' ignorance around mental wellbeing or a lack of confidence in having wellbeing-related conversations. Ignorance forms part of this obstructive behaviour and inadvertently hinders employee participation. Conversely, as Leah (an employee) describes, a leader may lack knowledge on mental health and wellbeing and yet still attempt to accommodate and enable participation by asking employees, "can I, you know, do you know of this [initiative]? Is this something that could help you?" For some managers, even if they would like to support, they may not know how to act on their observations that an employee is not themselves. Or they may find it too uncomfortable or challenging to raise that conversation with them, as evidenced by the following comment:

> *"For some people, even having a wellbeing conversation is uncomfortable. I know for a fact because there's managers that have come in and said, 'How do I have a… nice conversation with my staff member? Like, how do I have a wellbeing check in with them? I don't know what to say'. So, it doesn't come naturally to them. And it's more uncomfortable for them than it is for the person they're trying to help."* (Sophie, an employee)

Marcia (an employee) discussed wanting "education and support streams in place" for people to "recognise the signs and symptoms" of mental ill-health in employees. Further, she felt that it was important for people to also have the confidence and "ability" instilled in them to have

mental health conversations. Marcia explained that "it's bloody hard for people to sometimes go, I recognise that something's not right but how do I approach this conversation? And actually, if I approach this conversation and they tell me something, how do I respond?" Several other participants agreed, such as Leah (an employee) who talked about how "leaders perhaps need to be better equipped to deal with [employee mental health]." She shared an experience of temporarily losing a team member to stress and burnout and how it was "sad that we got to that point without any … suitable intervention …" Leah believed that managers should be "watching and listening and thinking about mental health and wellbeing being … just a normal, everyday conversation" in order to recognise early warning signs and prevent employee mental ill-health.

Accommodating

While overt or direct obstruction of employee participation in mental wellbeing initiatives is likely to be fairly uncommon, a behaviour that was clearly evident in the data was *accommodating* participation. Managers can accommodate employee participation by showing mere compliance or 'box-ticking' where they allow a minimal level of participation to comply with organisational policy or their perception that as a manager, they are obligated to support staff wellbeing. However, some participants did not perceive their manager to be genuinely committed to supporting employee mental wellbeing, instead showing a somewhat limited level of support. As seen in the middle of the continuum in Figure 2, this category is made up of two properties: *observing employee wellbeing* and *accommodating* employee participation. The first order code *accommodating* was elevated to the second order focused code.

Hazel (an employee) spoke about how managers need to be "really switched on and aware of things" to *observe employee wellbeing* and identify behaviours that may have a bearing on employees' mental health, such as skipping lunch breaks or working long hours. Hazel felt that "sometimes that's not the case" and it is the manager's responsibility to act on these observations, saying "it's up to the managers to then go, okay, I'm aware that you don't take your lunch break, so … just gonna offer that person …" Other participants agreed, noting that sometimes managers were not particularly perceptive of employee wellbeing, they seemed to be unsure of how to act on their observations, or found the conversation too uncomfortable. Several other participants, including Pauline (an employee) spoke about their manager accommodating participation in a rigid, minimal way by being "strict and to the books" so that "if [employees] wanted to do that [wellbeing initiative] they would actually have to apply for…

a half hour of leave or whatever that works out to." Similarly, Ann (an employee) mentioned how some employees only request minimal changes to participate in wellbeing initiatives, such as "to be able to do something as basic as start 15 minutes early once a week." Even so, it appeared that some managers are not even willing to accommodating this flexibility, instead saying "you have to be here til five and your half hour lunch break is still then and that's all you're having."

While some of the above quotes are positive and show employees being allowed to participate, they suggest a limited or minimal level of accommodation by managers. The comments also suggest that some managers are currently unaccommodating of participation: they do not allow their employees flexibility in their workday. Further, the quotes suggest some structural boundaries constraining how much flexibility managers can offer, such as adhering to policy by getting employees to apply for leave to participate. However, other managers appeared to show discretion over how their subordinates utilise their time by working around those boundaries, enabling participation. As May (an employee) mentioned, "there seems to be real differences of opinion about how much time people have got [to participate]." The limited or minimal level of accommodation appeared to deter some individuals from participating, including Noah (an employee), because they did not feel confident enough to approach their manager "cap in hand" for permission or to apply for leave to participate. As mentioned previously, Noah chose not to do so due to fear of being stigmatised or judged by his manager. To alleviate this fear and reluctance, many participants spoke about wanting their manager to promote and actively encourage their participation in wellbeing initiatives and show genuine support for employee wellbeing instead of merely allowing participation. This encouragement would positively influence their participation because, as Hazel (an employee) said, it gives employees "the green card" and support that they need from their manager to feel that they can participate.

Promoting

Beyond *accommodating* participation is *promoting*, which sits on the opposite end of the continuum to *obstructing* (see Figure 2). Promoting is made up of *showing authentic vulnerability* (around mental health), *building trusting relationships*, *genuinely caring*, *encouraging,* and *role modelling* participation. The degree to which these behaviours positively influence employee participation increases along the continuum, where role modelling is the most promoting behaviour managers can exhibit. Promoting leadership behaviour was

frequently evidenced in the data. However, this behaviour was often described as a desired state, not currently exhibited by managers.

Several participants, including Fred (a manager) discussed how managers *showing authentic vulnerability* with regards to their own personal mental health and wellbeing "is an important part of the leadership of the organisation" but that "sometimes we're not that good at that." Fred explained that when leaders show this vulnerability and say "yes, I'll talk about when things are going poorly for me and why, and my self-reflections and learnings from that" it normalises mental health conversations and "encourages others that… it's okay to not be okay." Several other participants agreed, such as Isabel (an employee) who felt that the more leaders "expose themselves as… vulnerable human beings" the better, because it "validates your own experiences." Similarly, Leah (an employee) felt that hearing authentic vulnerability from people "who you see every day" is more meaningful than hearing "all the messages from the Mental Health Foundation and so forth…" because it resonates more with employees and "helps to sort of bring it down to that real practical level." This authentic vulnerability signals to employees that managers see the value in mental wellbeing initiatives and makes it more comfortable for employees to share when they are experiencing their own mental struggles.

The next property of *promoting* is *building trusting relationships* between managers and employees. Jeremy (a manager) described how authentic vulnerability is "about creating trust and ensuring people know that if they do need to talk then they can do that without judgement." Marcia (an employee) also believed that showing some vulnerability with others and seeing them do the same develops a personal "connection with your team" and actually benefits both parties because "knowing what's going on in their world actually helps me because I feel like I'm helping them, so I think it's about that [trust] building." Contrastingly, some participants expressed concerns that their managers are not always authentic in supporting employee wellbeing. One respondent in the organisation wide survey (designed to determine current participation rates) commented that "sometimes I feel that some managers pay lip-service to staff wellbeing…" and that they lacked sincerity, making them question their trust for those managers. This remark relates to the next property of promoting, which is *genuinely caring* about employees and their mental wellbeing. Showing genuine care towards their staff shows employees that managers are not "paying lip-service", "[ticking] boxes that need to be ticked" or showing mere compliance by allowing participation. Instead, genuine care reassures employees that their manager sincerely cares for them on a personal level and wants to support

their mental wellbeing. As Hazel (an employee) described, a manager who expresses "genuine interest" in an employee's personal life, for instance, asking how their weekend was, "can then find out an awful lot more without actually being nosy but is then able to support." Similarly, several other participants such as Annelise (an employee) spoke about needing "to feel that they're cared for" at work. Hazel also explained how this genuine interest makes coming to work "really nice" because "somebody is going to be interested in me."

Many participants discussed how managers could positively influence employee participation by *encouraging* staff to utilise the mental wellbeing activities on offer. Several participants, such as Hazel (an employee) discussed feeling like they would be "judged" for "slacking off" or "wasting time" by engaging in wellbeing initiatives. Explicit encouragement from top leadership can break down this perception and reassure employees that they can participate without judgement or sanction. Leah (an employee) described wanting leaders "saying to people, you can do this [initiative] in your work time, and we encourage you to do this in work time" because it "gives people the freedom to know that they can do it." Alice (an employee) also agreed, stating that leaders saying, "if you want to do Te Reo[3] [lessons], we encourage you to do that because we back that and… you don't have to make up that half an hour" because it is unambiguous assurance that employees should participate in initiatives during their work time. Sophie (an employee) described working with "a lot of passionate and committed people" who "put their job first" and how if leaders encouraged them to participate in wellbeing initiatives by saying "actually, tools down" then productivity and performance would naturally follow. Sophie also mentioned that "some of the managers are some of the biggest advocates for [wellbeing initiatives]" and that their subordinates are most likely to take that encouragement from their manager and participate.

The final property of *promoting* is *role modelling* participation, which data showed to positively influence employee participation to the greatest degree. Several participants, such as Pauline (an employee), spoke about how when leaders role model participation, this encourages and assures employees that they can participate too. Pauline felt that "if leadership are using these [initiatives], then staff in general are going to be more open to or feel that they're more able to use them as well." May (an employee) explained that when leaders role model participation, they "walk the talk"; behaving in ways that are consistent with their claims about

[3] The Māori language.

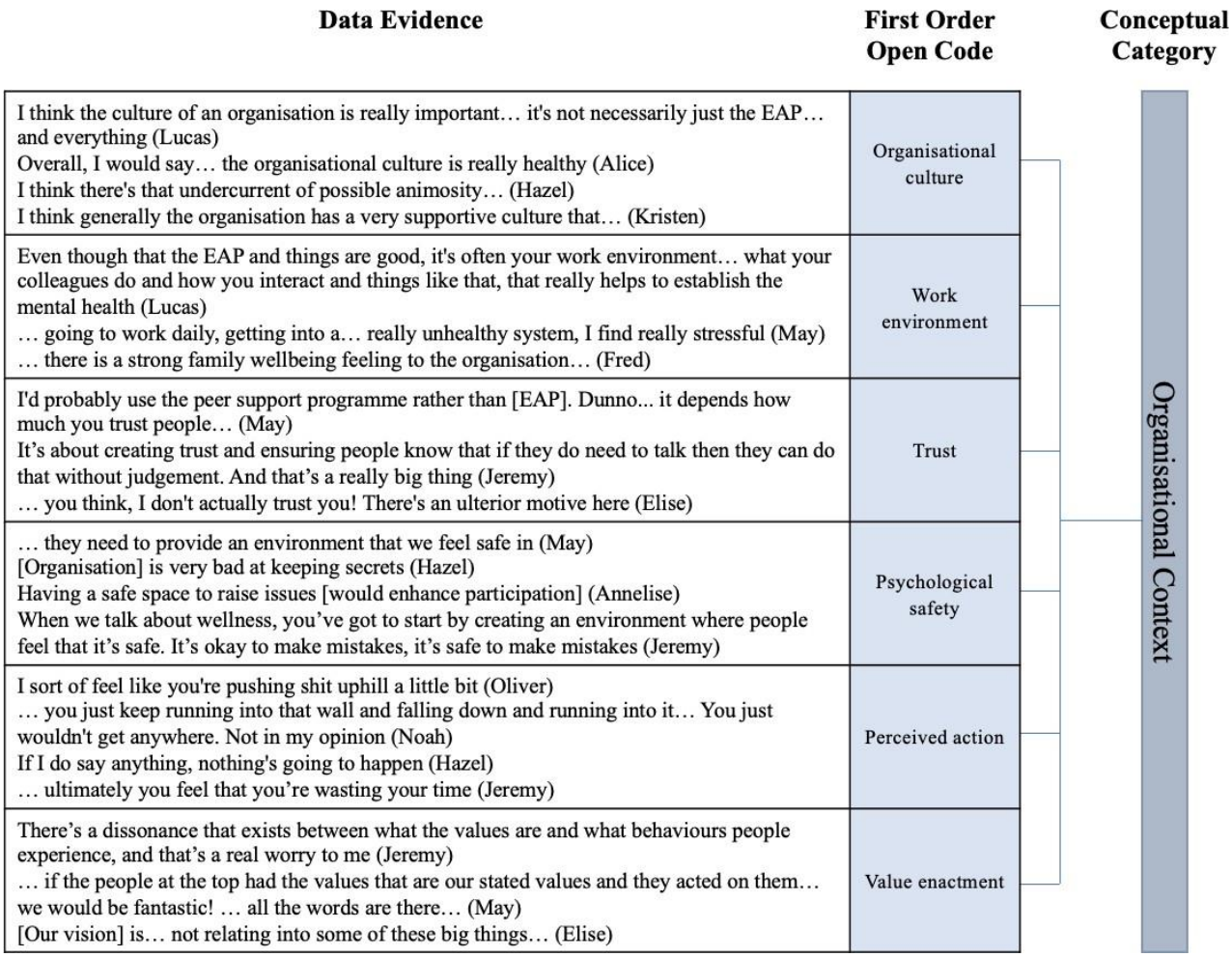
the importance of mental wellbeing at work by engaging in wellbeing initiatives themselves. May also noted that role modelling shows employees that the initiatives have value, making them more inclined to "buy into [wellbeing initiatives]." Alexander (an employee) believed that role modelling was the most effective way to enhance employee participation, noting that "that's where it [wellbeing promotion] succeeds, is where it's sort of led from the top down." The data also indicated that when managers can take the time to engage in wellbeing activities despite their busy jobs, high workloads, and work pressures, they demonstrate to employees that they too can step away from their daily tasks to do something for their mental wellbeing. Leah (an employee) was interested to learn what the organisation's CE does to look after their wellbeing and manage stress. She was interested to see if herself or others might look at the CE as a role model and consider adopting similar practices, saying "[CE's] got the biggest most stressful job in theory… what is [CE] doing that works for [them]? Therefore, … if [CE] can take the time to do that, down it flows kind of thing." The above findings illustrate how leadership, particularly that of line managers, has a direct influence on employee participation in workplace mental wellbeing initiatives, and that these leadership behaviours can positively or negatively influence participation in varying degrees along the leadership continuum.

Category Two: Organisational Context

Another strong theme to emerge from the data was the organisational context; the overall environment that indirectly influences employee participation. Figure 3 below presents the coding tree for the category of *organisational context* and its properties: *organisational culture, work environment, trust, psychological safety, perceived action,* and *value enactment.*

Figure 3

Coding Tree for Organisational Context



Many participants spoke about how the leaders influence the culture and work environment in the case study organisation, which may be one of high psychological safety and trust or low psychological safety and distrust, depending on the sub-cultures within different teams, departments, or units. Further, many participants spoke about leaders in the organisation failing to enact the espoused company values or neglecting to act on issues that employees raise with managers.

Culture and Work Environment

Most participants spoke about the importance of the case study organisation's culture and work environment, noting that mental wellbeing initiatives can be the "ambulance at the bottom of the cliff", as May describes below:

> *"... the wellbeing programmes, as good as they are, are the ambulance at the bottom of the cliff. They do help wellbeing but what would help more for people's wellbeing would be having a management culture that was sophisticated enough, and not so focused on self-interest, to be able to identify key stressors for people such as office accommodation, restructures, and bullying in the workplace and take active steps to reduce, minimise these… You need a whole lot of wellbeing programmes to compensate for that added stress."* (May, an employee)

Many participants shared a similar view to May, speaking about how a positive company culture needs to come first and foremost to act as 'the fence at the top of the cliff' to prevent, as far as reasonably practicable, employees experiencing mental struggles in the workplace. Elise (an employee) spoke about desiring a management culture that can identify and address the "day to day niggles that just get bigger and bigger" because they feel like "a thousand cuts" impacting her mental wellbeing. Jeremy (a manager) believed that the organisational culture and work environment are crucial for supporting employee mental wellbeing, commenting that "if the culture is right, all roads lead to happiness, generally speaking. And if it's not, and you're having to rely on this Employee Assistance stuff, then God help you because you've got it wrong." Jeremy considered initiatives such as EAP to be "a poor substitute for a healthy culture" and believed that a positive company culture and engagement with managers "determines the general buy-in of staff." In a similar vein, Lucas (an employee) believed that the work environment "has a significant bearing on your mental health."

Asher (a manager) believed that the organisation could offer various initiatives to staff, but "so long as the culture in behind that is such that it's genuine, then it doesn't really matter what [initiatives] you put in place." May (an employee) felt that her "biggest mental 'unwellbeings'… I directly attribute to working for [organisation]" stating, "you can bring all this stuff [initiatives] till the cows come home, but actually, 'til you change your own management culture, it doesn't mean squat." Pauline (an employee) also felt that the organisational norms prevented her from engaging in wellbeing activities, explaining how she was unable to go walking during her lunch break for her mental wellbeing because she "quite often [has] clashes at lunchtime." Other participants agreed, saying "there's too many meetings being scheduled at lunchtime." As these comments suggest, an organisation's culture, work environment, or norms can hinder employee participation when employees perceive the culture to be inconducive to supporting wellbeing. The data indicates that staff feel that wellbeing

initiatives are not always sufficient or worthwhile to improve mental wellbeing as key workplace stressors or norms remain. In this way, the organisation's culture influences employees' perceived value of initiatives.

Trust and Psychological Safety

In addition to the organisational culture and work environment, the data suggests that employee participation in mental wellbeing initiatives is likely to be enhanced when the organisational context is underpinned by trust and psychological safety. Staff need to feel psychologically safe to openly share when they may be struggling with mental distress or to raise issues with managers. Fred (a manager) believed that participation depends on whether employees have "strong and trusting" connections with "their co-workers, their managers or the people who are designated to be the first people to support [employees]." Similarly, May (an employee) felt that for employee participation to be increased in the organisation, "the biggest thing they need to change is the work environment… they need to provide an environment that we feel [psychologically] safe in." The data suggests that when there is trust and psychological safety embedded within an organisation's culture, employees feel that they can speak up about mental struggles and participate in initiatives without fear of judgement, as illustrated in the comment below:

> *"When we talk about wellness, you've got to start by creating an environment where people feel that it's safe. It's okay to make mistakes, it's safe to make mistakes… This might seem sort of secondary to wellness, but it's not. It's about creating the environment where people feel trusted and valued. That leads into 'I can share how I feel, and I know I'll be supported'."* (Jeremy, a manager)

Perceived Action

The data indicates that leaders influence an organisation's culture, in part, through their actions around employee mental wellbeing. Some participants, including Oliver (an employee), felt that there was "a disconnect between the lower-level managers and the higher-level managers" in the organisation regarding wellbeing-related communication. Oliver discussed how wellbeing-related ideas developed by higher-level management, HR, and Health and Safety were "great" but "put into the lower-level management, managers actually acting on it, a little bit different. Not so great. It seems like it's [wellbeing] at that higher level, but instead of it filtering down, it gets diluted to nothing." Some participants also felt that some of the

managers' actions undermined the culture of wellbeing the organisation was trying to establish. For instance, Jeremy (a manager) spoke passionately about how managers' actions sometimes imply that employees must spend some of their weekends working, saying that sometimes managers "submit something to staff at 5:30pm on a Friday afternoon and have a meeting on Monday morning at 8:00am" giving employees no work time to prepare for the meeting. Jeremy felt that actions such as these deprive staff of the rest and recuperation that they need in order to have high mental wellbeing.

The data also indicates that trust and psychological safety can be hindered when managers do not act on wellbeing-related issues that employees communicate to them, such as issues with participation in specific initiatives, work-related stress, conflict, high workloads, or work-life balance. Document analysis indicated that in 2018 the case study organisation developed a plan for peers to review anonymous ideas and suggestions put forward by employees, as opposed to having them reviewed by the senior management team, which "could raise awareness of issues and alleviate tensions due to [management's] perceived inaction." Perceived inaction around employee wellbeing was a strong theme that emerged in the analysis and was initially coded as *futile to raise issues*. When employees perceived inaction from managers, they were discouraged from participating in wellbeing initiatives because they felt that there was little point if key issues that negatively affected their mental wellbeing remained unresolved by managers. Many employees felt that they did not have a voice and were "wasting their time" by raising issues because they "don't get listened to" which ultimately eroded the trust they had in their manager. Oliver (an employee) spoke up about his participation in [initiative] not being accommodated, however, "nothing got done about it." Oliver felt that this was "very unfair" because he is "passionate" about [a specific initiative] and "want[s] to do it" but when he does not perceive there "to be any push from… higher up to actually make that happen… I sort of feel like you're pushing shit uphill a little bit." Noah (an employee) had a similar experience, when he raised a work issue that was negatively affecting his wellbeing, as shown below:

> *"I did take [work issue] higher up because I was so annoyed about what was going on. And nothing came of it… it didn't make any difference. And that was extremely frustrating. Yeah, that was 'I'm going to punch someone' at the time, and I'm not really a violent person at all."* (Noah, an employee)

May (an employee) felt undervalued when her voice was not being heard and was "not sure how much [employees] actually drive the work at all." Claire (a manager) said that the organisation has been "raising topics of conversation around high workloads … we've been talking about that and talking about that and talking about that … but we're not doing anything about it." This comment suggests that even some of the managers may not have agency to make certain changes within the workplace, such as reducing workload or influencing wellbeing initiatives. However, when employees perceive the organisation to say one thing, such as "how important it is to have good conversations," but then see that management "talk about it, but [are] not thinking about how [to] reduce somebody's workload" employees feel "frustrated" and often resign themselves to the fact that "it is what it is." Employees sometimes considered wellbeing initiatives to be pointless when work-related issues such as high workloads worked against the cultivation of wellbeing in the organisation, thus dissuading them from participating. These findings suggest that *perceived action* from management makes employees feel that they have a voice, are able to communicate their views, see that their views are able to influence matters at work, and feel valued and listened to.

Value Enactment

Many participants spoke about leaders' enacting, or failing to enact, organisational values that support employee wellbeing in daily behaviours. The document analysis indicated that the case study organisation's values included acting with integrity, honesty, and trust, keeping the customer informed, improving every day, taking responsibility, and working with the customer and each other. An organisational objective between 2017-2020 was also to have a value's-driven culture. Jeremy (a manager) perceived a discrepancy between leaders' words and actions, both generally and in relation to wellbeing, commenting that "there's the set of values that corporate will talk about, but they don't live by them themselves." Several participants also perceived this discrepancy, including Elise (an employee) who stated that "if we truly lived [our] vision and the principles that sit underneath it, everybody's wellbeing would improve. But that has to come from the top." All participants that mentioned this discrepancy said it dissuaded them from participating in wellbeing initiatives because the organisation was sending mixed or contradictory messages, particularly around wellbeing and work-life balance. The contradictory messaging meant that many employees did not believe the initiatives were benevolent. As the following comments show, the organisation says they value employee wellbeing (espoused) but then has expectations and norms that go against those words (enacted):

"We're told, you know, 'take time out'… 'don't think about work'… 'when you're not working, have clear boundaries between work and home' and that. A member of staff has just told me she's on leave and people are emailing and going, 'I want this information now!' and she's going, 'but, I'm on leave, I can't give it to you', 'but I want it now!'… So, that's the organisation that's supposed to be looking after our mental health and wellbeing. And this is the experience." (May, an employee)

"… we still have these high expectations, and we still expect people to deliver at that rate… but we're going, 'oh but, you know, it's really important to have a good work life balance! And, you know, you shouldn't be sending me emails at 10 o'clock at night!' … I struggle a little bit because I think some of our employees are kind of like, 'we say all of these things, but I still have to deliver at this rate!'" (Claire, a manager)

"I think it was last year and [CE] said 'right, we're going to have a year where we're not going to do a whole heap of extra projects… the whole organisation has been under a huge amount of pressure and we want to back off a bit, give people some breathing space… And the next thing you know… we've got a [large scale project], we've got this, we've got that, we've got the next... and we're all sitting there going, 'what happened about the easing things off and giving us all a bit of a break?" (Elise, an employee)

"[x] has set some amazing frameworks in place, [x] really has! But… they're not acting on them… See one of the barriers is you simply don't want to [participate], because you feel disenchanted with the [organisation] and you think, 'oh stuff it, I'm not participating'... I'm not giving this organisation any of my time… I bought into [initiative] because I thought, 'this is really good. I like what they're saying here'. But now I want to pull out." (May, an employee)

As the above comments suggest, when employees perceive a discrepancy between leaders' words and actions around wellbeing or receive mixed messages about wellbeing or work-life balance they can become "disenchanted" with the organisation. It appears that in such cases, employees perceive wellbeing initiatives to be disingenuous, dissuading them from

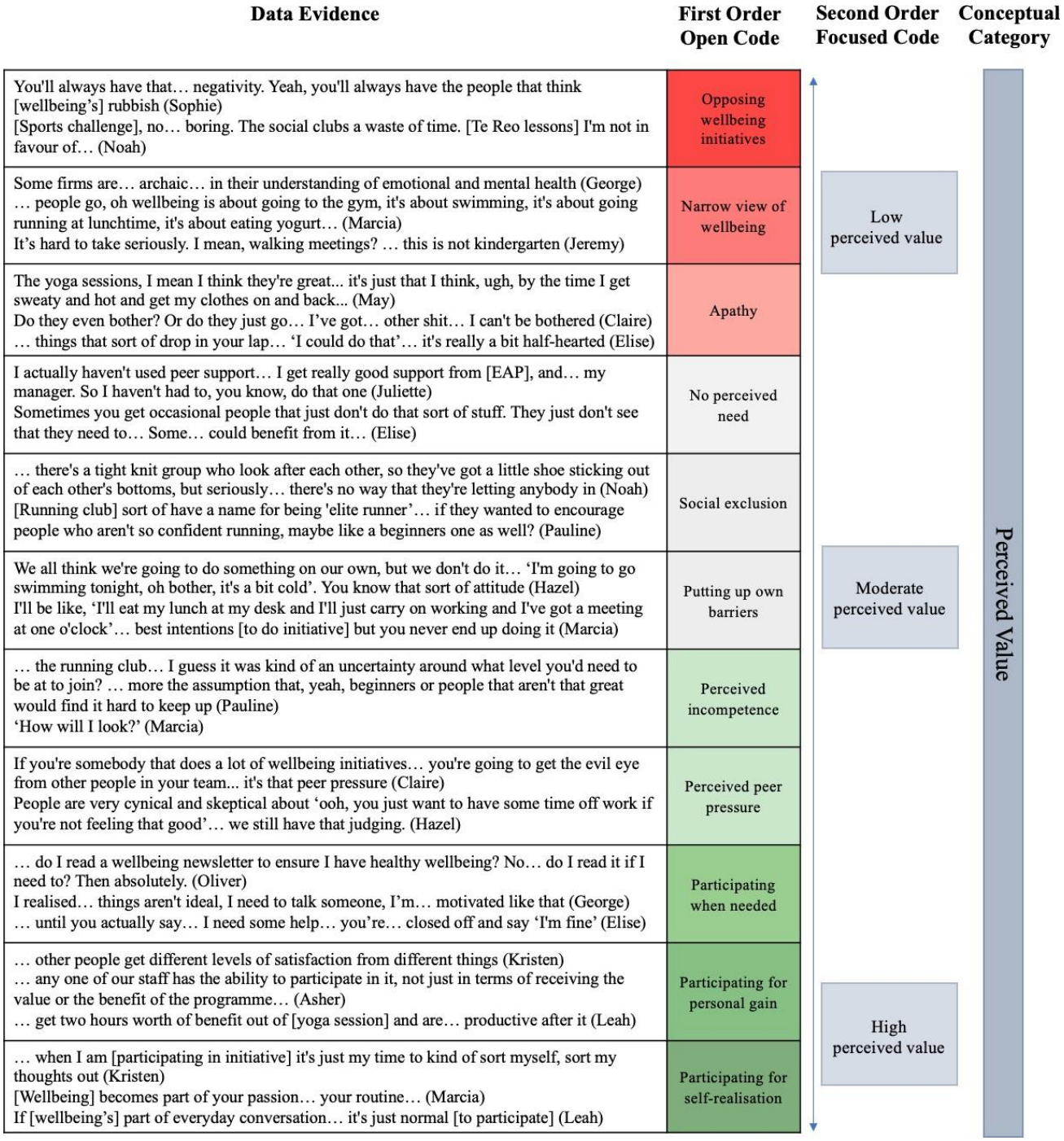
participating. Further, when employees do not feel heard or perceive inaction from management when raising issues affecting their wellbeing, they may actively resist participating. Thus, leaders can indirectly influence participation by influencing the overall backdrop of the organisation, the culture and work environment, trust and psychological safety, perceived action, and value enactment.

Category Three: Perceived Value

The analysis revealed that employees' perceived value, the benefit or gain that an individual attaches to mental wellbeing initiatives, influences their motivation to participate. Figure 4 below depicts the coding tree for the category labelled *perceived value.* Individuals with low perceived value show low motivation to participate. They may *oppose wellbeing* initiatives, show a *narrow view of wellbeing*, feel *apathy* towards participating, or see *no perceived need* to participate. Individuals with moderate perceived value are somewhat motivated to participate but often believe that other barriers outweigh the benefits of participating in initiatives. These barriers include *social exclusion*, *putting up own barriers* by making excuses, *perceived incompetence*, or *perceived peer pressure*. Some individuals with moderate perceived value are motivated enough to overcome these barriers to participate in initiatives but only *participate when needed*. Individuals with high perceived value recognise the benefits that can be gained from participating in mental wellbeing initiatives and having high wellbeing and are therefore highly motivated to participate. These individuals therefore *participate for personal gain* or better yet, *participate for self-realisation*. Perceived value was thus conceptualised along a continuum, mirroring the leadership continuum presented earlier, featuring three levels of individuals' perceived value of mental wellbeing initiatives: low, moderate, and high.

Figure 4

Coding Tree for Perceived Value Continuum



On one end of the continuum, some individuals perceive low personal value in mental wellbeing initiatives. Individuals that perceive the lowest value may *oppose wellbeing initiatives* in much the same way that some leaders overtly oppose wellbeing initiatives, considering some initiatives to be "rubbish" or "fluffy crap." Noah (an employee) considered

the social club and Te Reo lessons to be "an absolute freaking waste of time." Noah also felt that he would not receive any personal gain or value from initiatives such as walking meetings or daily gratitude, saying "[I] don't know that that would do much for me to be honest. That would be a big fat 'No' [to participating]. How does that sound?" May (an employee) felt that the workplace chaplaincy was "useless" because open offices made it difficult to have private wellbeing-related conversations. Oliver (an employee) commented that he would "die before [he] did [x's] boot camp" and would not engage in the book club because "um, book club? What is a book? (laughs)." As these comments suggest, individuals with low perceived value in particular initiatives show low motivation to engage in them.

Some individuals show a *narrow view of wellbeing*. Claire (a manager) describes how "people's perception of wellbeing automatically gravitates to the running clubs or the… yoga sessions or the massage… They don't actually understand what … holistic wellbeing look[s] like." Marcia (an employee) also described a narrow view of wellbeing, explaining how "people go, oh wellbeing is about going to the gym, it's about swimming, it's about going running at lunchtime, it's about eating yogurt and cereal and all the rest of it." However, Marcia has come to understand that wellbeing is actually about "creating that person as a whole" and "building that resilience" in order to face adversity, stating that wellbeing is "actually just about what fills your bucket." The data suggests that individuals with a narrow view of wellbeing are not motivated to participate because they inaccurately perceive the nature of wellbeing activities to be about "all that physical stuff" discussed above. If individuals had a more complete understanding of wellbeing (particularly mental wellbeing) they may realise that wellbeing initiatives are not the "faddish", "fluffy" activities they initially thought them to be. Instead, they may recognise that initiatives draw on common daily behaviours (i.e., *The Five Ways to Wellbeing*: connect, be active, take notice, keep learning, and give) and therefore may be more inclined to participate.

Other participants who perceived low personal value spoke about *apathy.* May (an employee) mentioned being unmotivated to exert effort to participate in wellbeing initiatives, stating that "the barrier to the yoga sessions is probably the logistics of getting organised at lunch for an hour, and getting your clothes changed, and getting hot and sweaty, and blah blah blah." Similarly, Hazel (an employee) felt that she was no longer getting any personal gain from engaging in some wellbeing initiatives and mentioned that she "cannot be bothered… the apathy sets in, really." The data suggests that participants who are opposed to wellbeing

initiatives, have a narrow view of wellbeing initiatives, or "cannot be bothered" to participate tend to have low motivation to participate. These individuals believe there is a greater cost to participating than the benefit they will gain by doing so.

Some participants simply saw little to *no perceived need* to participate and thus expressed low motivation to participate. For instance, Ann (an employee) did not participate in the peer support programme because she has "just not had the need. I've got a really super supportive manager, so I just talk to her about everything." Oliver (an employee) also "didn't really feel the need to" utilise the peer support programme because he was utilising EAP. These comments show that for some individuals, not having the need to participate in workplace wellbeing initiatives is legitimate. They may already have resources in place to be mentally well or substitute similar resources to cater to their needs, such as getting support from a manager instead of utilising EAP. Several participants also spoke about participating in wellbeing activities outside of the workplace such as gardening, going for a walk with their children, or cooking and how these activities already supported their mental wellbeing. Jeremy (a manager) commented that some employees do not perceive the need to participate in wellbeing initiatives because they are already comfortable with their state of mental wellbeing and "they've actually got balance in their life."

However, the analysis also revealed that several participants perceived no need to improve their mental wellbeing and considered themselves to be "fine", and yet discussed challenging emotional situations in the interviews and in some cases became visibly upset. This dissonance suggests that these individuals may not have been experiencing high mental wellbeing after all, but perhaps stigma or perceived negative consequences prevented them from acknowledging their distress. Some participants also acknowledged that while they had no personal need to participate in mental wellbeing initiatives themselves, such initiatives can be of value to others. For instance, while Jeremy (a manager) considered some initiatives to be "hard to take seriously" he acknowledged that others may be highly interested in participating, saying "there'll be some people who buy into this." Similarly, Asher (a manager) mentioned looking at available initiatives and having "a bit of a chuckle" because they are "not for me… but I can see exactly why they're doing it and I think some people will absolutely love it."

In the middle of the continuum in Figure 4, some participants see moderate perceived value in engaging in wellbeing initiatives. The data suggests, however, that their perceived value is

often not high enough to overcome other barriers. For instance, as described below, Noah (an employee) considered *social exclusion* from a group that participates in an initiative together to outweigh his perceived value of the initiative, making it a barrier to participation:

> *"It's that barrier whether there's a tight knit group who look after each other, so they've got a little shoe sticking out of each other's bottoms, but seriously. They're a very tight knit group, and there's no way that they're letting anybody in."* (Noah, an employee)

For some participants, *perceived incompetence* outweighed their perceived value of wellbeing initiatives. For instance, Marcia (an employee) had not participated in yoga sessions because she feared being unskilled compared to others, commenting that "yoga scares the jeepers out of me… because I'm just not really that strong or flexible" and worrying about "how will I look?" This "fear and nervousness about trying something new" was causing her to avoid participating despite the fact that she "definitely want[s] to do it." Similarly, Alice (an employee) mentioned "people's own sort of confidence or self-image" influences their decision to sign up to participate in sport-related initiatives. Hazel (an employee) *perceived peer pressure* from colleagues to do her work instead of "wasting time" utilising wellbeing initiatives, and this peer pressure prevented her from participating, as shown below:

> *"People are very cynical and sceptical about 'ooh, you just want to have some time off work if you're not feeling that good'… so, we still have that judging. You know, 'they're just wasting time they don't want to get on and do the work…'."* (Hazel, an employee)

These comments suggest that even when employees "definitely want to do [initiatives]" they can still allow "fear", "nervousness", "confidence" or "self-image" to become barriers that override their perceived value of the initiative. Further, individuals that have moderate perceived value are more likely to *put up their own barriers* by making excuses for not participating. Marcia (an employee) spoke about making excuses not to go for a walk every day for her mental wellbeing, commenting that "if you weren't motivated to do it, you'd probably go, oh, I can't do that because my job doesn't allow me to… we all do it! It's just human nature that we kind of throw up excuses." Ann (an employee) also questioned to what extent her work schedule and time pressures acted as barriers to participation, asking herself

"is it really the work or is it just me? Am I creating the barrier by not allowing… 15 minutes of [my] time in the morning [to do a wellbeing activity]?"

Some participants described *participating when needed* and how they are only motivated to participate when they perceive their need for the wellbeing initiative to be great enough, therefore showing a moderate level of perceived value. Oliver (an employee) was motivated to participate in initiatives "when I need them" explaining how "the wellbeing stuff is really when it's needed… do I read a wellbeing newsletter to ensure I have healthy wellbeing? No … do I read it … if I need to? Then absolutely." While it is positive that individuals such as Oliver do partake in mental wellbeing initiatives, the data suggests that these people are taking a reactive approach. It appears that they allow the mental health issue to worsen until it gets significant enough for them to need help, as opposed to regularly utilising mental wellbeing activities to maintain high mental wellbeing and realise their full potential. Thus, on the other end of the continuum, some participants perceive high personal value in mental wellbeing initiatives. These participants understand the benefit that can be gained from engaging in activities that support mental wellbeing and are therefore highly motivated to participate in them for personal gain, such as increased focus, reduced stress, or increased happiness. Isabel (an employee) discussed having a busy work schedule and how she tends to "choose the most added value [initiatives] and do those" to ensure that "there's something to be gained for the time invested." Asher (a manager) mentioned that the current system for offering wellbeing initiatives is ideal because "any one of our staff has the ability to participate in it … in terms of receiving the value or the benefit of the programme but also creating and adding to the programme." The data suggests that allowing employees to shape initiatives can increase their perceived personal value in the activity and ensure that it fits the staff's needs.

On the far end of the continuum, the most highly motivated employees perceive high value in mental wellbeing initiatives and participate to maintain high levels of mental wellbeing and self-realisation. Hazel (an employee) goes to EAP "on a regular basis" and will "make the time to do that" because she finds the initiative to be highly valuable for her mental wellbeing. Many participants spoke about embedding wellbeing into their daily lives, making wellbeing "part of what you do", "part of the way you operate", or "part of the fabric and the culture of the organisation." Sophie (an employee) spoke about participating in various wellbeing initiatives and working on her own mental wellbeing, as well as others, on a daily basis because "I'm a huge advocate for all of it… it's really important to me." Sophie has come to appreciate the

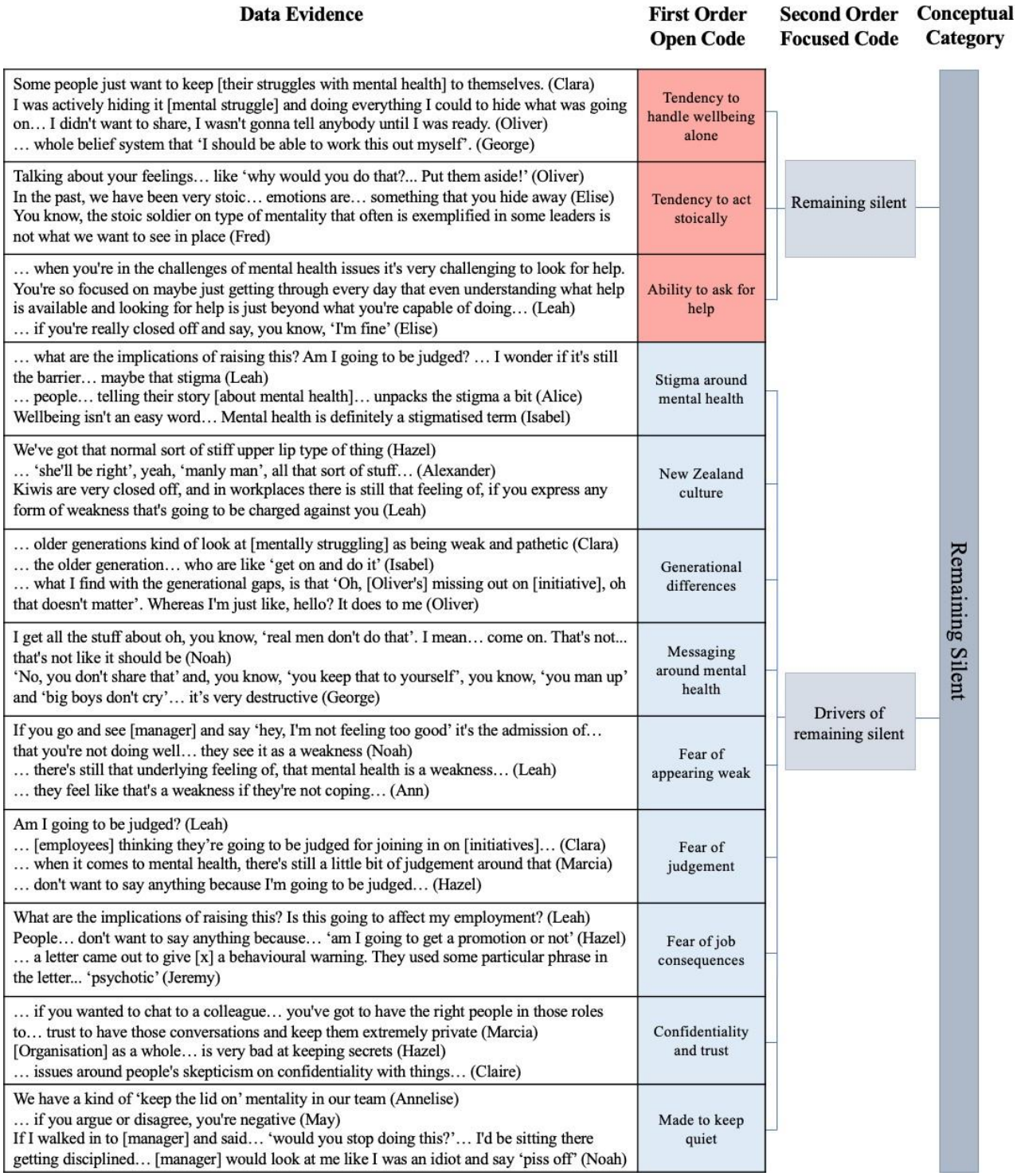
importance of having high levels of mental wellbeing for her career and day-to-day life. She now recognises that "[wellbeing] really is a day-to-day thing." Similarly, Marcia (an employee) commented on how when you do "little things" for your mental wellbeing every day, it "becomes part of your passion … your routine … and then you start to feel better and you go, oh, actually, there's something in this for me, and there's something in it for my family." The data also suggests that leaders can influence employees' perceived value of mental wellbeing initiatives. Leaders that obstruct participation by opposing or dismissing wellbeing initiatives may influence employees to gradually take on these beliefs themselves and thus perceive low value in wellbeing initiatives. Conversely, leaders that consider wellbeing initiatives to be "awesome", "really important", or "a valuable part of the day" may increase employees' perceived value and motivation to take part. Claire (a manager) noted that "people quite often will take their lead from their leader, so if their leader is into it, they'll be into it. If their leader's not into it, then they won't be."

Category Four: Remaining Silent

Remaining silent was another powerful theme to emerge from the data. It appeared that individuals tend to treat mental health and wellbeing as a personal issue and therefore remain silent about it. Figure 5 below depicts the coding tree for the category labelled *remaining silent,* featuring three properties that make up this behaviour; *tendency to handle wellbeing alone*, *tendency to act stoically,* and *ability to ask for help*. The coding tree also illustrates nine potential factors that appeared to drive this behaviour, as shown below.

Figure 5

Coding Tree for Remaining Silent



Many participants spoke about the *tendency to handle wellbeing alone*. Pauline (an employee) described "holding out" for participating in EAP because she felt that she "should be able to get through this [mental struggle] on [her] own." Similarly, Oliver (an employee) described "actively hiding" his mental struggle because he did not feel ready to share it, as shown below:

> *"I didn't want to share [mental health struggle], I wasn't gonna tell anybody until I was ready … I went silent … would I have shared it with [manager]? Did I feel comfortable to share it with [manager]? No. Why? Because of [manager's] behaviour and who [manager] is. Should someone like that even be in a team leader or management role? Probably not."* (Oliver, an employee)

The above quote suggests that a leader's behaviour can have a direct, positive or negative influence on employees' decision to share their mental challenges with their manager or utilise wellbeing initiatives. George (the organisation's EAP representative) noted that a significant barrier "that can hold people back" is their "whole belief system that, I should be able to work this out myself." George described observing individuals handling mental challenges individually due to a "lack of understanding… that we were never designed to be islands." This tendency to "keep that [mental health issue] to yourself" dissuaded employees from participating in mental wellbeing initiatives such as EAP or the peer support programme, or even from confiding in their manager.

Tendency to act stoically refers to an employee's likelihood of exhibiting a "stoic soldier on type of mentality" and "hide away" emotions, again preventing them from feeling that they could seek help by openly participating in mental wellbeing initiatives. Leah (an employee) mentioned that people tend to "scoot round the [mental health] issue, take a sick day, but not explain why that might be, rather than sort of owning up and saying, 'I'm having struggles'." Marcia (an employee) described her personal tendency to respond defensively to someone asking her if she is okay, replying with "Yeah, yeah, yeah! Of course! I'm fine! Yeah, I'm fine…" even if this was not the case. These comments suggest that an individual's denial of their distress and insistence that they are "fine" leads them to disregard and ignore mental wellbeing initiatives instead of participating and attempting to address their mental challenges.

Some employees showed low *ability to ask for help*. As Marcia (an employee) demonstrated above, participants find it hard to ask for help when they are mentally struggling and insist on

telling friends, co-workers, or managers that they are "fine" even when they are experiencing mental challenges. Several participants also discussed how seeking out mental wellbeing resources when experiencing a mental health issue can be an overwhelming, daunting task that acts as a barrier to participation. This view is illustrated in the following comment:

> *"I sometimes think when you're in the challenges of mental health issues it's very challenging to look for help. You're so focused on maybe just getting through every day that even understanding what help is available and looking for help is just beyond what you're capable of doing at that time."* (Leah, an employee)

The above quote suggests that when individuals are experiencing a significant mental health issue, they do not have the agency to seek out suitable initiatives because their personal resources are so diminished. In the document analysis stage of the research, it was found that the case study organisation's wellbeing strategy aims for individuals to take accountability and ownership for their own wellbeing, as well as the wellbeing of others. However, the data suggests a tension between asking staff to do so and showing staff the various available initiatives that may help someone in need. The data also suggests that merely offering a range of mental wellbeing initiatives and inviting employees to help themselves may not always be useful because some employees are simply not capable of seeking them out and arranging their participation.

The data also suggested several potential drivers of remaining silent. Many participants considered *stigma around mental health* to be the most significant barrier to participation in mental wellbeing initiatives because individuals feel weak or judged for participating. Leah (an employee) spoke about her reluctance to utilise wellbeing initiatives such as EAP or the peer support programme, saying "if I was suffering greatly… I would feel somewhat reluctant to be raising it openly" because there is "a level of judgement" and "stigma attached to owning up to having any form of struggles." Ann (an employee) talked about her fear of being stigmatised causing her to "hide from it [mental challenges], rather than own it" and therefore not take part in wellbeing initiatives. Conversely, Oliver (an employee) mentioned trying to "push through" stigma and "normalise" mental health conversations, saying "I feel like it [mental health] should be spoken about… just like a cold or flu or a cough… it's just as important."

Participants described how *New Zealand culture*, *generational views on wellbeing*, and *messaging around mental health* and wellbeing can reinforce the stigma around mental health and wellbeing. Several participants spoke about how people in New Zealand tend to deal with mental health challenges as a personal issue and "get on with it", favouring "self-sufficiency" and a "stiff upper lip", instead of addressing such challenges. This stoic tendency disinclines individuals from utilising wellbeing initiatives because, as Isabel (an employee) put it, negative views around mental health have led people that cannot "[deal] with the things that life presents" on their own to feel like "an inadequacy." Alexander (an employee) also talked about "that whole Kiwi[4] situation" where if someone asks "How you doing? You answer, 'Good' … you don't say, 'Oh, actually I'm doing bad, this sucks and rah rah rah' cause … that's not who we are as a people." These comments suggest that societal attitudes towards mental health can dissuade employees from engaging in mental wellbeing initiatives as they would rather be stoic and avoid being considered weak or inadequate by managers or co-workers for not being able to cope with mental challenges.

The analysis suggested that differing *generational views on wellbeing* can influence employee participation. Leah (an employee) discussed how the tendency to be stoic, "keep everything to ourselves", and "that whole persistence of *she'll be right*" is a "generational culture." Many participants concurred. Oliver (an employee) mentioned that "people that are 50, 60, 70, they're a lot more 'shut up and get on with it' rather than actually dealing with your issues." Blossom (an employee) believed that "old school thinking, in that you just suck it up… you don't talk about how much you're suffering …" has been passed down from generation to generation. Clara (an employee) felt that "older generations" view mentally struggling as being "weak and pathetic." As these comments suggest, individuals with these attitudes may be less likely to acknowledge their mental health challenges or participate in mental wellbeing initiatives because they tend to "suck it up", "soldier on", and "get on with it" instead of seeking out activities that support mental wellbeing. Further, as discussed previously, leaders displaying these attitudes can negatively influence employee participation by implying that employees should also suck it up, soldier on, and get on with it instead of seeking help from wellbeing initiatives.

[4] An informal term for 'New Zealander'.

The analysis indicated that *messaging around mental health* in society, which can also exist in the workplace, can be harmful and negatively influence employee participation. When individuals hear messages which cause them to repress their emotions, such as "don't share that" and "harden up", they are less inclined to talk about their own mental struggles or disclose that they are struggling by utilising wellbeing initiatives, as shown in the following comments:

> *"When we're not allowed to be authentic, when we're told that, 'no, you don't share that'… 'you keep that to yourself'… 'you man up' and 'big boys don't cry'… those sorts of things… It's very destructive."* (George, EAP Provider)

> *"[My boss] says 'harden up', 'move forward', 'forget about all those things!' [emotionally upsetting work issues]. Well, some of the things I've forgotten about, but some of it really hurt and it's definitely had an effect on my life. Definitely."* (Noah, an employee)

As these quotes illustrate, this kind of messaging is destructive and hurtful for the individual and suggests that supressing emotions is not an effective way to deal with mental struggles because those struggles still have an effect on an individual's life. The data also indicates that when leaders communicate in this harmful way employees are significantly less inclined to participate in mental wellbeing initiatives because they feel they are being dismissed and silenced, and feel "weak" for seeking out help instead of hardening up and forgetting about mental challenges. Many participants discussed the idea that "mental health is a weakness." Noah (an employee) spoke about his *fear of appearing weak* and the tendency to act stoically and handle his mental health individually as opposed to participating in mental wellbeing initiatives, saying "I think – no, not 'I think', I *know* that if you … started doing a lot of these [wellbeing] courses and taking time out to do them, you would be seen as weak." Ann (an employee) also spoke about how individuals perceive themselves to be weak when they are suffering with a mental health issue and "feel like that's a weakness if they're not coping", causing them to feel "ashamed" of their suffering. Participants that fear appearing weak appear to avoid seeking out help by utilising mental wellbeing initiatives. Pauline (an employee) demonstrated this view by saying, "if I get support [from EAP], then I am admitting to a weakness."

The data indicates that stigma, New Zealand culture, generational views, and destructive messaging around mental health and wellbeing have permeated society gradually over many years to the point where they largely go unnoticed. The data suggests, however, that these factors can manifest in places such as the workplace and part of what drives this manifestation is the behaviour of the leaders. Many participants stated that they fear speaking up about mental struggles in the workplace because of *fear of judgement* from managers or co-workers. Noah (an employee) spoke about avoiding utilising EAP because he "didn't want [managers] to find out about it. I was … I was um, yeah, scared I suppose. Yeah. I was scared… of their judgement." Noah mentioned that he should not have let his fear of the managers' judgement dissuade him from participating in an initiative he saw value in, saying "I suppose I was worried about what they'd say, whereas I should have just said, 'stuff you', and gone." As mentioned previously, Leah (an employee) commented how people tend to "scoot round" mental health issues because "there's still a perception of a level of judgement." Hazel (an employee) commented on the tendency for people to avoiding saying anything about their mental health because they fear they are "going to be judged." Beyond this fear of judgement, some participants felt a *fear of job consequences*. Claire (a manager) commented on employees' disinclination to raise anything that may suggest that they are not mentally healthy in case it puts their career at risk, saying "people… don't want to say 'I'm not coping', because then they don't want to lose their job." May (an employee) described personally feeling reluctant to disclose her high stress levels with a manager, saying "I'd be a bit worried about saying I was really stressed all the time" because of "what that might effect on my career." Similarly, Leah (an employee) described her reluctance to participate in EAP or the peer support programme because she was concerned about "the implications of raising this … Am I going to be judged? Is this going to affect my employment?" Marcia (an employee) personally worried that if she gave any indication of mentally struggling then management may ask "are you strong enough to do this job? Is the pressure too much? Can you not handle people?" Annelise (an employee) had personally experienced this: she was struggling with work-related incidents that caused her to become emotionally upset and her manager asked "are you *sure* you're cut out for this?" Annelise was hurt by this response and said that it was "not what I needed. I needed support."

Several participants also described worrying about their mental health issues being documented in company records. Jeremy (a manager) shared an experience of a colleague "getting a warning on [their] file" and being labelled as "psychotic" for their mental health issues. He described being "aghast that someone would write this!" and mentioned that the person "ended

up having a lawyer get involved who said this [diagnosis of mental illness] has got no basis whatsoever, this is opinion." Leah (an employee) also feared that "if you express any form of weakness, that's going to be charged against you" in company files. These comments illustrate that fear of job consequences acts as a barrier to participation because employees do not want to disclose or imply that they are not mentally coping by utilising initiatives. Instead, employees often choose not to engage in mental wellbeing initiatives to uphold the impression that they have good mental health.

Some participants described how *confidentiality and trust* issues deterred them from participating in wellbeing initiatives, such as EAP and peer support, or even confiding in their manager about a mental health issue. Hazel (an employee) described feeling "very hesitant" to have a private conversation with her manager because they are "not the best person to have a secret conversation with." Hazel (an employee) talked about gossip in the organisation and how some managers do not know how to respond to employees sharing private information with them but are then comfortable to say "Oh, do you know so and so? Oh, so and so says this …" This gossip then causes employees to worry that "if [they] do say something, will everybody know?" Claire (a manager) mentioned that "confidentiality is really important" but that some employees are inherently "sceptical" that there is "some kind of cynical back door, and the HR manager knows everybody that's going to counselling." Ann (an employee) agreed, commenting that some employees may be "paranoid" or "that trust isn't quite there… so they'd rather not [utilise EAP] just in case." Fred (a manager) mentioned that confidentiality and trust issues may be of most concern to employees who have "been burned by this before" and had their confidentiality breached, experiencing "a loss of trust and confidence in a relationship."

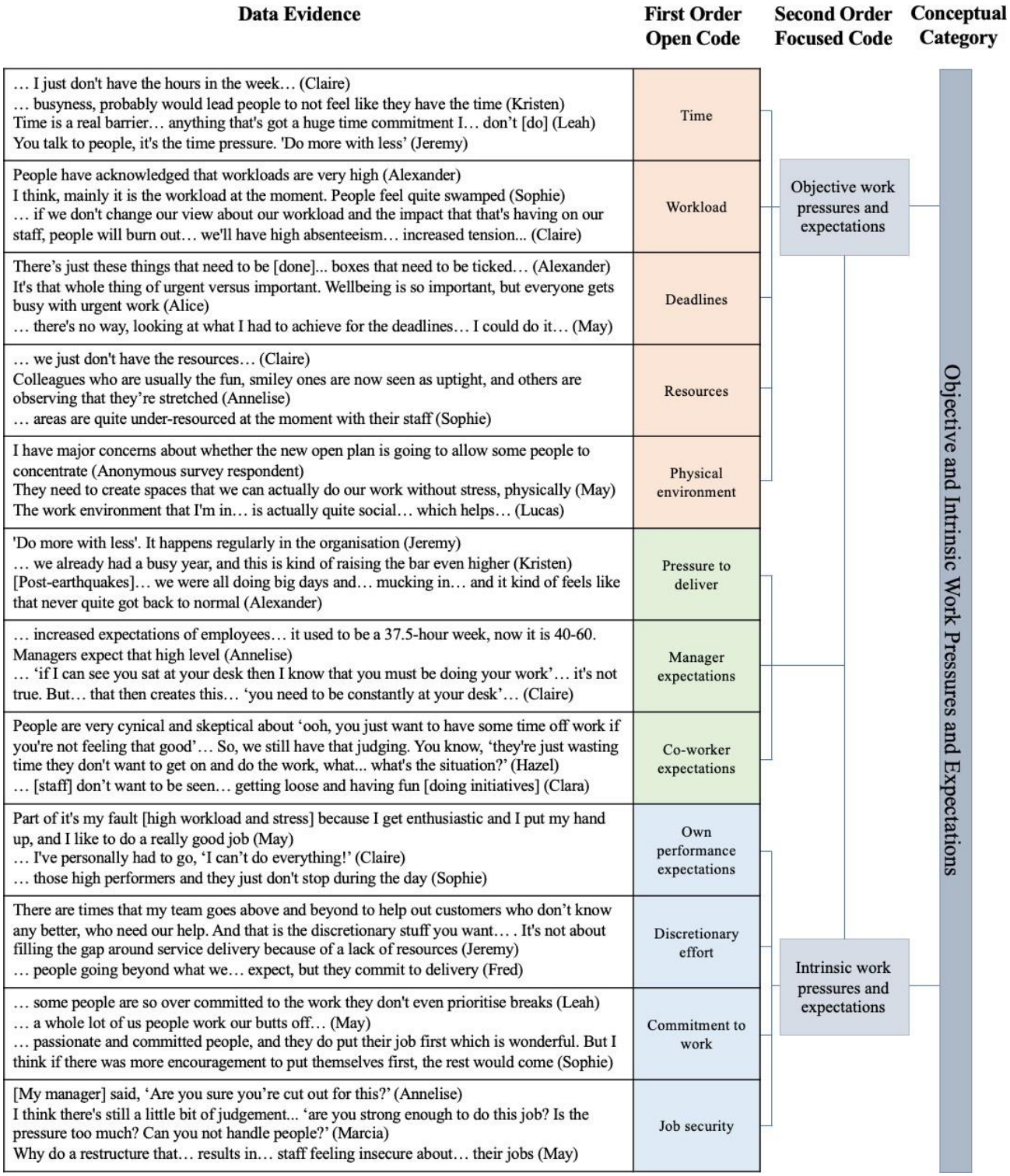
Some participants discussed being *made to keep quiet* about work or personal-related issues causing them mental distress by their managers. For instance, when Annelise (an employee) was experiencing emotional distress due to work-related concerns she was "told not to complain" and "you're not allowed to be negative." Several other participants mentioned similar experiences, such as May (an employee) who mentioned witnessing a colleague being shut down when he raised a work-related concern with a manager, recalling "the tone of voice that he was being spoken to was… intimidating! And he shut up!" Being made to keep quiet, or observing a colleague spoken to in this way appeared to discourage employees from participating because they did not want to be shut down or dismissed for being "negative" for needing to utilise initiatives or raise issues to address mental ill-health.

Category Five: Objective and Intrinsic Work Pressures and Expectations

Work pressures and expectations were another significant theme to emerge from the data. Figure 6 below depicts the coding tree for the category labelled *objective and intrinsic work pressures and expectations*, distinguishing between work pressures that are real or objective and perceived or intrinsic. These sub-categories highlight the fact that work-related barriers to employee participation in mental wellbeing initiatives may be real or self-imposed.

Figure 6

Coding Tree for Objective and Intrinsic Work Pressures and Expectations



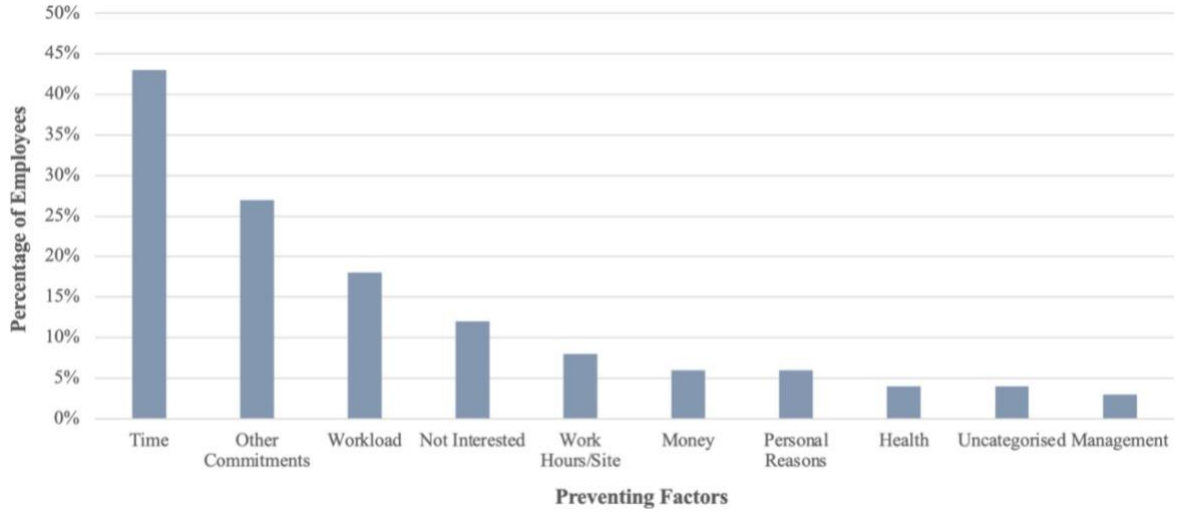
Objective Work Pressures

The first sub-category labelled *objective work pressures* captures the real, extrinsic, concrete work pressures that emerged from the data that can act as barriers to participation, including *time, workload, deadlines*, *resources,* and *physical environment.* The majority of participants spoke about time being a significant barrier to participation, saying "it's the time pressure", "we're busy, we're flat out", and "I just don't have the hours in the week." Jeremy (a manager) also mentioned that the organisation regularly puts added strain on employees' time constraints by instructing staff to "do more with less." Kristen (a manager) discussed how her team had significant time pressures, making utilising wellbeing activities a low priority or an impossibility, saying "people feel like they don't have the time available to do something [initiative] that is not considered productive." Marcia (an employee) explained how she struggles to juggle participating in wellbeing initiatives in her busy job where "you could get called out here or called out there or a meeting scheduled … you kind of feel a bit pushed and pulled and then you've got a report that's due so you need some desk time …"

This finding concurs with the results of a wellbeing survey carried out by the organisation in 2018 which was examined during the research's document analysis stage. The organisation's survey was designed to gather feedback from staff to inform the development of their company wellbeing strategy. It included a question which sought to examine the "factors that prevent employees from participation in wellbeing activities", and the most commonly reported factor was *time*, with 43 percent of respondents selecting this factor (see Figure 7 below).

Figure 7

Case Study's Survey of Factors that Prevent Employees' Participating in Wellbeing Activities



Note. Adapted from case organisation's 2018 survey results.

Most participants also spoke about *workload* in conjunction with time. As shown in Figure 7 above, *workload* was the third most reported factor that prevents employee participation in wellbeing activities, with 18 percent of survey respondents selecting this factor. Every interview participant that mentioned their workload felt that it was "really high", "horrendous" or that they had "way too much on their plate." Workload was therefore identified as a significant barrier to participation, as these staff members lacked the time or capacity to participate in mental wellbeing activities at work. The data also suggested that these high workloads were potentially negatively affecting staff wellbeing as they were working at a "constant high level" without periods of rest in between, as evidenced in the following comment:

> *"I find my workload really high … I guess it's not only your full workload, it's the full workload all the time … everyone can cope with peaks and putting in the extra effort for those peaks but we never have the troughs to kind of regroup between them, it's a constant high level. And that's really challenging … at a top productivity, great output, healthy staff level, I don't think it's sustainable. But … it is what it is."* (Leah, an employee)

Another objective work pressure participants identified was concrete *deadlines* set by the organisation. Deadlines act as a barrier to participation because employees do not have

available hours to spend on wellbeing activities with deadlines fast approaching. Some participants felt that these tight deadlines "undermine" the culture of wellbeing that the organisation is trying to cultivate. May (an employee) mentioned feeling "stressed" and "struggling to meet the deadlines." She felt that wellbeing initiatives did not adequately compensate for that stress, saying "if you've got work deadlines … you still have to meet the deadlines. So, it doesn't matter what's [what wellbeing activities are] around you, you still have to do it." Similarly, Alexander (an employee) spoke about being overwhelmingly busy and approaching burnout: "I've got nothing left, the tank is empty, I'm doing as much as I can, I kind of can't see the way out." Alexander felt helpless because he could not participate in wellbeing initiatives due to his workload and deadlines, and expressed feeling guilty if he were to participate and put that stress on another colleague, as shown below:

> *"... workloads are only getting bigger ... however, these things need to be done ... they're deadlines, they're not going to change. If ... you need help you need to say you need help, but it's got to be done ... and if you're not doing it, someone else is doing it."* (Alexander, an employee)

Another objective work pressure interview participants discussed that inhibits participation was a lack of *resources*, specifically a lack of staff. Sophie (an employee) spoke about how many teams in the organisation "are quite under-resourced at the moment with their staff", putting added strain on employees and reducing their capacity to participate in wellbeing activities. Sophie mentioned how the COVID-19 pandemic placed added financial pressure on the organisation, saying "we just haven't had the budget to be able to resource areas, so everyone's a little bit stretched." Jeremy (a manager) felt frustrated that the organisation was instructing staff to "do more with less" without "assess[ing] what the scope of the work is" and "work[ing] out if you've got the resources for the work." Jeremy mentioned how many staff members frequently exert discretionary effort but that it had started to feel obligatory, as shown below:

> *"[Discretionary effort is] not about filling the gap around service delivery because of a lack of resources. It can be on occasion when people are sick, or away on leave and we'll do what we can. But to me, when you're expecting people to do that, it's hard on people and you start to burn the candle at both ends."* (Jeremy, a manager)

Further, the data suggests that the added strain of being under-resourced causes employees additional stress, making them more in need of mental wellbeing initiatives and yet less able to utilise them. This added strain again makes employees perceive mental wellbeing activities to be insufficient in reducing stress and keeping staff in a state of high wellbeing, as evidenced below:

> *"… what we should be doing to really help our employee wellbeing is going, 'We can't sustain this level of performance on this number of resources. So, either we employ more people to be able to do the job or we have to reduce our level of expectation. We have to reprioritise what that workload looks like'. But there has to be a fundamental shift. Not just going, 'Oh, but you can take some time off. It's fine!' and they'll go, 'Oh yeah! And my work will still be there when I come back and I'm still stressed about it!'"* (Claire, a manager)

The final objective work pressure participants discussed was their *physical environment* at work. Some participants expressed concerns about internal offices, open plan offices, and temporary office accommodation disrupting their concentration and ability to get work done, subsequently causing them to feel stressed. Some participants were concerned about the lack of privacy in open plan offices to talk to others when experiencing mental struggles. Hazel (an employee) also mentioned that the lack of privacy in open plan offices prevented her from fully utilising the services of the workplace chaplain, saying "if you have a chat [with workplace chaplain] … we can hear all conversations there, you're not gonna have a private conversation … There's very few private spaces that you can go to …" May (an employee) expressed similar concerns, as evidenced in the following comment:

> *"[Workplace chaplaincy]… I find that really useless because, yes [chaplain] is lovely and [x] comes around, but [x] stands by your desk and says, 'Hi, how are you?' and you go, 'Yeah, I'm fine, thank you'. If you had a problem… I guess you could say 'Hey, I need to talk to you' and then you could go somewhere and talk, but it's not conducive to, you know... there'd be five or six people [around] and you'd go, 'Oh, actually I'm a bit down, can I go and talk to you?' I mean yeah ..."* (May, an employee)

The above comments illustrate that the physical environment can act as a barrier to participation because the lack of privacy leads employees to be stoic instead of expressing their concerns about their mental wellbeing with a workplace chaplain and/or a peer supporter, colleague, or manager.

Objective or Intrinsic Work Pressures

The middle of the coding tree in Figure 6 captures the unique and interesting finding that work pressures may be either real and objective or perceived and intrinsic. These objective or intrinsic work pressures have three properties: *pressure to deliver*, *manager expectations,* and *co-worker expectations*. The data indicates that pressure to deliver, for example, may be because of the organisation setting projects and tight deadlines, or may be somewhat self-imposed, where employees put pressure on themselves to deliver at a high level due to their own performance expectations. For some participants, pressure to deliver was real as the organisation did not lower expectations when the budget was constrained, as captured below:

> *"… there's less capacity … but there's still an expectation around levels of service not changing and so it's kind of … 'do more with a lot less' and everyone's like, 'Ahhhhh! … yeah okay, um sure! We'll, we'll try and figure it out'."* (Alexander, an employee)

> *"We've got to take the lead and do something about [unsustainably high workloads/high expectations] and that also involves not just us internally as an organisation but we need to get our council on board because our council sets the tone. They're the ones that set the expectation around workload. And, you know, we need to have a voice to be able to speak up and say, 'actually, we can't do it. If you're not going to give us any more money to get some more staff, we can't deliver that expectation, because it's just too much'. But what we tend to do, is we just say yes to everything."* (Claire, a manager)

The above quotes demonstrate that real pressure to deliver acts as a barrier to employee participation because the organisation is piling more work on employees, reducing their capacity to engage in wellbeing activities. As mentioned previously, the final comment above also suggests that some managers lack agency to make staffing changes to improve workloads. For other staff members, however, pressure to deliver may either be objective *or* intrinsic. For

instance, Jeremy (a manager) mentioned feeling "pissed off" that the discretionary effort he exerted is now always expected of him, so he now "feel[s] obliged to do this because I've got to deliver the service." Several other participants, such as Annelise (an employee) shared the same concerns, feeling pressure to deliver at an unsustainably high level, saying "when you're working above your required level for an extended period of time, you're then expected to always work at that level." These quotes demonstrate that some employees may feel pressure to deliver because the organisation is saying "do more with less" and *explicitly* putting pressure on staff, or because they "feel obliged" to deliver and show discretionary effort and now feel that they are "expected" to maintain that high standard. These comments show that whether pressure to deliver is real or perceived, it acts as a barrier to participation as employees feel unable to take time out for wellbeing activities.

Other factors that potentially influence participation are *manager expectations* or *co-worker expectations*, which may also be either objective or intrinsic. Employees may observe their managers' overt comments and behaviours that explicitly inform them of their real expectations, or they may interpret their managers' comments and behaviours, potentially inaccurately, and develop an internalised misunderstanding of their managers' expectations of them. The following quote suggests a real, explicit expectation that some managers may have of employees and how this directly influences employee participation in wellbeing initiatives:

> *"[Managers] doing the clock watching thing or, you know, making a flippant comment about… working hours and things like that… people remember that stuff. And that's what makes them go, 'I can't go and join Te Reo or I can't go to a thing [initiative] because, actually they expect me to be back at my desk at a certain time or, you know, they're looking at what time I leave and then making a note of it and watching what time I come back', and there is that… explicit kind of pressure on them to perform and behave in a certain way."* (Claire, a manager)

However, the data also showed that manager or co-worker expectations were not always explicit but interpreted, potentially inaccurately, by employees and are therefore perceived:

> *"… if you're somebody that does a lot of wellbeing initiatives… you're going to get the evil eye from other people in your team that's like, 'oh, you know, she's*

just gone to another thing and now she's having a lunch break so that's another hour and a half'… it's that peer pressure." (Claire, a manager)

"[My boss's] comment to me was that not everyone has the time to join in and have fun [doing wellbeing initiatives]. Although I knew that it was likely only because she was catching up on workload that she made this comment, I still took it on board and going forward have been more selective about which wellbeing initiatives I take part in. Even though my boss does say that she supports wellbeing initiatives, subconsciously I remember this comment and make sure that I don't do too much or have too much fun at work." (Pauline, an employee)

The above quotes demonstrate that employees can potentially interpret co-workers' or managers' behaviours or comments in a way that was not intended. An employee could misinterpret a comment or an innocent look as "the evil eye" which may lead them to believe that their co-worker disapproves or judges them for participating in wellbeing initiatives, which may or may not be the case. The following quote demonstrates how employees' perceptions of their managers or co-workers' expectations influence their decision to participate and how these perceptions may not actually be true:

"I don't actually think it's managers saying that they [employees] can't [have fun at work], it's more people thinking that their managers think that way. A lot of managers that I talk to, they're all on board, so it's just people's different perceptions of how they think they'll look to other people." (Clara, an employee)

Intrinsic Work Pressures

The third sub-category in Figure 6, labelled *intrinsic work pressures*, captures the perceived, internalised, or self-imposed work pressures that can act as barriers to participation. Intrinsic work pressures have four properties: *own performance expectations*, *discretionary effort*, *commitment to work,* and *job security*. These intrinsic work pressures can negatively influence employee participation. The data showed that some participants put pressure on themselves to perform at a high level and meet their *own performance expectations*. For instance, May (an employee) mentioned working additional hours than contracted because she "like[s] to do a really good job … I work my butt off and I'm actually known to get really good results. That's because I give a damn!" Similarly, Claire (a manager) had high expectations of herself and felt

that she "had to be a part of" every process, committee, or group because she had the "breadth of knowledge or the skill, the expertise. But I just can't do everything!"

The data indicates that the nature of local government work and being "civil servants" means that many employees in the organisation are committed to serving the community to the best of their ability. While this is an admirable and noble pursuit, Sophie (an employee) felt that some employees are so committed to serving others that they show *discretionary effort*, sometimes to a point where they no longer prioritise their own mental wellbeing, instead they "put their job first." Elise (an employee) personally felt that her priority at work was not her mental wellbeing but that her "biggest responsibility is to our community… they're the reason we're here!" Jeremy (a manager) discussed how staff being "community focused" can lead them to deliver discretionary effort "in spadefuls" at the expense of their own mental wellbeing because they overwork themselves, saying discretionary effort "wears thin after a while, you know. It starts to build resentment." The data suggests that self-imposed pressure prevents employees from utilising wellbeing initiatives and that this can be at the expense of their own mental wellbeing.

The analysis showed that some staff members were going beyond discretionary effort and showed a high level of *commitment to work*, sometimes to the extent where they were over-committed to tasks. Leah (an employee) mentioned that many of her colleagues, including herself, are "so over-committed to the work they don't even prioritise breaks … so, yeah. They absolutely wouldn't prioritise these [wellbeing initiatives] … I generally don't do lunchtime, which is … not great." Fred (a manager) explained that being over-committed to the work meant that some employees would not engage in mental wellbeing initiatives even if they were granted "an hour off to do X, Y and Z [wellbeing activities] and … that's legitimate, people will still struggle to take it, even if it is discretionary for them." Fred mentioned that some employees would merely use that extra time to just get more work done, "being over-committed to the task." Several other participants agreed, including Clara (an employee) who did not believe that being given work time to participate "will actually happen … it's hard enough trying to get people to take their allocated breaks" and Hazel (an employee) who commented that "I know some people in different departments that are like that … I can't [participate]! I can't even take a day off because I'm so busy!"

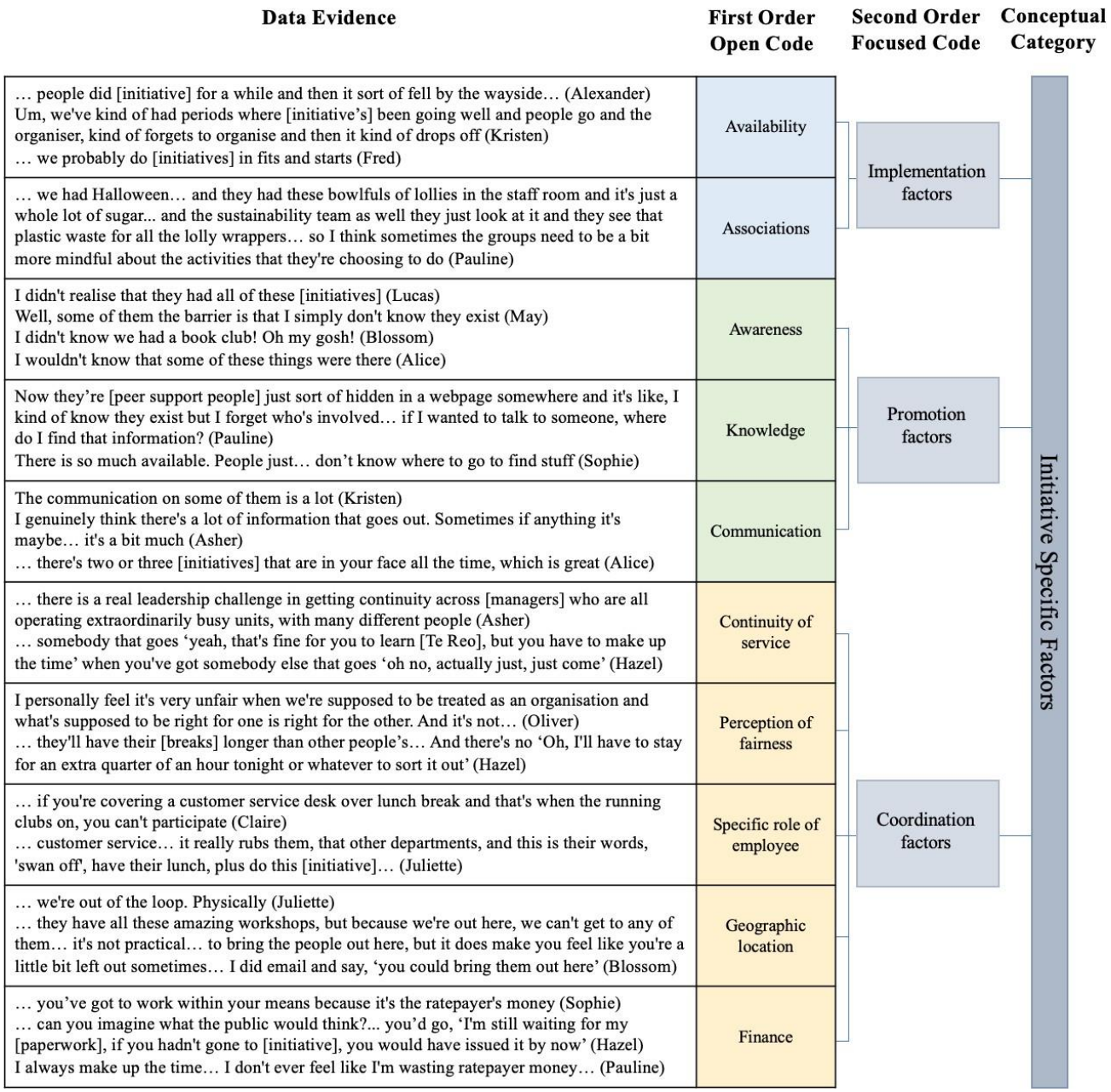
Some participants mentioned not participating in initiatives because they lacked *job security* due to an organisational restructure and COVID-19 threatening their employment. The data showed that job insecurity negatively influences participation because employees do not want to be seen to be "slacking off" by participating or perceived as "weak" for struggling mentally. Therefore, some employees choose to avoid these negative perceptions by not utilising mental wellbeing initiatives. The data showed a connection between own performance expectations, discretionary effort, over-commitment to the task, and job insecurity. The participants that talked about working through their lunch breaks, working their "butt off", and being over-committed to the work were the same participants who expressed concerns about the security of their jobs. For instance, as mentioned previously, May (an employee) was reluctant and "worried" to utilise wellbeing initiatives that indicated to others that she was stressed in her job because of "what that might effect on my career." Similarly, Leah (an employee) discussed extinguishing all other potential options for mental health support before utilising EAP or the peer support programme, saying they "wouldn't be my first port of call. I'd be thinking long and hard about, what are the implications of raising this? … Is this going to affect my employment?" Thus, worrying about the security of one's job dissuaded employees from participating in mental wellbeing initiatives. This category demonstrates that whether work pressures and expectations are objective or intrinsic, they can act as barriers to participation in mental wellbeing initiatives.

Category Six: Initiative Specific Factors

The final category that emerged from the analysis relates to the initiatives themselves. Figure 8 below depicts the coding tree for the category labelled *initiative specific factors,* and outlines the three sub-categories: *implementation factors, promotion factors,* and *coordination factors*.

Figure 8

Coding Tree for Initiative Specific Factors



Some participants spoke about *implementation factors* such as initiative *availability*, which acted as a barrier to participation when initiatives were discontinued or no longer available. Kristen (a manager) spoke fondly of a social initiative that her team was enjoying. However, Kristen mentioned that occasionally, "the organiser kind of forgets to organise and then it kind of drops off." Fred (a manager) also agreed, speaking about how the organisation often runs initiatives "in fits and starts. Somebody will have an idea, 'Why don't we do one of them?'

'Yep! Okay!' and we're away …" However, Fred commented on how some initiatives are suddenly discontinued, describing a "broadsheet on wellbeing … sent to all staff which will typically pick up on … a theme of *The Five Ways to Wellbeing* or some tips and things." He assumed that this initiative had discontinued because "I haven't seen one for, it feels like two or three months at least." If wellbeing initiatives drop off and become unavailable, employees simply cannot participate in them anymore. Another implementation factor that acted as a barrier for some employees was that some initiatives had unintended negative *associations*. For instance, Pauline (an employee) described how a wellbeing committee in the organisation celebrated Halloween with "these bowlfuls of lollies in the staff room… a whole lot of sugar that people do not need" and how "the sustainability team as well, they just look at it and they see that plastic waste from all the lolly wrappers." Pauline was disheartened to see that activities such as these are "almost a negative, like they don't really help wellbeing that much" which dissuaded her from participating. Pauline felt that "sometimes the groups need to be a bit more mindful about the activities that they're choosing to do."

The data indicated that several *promotion factors* influence employee participation. Many participants showed a lack of *awareness* of available mental wellbeing initiatives and were surprised to see the complete list of initiatives that the organisation offered. May (an employee) mentioned that for some of the initiatives "the barrier [to participation] is that I simply don't know they exist." Upon first seeing the list of initiatives in the all-staff survey conducted to gather initial participation rates, one respondent commented "I knew of [x's] boot camp but didn't know it was an ongoing theme. I was also unaware of the book club. Where do I found out this stuff?" When the list of initiatives was shown to the interview participants, some were pleasantly surprised. Blossom (an employee), for example, exclaimed: "It's an amazing list! And I had no idea that there were actually that many things, like once you see it like that, it seems so good!" Alexander (an employee) made a colleague aware of a Tai Chi activity and recalled their enthusiastic response, "I didn't know this was a thing! I'm really keen!" Alexander also mentioned how that colleague has "been around for ages and I think these sessions have been going for ages, so [x] just hasn't come across it." Other participants such as Alice (an employee) were disappointed that they were not previously aware of all available initiatives because they had been missing out on participating for some time, stating "I have no idea when the Te Reo lessons are. I have no idea about the book club." While some participants spoke about being somewhat aware of the initiatives, they lacked the *knowledge* of how to go about participating in the activities, as Leah describes below:

> *"In terms of the mentoring, it would be quite neat now that I've sort of seen it … to think about doing that. But I don't know how to approach ... how do I go about that? Do I find one? Do I put up my hand and say I need one and there's a list of people that have offered? So, that's … a barrier for me."* (Leah, an employee)

Similarly, Juliette (an employee) felt that the peer support programme needed more promotion and *communication* because her team were unsure about how the initiative worked, asking "well, what do they do?" and "What's peer support? What is involved?" Conversely, some participants felt that there was excessive communication about some wellbeing initiatives, to the extent where it "aggravated" them. Kristen (a manager) mentioned that while there was "probably more we can do in terms of awareness" she did not want the organisation to be "constantly sending more emails, because I know I get aggravated with it... my inbox is so cluttered… it's just one more I have to delete." Noah (an employee) also found it frustrating to receive numerous emails about an initiative he was not interested in participating in, saying "this morning, I had 90 emails. I couldn't believe it… The [committee] sent 12 of them for a run that they're going on, as if I really want to go and run." Thus, the data suggests a tension between making employees aware of the mental wellbeing initiatives on offer and not overloading staff with information, particularly when initiatives may not be of interest or relevance to some employees. As the following comment suggests, not communicating to staff about the initiatives on offer only reduces awareness and subsequently uptake:

> *"We've started to reduce the amount of all staff emails and flyers… because we want people to go to the intranet for that source of information [on wellbeing], but we find that when you ask people to go and seek it out, they quite often don't make time for it. Whereas if you chuck it at them, they'll quite often read it."* (Claire, a manager)

The data also indicates several *coordination factors* that influence participation, including *continuity of service* around wellbeing across the whole organisation. Asher (a manager) mentioned that as a large local government organisation made up of many different departments and geographically spread widely, "one of the challenges we have … is consistency and continuity of service around wellbeing." Several other participants also discussed consistency or continuity of service and how the way one manager "might approach wellbeing … may not be the same as the way [another manager] in another unit might approach

it." When employees experience a lack of consistency and continuity of service this influences their *perception of fairness*, where they perceive inequities across the organisation in terms of ability or flexibility to participate in these initiatives or the level of managerial support they receive. Asher (a manager) explained that staff members may compare situations and "see inconsistencies … in terms of well … [x] got this offer … or this level of support from his manager, and I didn't get that when I had a similar situation." Leah (an employee) also described being unable to help comparing her situation with others, saying "in any organisation like this where you have multiple teams across multiple disciplines in multiple buildings, there's always that … sort of feeling of maybe somebody else has got something better." Claire (a manager) provided an example of perceived inequity:

> *"... one particular individual at the moment ... feels like [x]'s constantly under scrutiny from other people in their team, because [x] does hockey and Te Reo and then [x] has her lunch and other people are like, 'Oh, you're never here!' and it's kind of like 'well, but I'm here late, or I'm here early' and so they don't see that other stuff ... it's already been pre-agreed with the line manager ... it's just, it's that perceived inequity."* (Claire, a manager)

Hazel (an employee) believed that the organisation needed to have "protocol" or a "policy" in place so that everybody had "the same", "fair" treatment around mental wellbeing. She explained that some staff members have a manager that says "yeah, that's fine for you to learn [Te Reo], but you have to make up the time" when other managers say "oh no, actually just, just come!" The data also showed that the *specific role of employees* can act as a barrier to participation and lead to perceived inequities across the organisation. For instance, Leah (an employee) discussed how customer facing staff members do not have the same flexibility to participate in wellbeing initiatives because they "can't get away at a certain time of the day to go to a yoga session because they're tied to a customer interaction." Leah felt that there is "some inequity in there and maybe some thought about how that could be overcome." Customer facing employees such as Blossom, felt frustrated that other staff members can "just flit off whenever they want" to participate in any mental wellbeing initiatives "whereas, we can't do any of those things!"

Some participants also described how *geographic location* was another inequity that prevented some employees participating in wellbeing initiatives. As the organisation is widely spread out

geographically and the majority of wellbeing initiatives are offered at the main office building, some staff members do not have the time or flexibility to travel there and back within a limited lunch break. Blossom (an employee) who works away from the main office building, felt "a little bit left out sometimes" because the main office runs "all these amazing workshops, but because we're out here, we can't get to any of them."

Participants stated that another factor that may influence employee participation is the challenge of *finance*. As a local government organisation dealing with ratepayers' money, the limited budget for wellbeing initiatives potentially restricts the number or range of wellbeing initiatives offered to employees compared to that of private organisations. Sophie (an employee) mentioned that the organisation wants to do "so much more" in terms of supporting employee mental wellbeing, and offer "more individualised" wellbeing initiatives but that "you've got to work within your means." Kristen (a manager) agreed, stating that "you need to be responsible" with ratepayer dollars and the organisation cannot spend it on "exorbitant" wellbeing initiatives. Isabel (an employee) also mentioned that the organisation cannot be seen to be doing too many wellbeing activities because "we've got ratepayers looking at what we do, so … it's a fine line between what's acceptable … for ratepayers to be paying for us to spend an hour doing something for our mental health and wellbeing." Hazel (an employee) did not want the public to be angered by seeing their rates go towards wellbeing activities for staff and thinking "what the hell are they doing? You don't go to work to do your running club, your book club, or anything, anything like this. You're there to work!" Pauline (an employee) agreed, noting that "you do have to make sure that … you are doing what you're paid to do." Interestingly, however, no participants spoke about desiring costly or individualised wellbeing initiatives. Instead, many participants stressed the importance of having a strong, healthy organisational culture in place which would ultimately reduce the need for wellbeing initiatives by preventing mental ill-health and supporting mental wellbeing on a daily, informal basis.

Conclusion

Using thematic analysis to analyse the data, this research has shown that employee participation in workplace mental wellbeing initiatives is influenced by: *leadership, organisational context,* the *perceived value* employees place on wellbeing initiatives, employees' tendency to *remain silent,* employees' *work pressures and expectations,* and *initiative specific factors*. The findings of this chapter bring to light the significant role of the leader in influencing each of these

factors, as well as how the organisational culture and work environment provide the overall backdrop within which the other factors exist. Further, the chapter has demonstrated that factors that influence participation can either be positively or negatively experienced, depending on how they are managed within a particular organisation, and therefore each factor may be a barrier or an enabler.

The following chapter presents a detailed discussion of the findings and relates them to existing literature. The discussion focuses more on the unique or interesting findings, as some of the objective or logistical barriers such as time, workload, geographic location, and finance were anticipated at the study's onset and are relatively obvious barriers to participation. They were also previously identified in the literature and therefore do not warrant detailed further analysis, particularly because these themes did not carry the most weight in the analysis. Thus, the following chapter provides a comprehensive examination of the influence of leadership on each of the key themes.

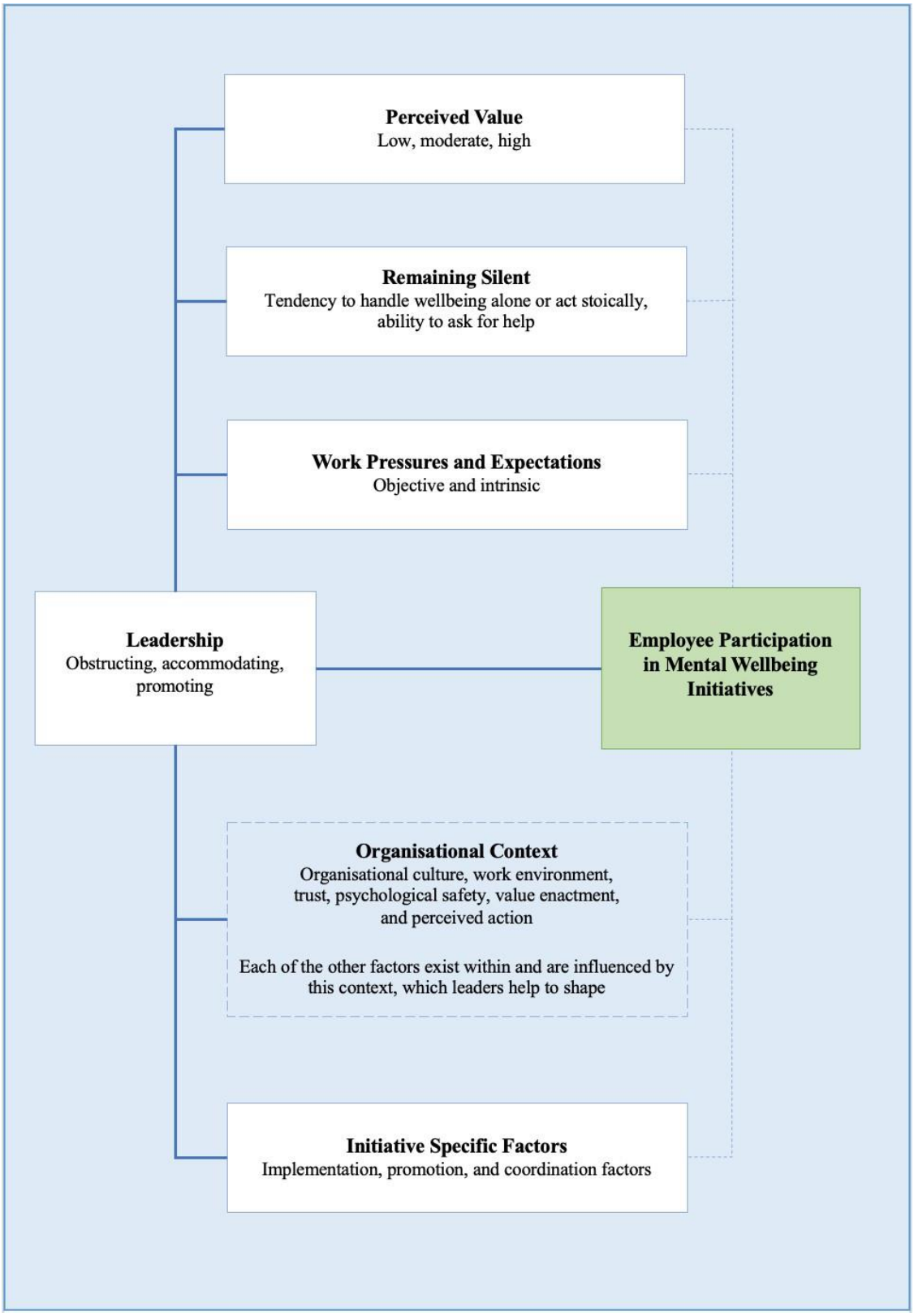
Chapter Five: Discussion and Theoretical Contributions

Introduction

This study identifies six factors that influence employee participation in workplace mental wellbeing initiatives: 1) leadership, 2) organisational context, 3) perceived value, 4) remaining silent, 5) work pressures and expectations, and 6) initiative specific factors. The most influential of these factors is leadership, hence its centrality throughout the discussion. This chapter interweaves the study's theoretical contributions with extant literature to explain how leaders both directly and indirectly influence employee participation in mental wellbeing initiatives. The chapter outlines the study's limitations and opportunities for future research. It concludes with a discussion of the practical contributions of the research.

Figure 9

A Model of the Factors that Influence Employee Participation in Workplace Mental Wellbeing Initiatives



The Role of Leadership

Figure 9 identifies a multiplicity of factors that influence employee participation in workplace mental wellbeing initiatives, the most significant of which is *leadership*. While extant research has mentioned the role of leadership, few studies have fully explicated how leaders influence employee participation. The present study addresses this gap and demonstrates that leaders exert both a direct and indirect influence on employee participation in mental wellbeing initiatives. This thesis argues that leaders can directly inhibit or enable employee participation by demonstrating key leadership behaviours of *obstructing*, *accommodating*, and *promoting* participation. Obstructing occurs when leaders overtly oppose wellbeing initiatives and are generally unwilling to accommodate employee participation, thereby acting as a direct barrier. Accommodating occurs when leaders neither overtly oppose or promote wellbeing initiatives, but instead demonstrate a degree of reticence to discuss mental wellbeing with staff or promote employee participation in mental wellbeing initiatives. The findings suggest that such behaviours may stem from a lack of mental health literacy or confidence in dealing with mental wellbeing in the workplace. Contrastingly, promoting involves leaders encouraging and/or enabling employee participation by demonstrating genuine care for employee wellbeing and actively supporting or even role modelling participation. In addition to this direct influence of leadership, this thesis further argues that leaders indirectly impact employee participation in mental wellbeing initiatives through their influence on the *organisational context*, within which all of the other factors exist. More specifically, the findings indicate that employee participation is likely to be greatest in organisations where leaders are able to establish a culture of trust and a psychologically safe work environment.

At an individual level, several factors influence employee participation. These factors include the *perceived value* that an employee places on a specific mental wellbeing initiative; employees' tendency to remain silent about mental health and wellbeing; context-specific *work pressures and expectations;* and *initiative specific factors.* Organisational leaders and managers have the ability to influence how each of these individual factors are experienced. For example, a leader can enhance employees' *perceived value* of mental wellbeing initiatives through promoting behaviours such as role modelling participation or destigmatising mental health and illness within the organisation and more generally. Conversely, obstructing behaviours, such as overtly opposing wellbeing initiatives, are likely to diminish the value employees attach to a particular initiative. Leaders can also influence the extent to which

employees *remain silent* about mental wellbeing challenges in the workplace by reinforcing or weakening the drivers of remaining silent, such as the stigma associated with mental health or through their influence on the organisational context. Leaders can also moderate the degree to which objective or intrinsic *work pressures and expectations* act as barriers to participation by creating time for employees to participate and by addressing unrealistically high work expectations that employees may have for themselves. Finally, leaders have some ability to address *initiative specific factors* to improve the implementation, promotion, or coordination of mental wellbeing initiatives. While some initiative specific factors, such as geographic location, may always be barriers to participation for some employees, promoting leaders have some ability to enable participation by ensuring initiatives are available, that employees are aware of them, and that they know how to sign up.

The findings also demonstrate that the determinants of employee participation in mental wellbeing initiatives are interrelated. Thus, when a leader affects positive change in one factor, this change has the potential to positively influence another factor, which ultimately removes barriers and creates enablers to employee participation. For example, a leader can increase employees' *perceived value* of mental wellbeing initiatives by affecting positive change in (a) their direct *leadership* behaviours and promoting participation in mental wellbeing initiatives, (b) by creating a positive and supportive *organisational context* that is conducive to wellbeing, (c) by reducing employees' tendency to *remain silent* by destigmatising and communicating positive messaging about mental health in the workplace, (d) by assuring employees that mental wellbeing initiatives may help them to manage their *work pressures and expectations* by increasing their focus, productivity, or performance, or (e) by addressing *initiative specific factors* such as increasing awareness or knowledge about specific initiatives in order to highlight their potential value. This thesis argues that if a leader merely influenced one of these factors it is likely to be insufficient to enhance employee participation as any of the other factors may still be preventing participation. When an effective leader positively influences each of these factors by removing barriers or creating enablers, the cumulative effect is an environment that promotes and enhances sustained employee participation in workplace mental wellbeing initiatives. Figure 9 depicts the dynamic interplay that exists between each of these factors, all of which can stand alone within the organisational context.

Discussion

Decades of literature has demonstrated the vital role that managers or leaders play in changing and inspiring employee behaviour (Dimoff & Kelloway, 2019; Schaubroeck et al., 1993; Tsutsumi et al., 2005). The present study adds to this literature by offering a more emic, nuanced, and in-depth understanding of how the three leadership behaviours of *obstructing, accommodating,* or *promoting* directly and indirectly influence employee participation in workplace mental wellbeing initiatives. As previously discussed, while existing literature on barriers and enablers to participation in workplace mental wellbeing initiatives or wider workplace health promotion programmes make some mention of leadership, this is often in passing or takes the form of vague, abstract statements (Person et al., 2010; Rongen et al., 2014). This lack of detail on leadership is partly attributable to the use of quantitative methods such as surveys, questionnaires, or systematic reviews that are unable to provide in-depth explanations of how leaders inhibit or enhance participation (Gulliver et al., 2010; Lakerveld et al., 2008; Rongen et al., 2014). Further, when extant research identifies barriers to participation, such as time limitations or inconvenient locations, there is seldom any mention of leaders' ability to moderate or remove such barriers (Person et al., 2010). The present study provides compelling evidence that leadership is the most significant factor that influences employee participation. It describes specific leadership behaviours and how employees experience those behaviours as problematic (i.e., obstructing) or perceive them to enhance participation (i.e., promoting).

The study's findings on the importance of leadership complement Mellor and Webster's (2013) research, who discussed leadership more specifically. They have noted the need for line managers to better understand the value of health promotion, and how managers can influence employees' attitudes or motivation through engaging behaviours (i.e., providing support) or disengaging behaviours (i.e., unhelpfulness). Mellor and Webster also identified managers' reluctance to focus on employee wellbeing and their inability to monitor employees' health-related needs as challenges to implementing workplace wellbeing initiatives. However, while Mellor and Webster's research identifies some leadership behaviours, their conceptualisation is somewhat vague and unclear, leaving some unanswered questions. For instance, the authors do not discuss what leaders 'providing support' or 'unhelpfulness' actually entails and how such behaviours act as barriers or enablers to participation, or why managers may be ill-prepared or unable to focus on employee health or wellbeing. The present study extends this

research by conceptualising and positioning specific leadership behaviours along a continuum, with obstructing at one end and promoting at the other. Importantly, it has identified the properties of each of these behaviours. Further, the present study proposes possible drivers of such leadership behaviours. For instance, although *obstructing* leadership behaviours are likely to be relatively uncommon, they may stem, in part, from leaders or managers' limited mental health literacy. Mental health literacy, a term coined by Jorm et al. (1997), refers to "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (p. 182). Mental health literacy goes beyond mere knowledge per se and encompasses potential action to improve one's personal mental health or that of others (Corrigan et al., 2014; Jorm et al., 1997). Some of the interviewed employees expressed the view that their manager lacked mental health literacy. Others noted that some managers did not know what to say to them or seemed reluctant to engage in any mental wellbeing-related conversations. A few of the managers also personally mentioned lacking confidence or expertise in dealing with mental wellbeing.

In the context of this study, mental health literacy refers to a manager's ability to, (a) recognise potential signs of poor mental health and wellbeing in staff, (b) talk about mental health and wellbeing with staff to manage potential issues, and (c) take action to help and support staff when mental health issues arise in the workplace (or prevent issues arising in the first instance). The findings suggest that a low level of mental health literacy may result in a manager displaying obstructing behaviours such as demonstrating a narrow view of wellbeing, perceiving those with mental health challenges to be psychologically weak, or believing mental wellbeing initiatives to be faddish as opposed to a means of reaching one's full potential. Furthermore, it is plausible that obstructing leaders with limited mental health literacy or ignorance around mental health may reinforce the stigma around these conditions. This argument supports extant research which suggests that leaders have the potential to exacerbate the stigma surrounding mental health, possibly unknowingly, through bias, avoidance, distrust, stereotyping, embarrassment, fear, and even anger or violence (Britt et al., 2021; Mental Health & Recovery Board [MHRB], 2021).

The study's results also suggest that mental health literacy is an antecedent of supervisor support, whereby a manager's level of mental health literacy influences the level of support they are able to offer to employees. Previous research has not yet explicated this relationship. By identifying mental health literacy as an important precursor of supervisor support, this study

makes a meaningful contribution to organisational support theory (OST), in particular, perceptions of supervisor support (PSS) in relation to employee wellbeing (Eisenberger et al., 1986). PSS is defined as employee assessments of whether their manager cares for their wellbeing and values their work (Dimoff & Kelloway, 2017; Eisenberger et al., 2002). Obstructing leaders are likely to show minimal support to employees, possibly unintentionally, because they do not know how to support them. Accommodating leaders may have moderate mental health literacy: while they may have the knowledge to recognise signs of mental ill-health, they may not necessarily know how to act on their observations, therefore showing minimal or reluctant support and lacking the 'potential action' aspect of mental health literacy. Leaders who exhibit promoting behaviours may have well-developed mental health literacy and therefore greater confidence to have mental wellbeing-related conversations and an ability to provide their employees with a high level of support. Given that examining leaders' mental health literacy was outside the scope of the present study, this study encourages future research to consider exploring mental health literacy as an antecedent of PSS. As Dimoff and Kelloway (2016) have noted, the way in which support is delivered to an employee is crucial. Similarly, Steinberg and Gottlieb (1994) have argued that well-intentioned, but unsuitable, clumsy, or overbearing support can have unintended consequences. This 'support' can range from merely being unhelpful to being psychologically damaging for the employee, particularly for an individual currently experiencing a mental health issue. These studies indicate that managers must not only "know what to do, but also how to do it" (Dimoff & Kelloway, 2016, p. 154). These two elements reflect knowledge and potential action in mental health literacy. Dimoff and Kelloway have also stressed that employees feel most supported when leaders successfully match the characteristics of the employee's situation with the type of support that the employee needs.

This thesis argues that employees will feel most supported and encouraged to utilise mental wellbeing initiatives by promoting leaders who show genuine care and authentic vulnerability. Such leaders build trust, encourage, or role model participation. This argument is consistent with Dimoff and Kelloway's (2019) finding that leaders can recognise when employees need mental wellbeing resources, help to identify suitable resources for employee needs, enhance employee access to resources, and encourage resource use. Similarly, Detert and Burris (2007) found that an employee's willingness to seek and utilise mental wellbeing resources may depend upon leaders' behaviours during the warning sign recognition and resource identification stages. Previous research has also found that leaders have the potential to be

resource champions by promoting mental health and wellbeing resources, openly discussing available resources, and destigmatising their use (Edmondson, 2003; Milliken et al., 2003). In conceptualising these three leadership behaviours and their relationship with mental health literacy and PSS, this study describes a set of leadership behaviours that can encourage and enable employee participation as well as offer suitable and well-delivered support to employees.

While it was not explicitly evidenced in the data, this thesis also proposes that leadership behaviours are likely to be replicated in an organisation's culture and work environment if the majority of the leaders engage in them. For instance, if most of an organisation's leaders exhibit obstructive behaviours then it is likely that the overall organisational context will also be obstructive and discourage employee participation. By highlighting the role of trust, psychological safety, value enactment, and perceived action of managers, this thesis helps to define an organisational context that is conducive to employee participation in mental wellbeing initiatives. Further, it is argued that organisational context provides the foundation or overall conditions that make employee participation possible. Previous research on barriers and enablers to participation in mental wellbeing initiatives or health promotion programmes has surprisingly made little mention of organisational culture or work environment (Linnan et al., 2001; Person et al., 2010; Rongen et al., 2014). In fact, several scholars have argued that there is a 'paradigm' of workplace health promotion that focuses on changing *individual* employees' health-related behaviours as opposed to changing the organisational *system* of work in which health promotion behaviours are to be embedded (Milner et al., 2015; Noblet & Rodwell, 2010; Sloan, 1987). Conversely, the present study provides compelling evidence for the need to focus on the organisational system or context in which wellbeing behaviours and initiatives are to be embedded, as opposed to continuing to focus on changes in the individual employee. Whilst many factors are individually experienced, such as *perceived value* or *remaining silent*, they exist within an overall system or organisational culture which must facilitate and encourage participation.

While extant research acknowledges that leaders are a 'potent source' of culture in an organisation (Schneider et al., 2017), who provide the primary impetus to developing and shaping organisational culture (George et al., 1999), and reinforce the culture through their behaviours (Murphy & Davey, 2002), past studies have failed to explain how specific leadership behaviours influence organisational culture. This study extends present

understanding by demonstrating that *promoting* behaviours may contribute to a positive, supportive, trusting, and psychologically safe culture and work environment where employees feel more comfortable to openly engage in mental wellbeing initiatives: the opposite is true for *obstructing* behaviours. This finding aligns with Dimoff and Kelloway's (2019) finding that leaders who are open and vulnerable, non-stigmatising, supportive, and participative may help create such an environment. Mellor and Webster (2013) also noted that there can be significant variability in the extent to which managers embrace wellbeing as part of an organisation's culture, therefore determining whether wellbeing is 'blocked' or 'filtered through' to employees. However, the authors did not explain why there is such variability in leaders embracing wellbeing or what specific leadership behaviours cause wellbeing to be blocked or filtered through to employees. Conversely, this study delineates the specific leadership behaviours that lead to wellbeing being blocked (obstructed) or embraced (promoted).

Value enactment was also identified as a critical contextual factor that influences employee participation in mental wellbeing initiatives, alongside trust and psychological safety. A mismatch between senior managers' words and the actions of lower-level managers regarding mental wellbeing is a significant deterrent of employee participation. The enactment of espoused values is a fundamental property of trust, which is critical for creating a culture conducive to wellbeing. An absence of trust may lead employees to feel psychologically unsafe and therefore reluctant to utilise mental wellbeing initiatives. Mellor and Webster (2013) also identified a mismatch between senior and lower-level management, noting that while wellbeing is often strongly embraced at a senior management level it often does not filter down through a complex management structure. In a similar vein, Spence (2015) proposed that employees may resist or even resent participating if they perceive the personal changes they are being asked to make (by participating in wellbeing initiatives) to be greater than the managers willingness to make the same changes. In such instances, employees may perceive mental wellbeing initiatives to be irrelevant or disingenuous. This finding aligns with extant research that also notes that values can be perceived as disingenuous, insincere, and cosmetic when they are not enacted, causing employees to exhibit selective, calculative compliance with the company values. In a worse-case scenario, it may in fact result in staff cynicism, resistance, and detachment (Murphy & Davey, 2002; Voss et al., 2006; Willmott, 1993). Similarly, Little et al. (2019) and Noblet and Rodwell (2010) found that employees are unlikely to participate in workplace health or exercise initiatives if they perceive managers' intentions to be insincere.

Insincerity is also exacerbated by contradictory messaging, which can frustrate employees and dissuade them from utilising wellbeing initiatives. For instance, employees may feel confused and frustrated about the organisation expecting staff to work during weekends, provide work-related information while on leave, or deliver at a high rate while also being told to maintain a work-life balance, clear boundaries between work and home, and dedicate time for wellbeing activities. The findings align with previous research which argues that leaders can reinforce organisational norms, often unintentionally, that contradict or undermine the very thing the organisation is attempting to cultivate (Jackson, 2021; Spence, 2015). For instance, an organisation may normalise employees skipping lunch breaks or congratulate them for "working exceptionally long hours" or "going above and beyond," while at the same time saying that the organisation wishes to support and improve staff wellbeing (Jackson, 2021, para. 24). Mellor and Webster (2013) similarly identified a 'target-driven organisational culture' as a challenge to implementing a health and wellbeing approach in the workplace, where leaders displayed a mismatch between company priorities and the wellbeing culture the organisation was attempting to promote. The present study extends Mellor and Webster's work by evidencing specific behaviours that leaders can exhibit to create a culture of wellbeing, such as genuinely caring about staff or role modelling participation.

Alongside value enactment, managers following through on what they say they will do is a determinant of trust and psychological safety. Thus, the actions of line managers has a significant influence on employee participation in mental wellbeing initiatives. For example, employees may experience frustration or become disheartened when they observe inaction from managers after raising work-related issues affecting their mental wellbeing. Employees may feel that there is little point in participating in initiatives when their manager does not seem to take action to reduce key stressors, such as bullying in the workplace. Employees value leaders who take action or do 'little things' that cumulatively impact their mental wellbeing. Such actions can include updating employees about how they are working to address their concerns, greeting them when they arrive at work, supporting or 'having a laugh' with them, giving them recognition, and showing genuine care and interest in their mental wellbeing. These 'little things' may seem insignificant on their own, however, combined they contribute to an organisational culture that cares for others and fosters employee wellbeing. Importantly, while employees may consider existing mental wellbeing initiatives to be excellent, they may feel more supported by this kind and caring organisational culture. Spence (2015) has argued that organisations may be ill-advised to make investments in wellbeing programmes and should

instead re-think their approach by focusing more on fulfilling employees' basic psychological need for autonomy, competence, and relatedness. The present study argues that employee mental wellbeing is best supported in an organisation that offers established wellbeing initiatives *within* an organisational culture that focuses on basic psychological needs, such as valuing and demonstrating kindness and connection. Employees feel valued when they see that managers take action to address and mitigate day-to-day niggles and ensure staff feel respected, listened to, and cared for. In New Zealand, the Māori term *Manaakitanga* is used to describe the process of "showing respect, generosity and care for others" (Moorfield, 2021). While it is not surprising that employees value Manaakitanga, it was surprising how much participants moved beyond discussing mental wellbeing initiatives to explaining the importance they place on this aspect of organisational culture. This finding reaffirms the importance of cultivating an organisational culture that cares for employee mental wellbeing and encourages participation in planned wellbeing initiatives.

Perceived Value

While the perceived value that employees place on mental wellbeing initiatives influences their participation, more importantly, the findings demonstrate that leaders can have a significant influence on employees' perceived value. While the term 'perceived value' was derived inductively from the data, it is akin to Spence's (2015) 'employee receptivity'. Employee receptivity is defined as the degree to which an employee is positively oriented towards a wellbeing programme, in terms of what it represents for them and the perceived value for themselves or others. Although extant research identifies several factors that relate to the value that employees place on wellbeing initiatives, most studies fail to identify the inter-relationship between the factors, instead reporting them as stand-alone barriers. These barriers include an employee's lack of interest in wellbeing topics or programmes offered, beliefs about the ineffectiveness of interventions, and the irrelevance of interventions (Corrigan et al., 2014; Person et al., 2010). This thesis argues that these factors are interrelated because they each represent the employees' assessment of the merit or desirability of a particular wellbeing initiative, or the perceived benefit to be gained from participating. Spence (2015) proposed service-needs misalignment (little relevance or interest to employees) as a *potential* barrier to participation in a workplace wellbeing programme but noted that this was merely a developing hypothesis. The findings of this thesis extend present understanding by proposing that these interrelated factors can be conceptualised as a perceived value continuum: from low perceived

value to high. It is further argued that where leaders sit along the leadership continuum is likely to determine where their subordinate sits along the perceived value continuum. For instance, obstructive leadership behaviours that project wellbeing initiatives as uninteresting, irrelevant, or even laughable may result in employees placing similarly low value on mental wellbeing initiatives. Such behaviours would hinder the degree to which an employee is positively oriented towards that particular initiative. Contrastingly, leaders that promote wellbeing initiatives may well increase the value employees place on wellbeing initiatives by creating awareness and knowledge of the initiative and how it can benefit employees' mental wellbeing.

It is further argued that effective leadership may mitigate other barriers to participation. For example, perceived incompetence and social exclusion may act as barriers to participation, even for employees who place moderate to high value on wellbeing initiatives. In such cases, while employees may wish to participate in a particular initiative, their fear of appearing incompetent or concerns around social exclusion may still prevent their participation. This finding supports previous research which identifies social comparison as a barrier to participation in exercise-related wellbeing initiatives (Rossing & Jones, 2015). The present study's findings suggest that such barriers may be overcome by promoting leaders increasing employees' perceived value of wellbeing initiatives, such that they perceive the benefits of participating to be greater than their nerves or concerns. Further, this study expands present understanding by highlighting that *no perceived need* to participate in mental wellbeing initiatives can be legitimate, where the individual is already comfortable with their state of mental wellbeing, or it may suggest that the individual believes they have no need when in fact they are experiencing mental health challenges. The latter may be explained by a lack of mental health literacy or the tendency to act stoically, possibly due to fear of being stigmatised or judged for being psychologically weak. While Gulliver et al. (2010) identified no perceived need to participate in mental health or wellbeing services, the authors did not determine whether the individuals had an *actual* need to participate. Given that this distinction has emerged as a potentially important determinant of employee participation that was outside the scope of the present study, this study recommends that future research considers exploring more fully employees' perceived and actual need for mental wellbeing initiatives.

Remaining Silent

Leaders can either influence (directly or indirectly) employees to *remain silent* about mental health and wellbeing in the workplace or encourage employees to break these negative patterns of behaviour. Such behaviour includes handling mental wellbeing individually or acting stoically, or showing inability or reluctance to ask for help. Previous research has identified reliance on self, difficulty or unwillingness to express emotions, the desire to handle the problem on one's own, and not wanting to burden someone else as barriers to mental health help-seeking (Corrigan et al., 2014; Gulliver et al., 2010). However, as these were quantitative review articles, they provide little detail as to why individuals tend to rely on themselves or find it difficult to express emotions. The present study extends this research by conceptualising the behaviour of remaining silent and identifying drivers of this behaviour. After reviewing the literature, many of the drivers of remaining silent were anticipated barriers. For instance, stigma and judgement around mental health were heavily cited in the literature and were thus not unexpected (Cautin, 2011; Corrigan et al., 2014; Gulliver et al., 2010; Penn & Martin, 1998). Similarly, New Zealand's culture around mental health (Gourley, 2018; Paterson et al., 2018), including the British influenced 'stiff upper lip' (Andrew & Dulin, 2007), and perceiving psychological distress as a weakness (King, 2003) were also unsurprising findings. Previous research has also identified fear of negative job consequences as a barrier to disclosing mental disorders in the workplace (Toth & Dewa, 2014) and concerns about being labelled in company records as a reason for non-engagement in mental health services (Heenan, 2006). Thus, it was unsurprising that these factors influence employee participation in mental wellbeing initiatives. The present study adds to the existing literature by highlighting how leaders can be partially responsible for driving the manifestation of factors that cause individuals to remain silent in the workplace.

For instance, obstructing leaders may exacerbate the tendency to remain silent by reinforcing the stigma or spreading harmful messages around mental health such as "man up" or "don't share that", or breaching employees' confidentiality and trust when they disclose mental health challenges. As previously mentioned, obstructive leadership may also create an organisational context that lacks trust and psychological safety, creating an environment in which employees are more likely to remain silent. When leaders manifest these unhelpful behaviours they act as barriers to participation because they discourage employees from seeking help by utilising mental wellbeing initiatives due to fear of being stigmatised and judged or feeling that they

must remain stoic and "soldier on" as opposed to getting help. Murray et al. (2008) found that stoicism correlates with lower levels of wellbeing (a view which contradicts the notion that being stoic is a factor of psychological resilience), suggesting that the manifestation of stoicism is potentially maladaptive. Contrastingly, promoting leaders may make a deliberate effort to actively destigmatise mental health and illness by communicating positive messages about mental health, normalising mental health conversations, and maintaining employees' confidentiality and trust. Such leadership behaviours act as enablers and enhance the likelihood that employees will participate in mental wellbeing initiatives, instead of suffering silently.

However, putting negative attitudes around mental health aside, employees may find it difficult to identify and seek out mental wellbeing initiatives when in a state of compromised mental health, because of their diminished personal resources. This notion is supported by literature which states that employees who are struggling with mental health issues may fail to recognise that they are in a compromised state, engaging in maladaptive coping behaviours, or experiencing mental crises due to the emotional and cognitive impairments associated with the underlying mental health concern (Dimoff & Kelloway, 2016, 2017; Folkman & Lazarus, 1984; Hunt & Eisenberg, 2010). Hobfoll's (1989) conservation of resources (COR) theory is helpful in explaining why individuals may struggle to seek out mental wellbeing support and resources. COR proposes that individuals who lack resources, which are loosely defined as objects, states, conditions, and other things that people value (Hobfoll, 1989), are susceptible to falling into a resource loss spiral. A resource loss spiral occurs when "one problem leads to another that aggravates the previous problem" (Bakker & Demerouti, 2018, p. 4). In other words, an initial loss results in the depletion of further resources for confronting the next threat or loss. This thesis argues that employees who face a significant mental health challenge may be inhibited from seeking out workplace mental wellbeing initiatives due to a lack of adequate resources and an inability to cope with work or other demands placed on them. Even where employees have a high awareness of mental wellbeing initiatives, dedicating further resources such as time and effort to seek out and gain new resources such as social support, online wellbeing resources, or EAP counselling may prove to be too challenging. As Bakker and Demerouti (2018) have noted, when an individual experiences resource losses they are prevented from shifting the circumstances into a gain cycle as they lack the necessary resources to acquire new resources and stop the loss spiral. Leaders can play an important role in assisting employees to escape a resource loss spiral by reducing job demands and/or creating resources for their employees.

The present study extends Bakker and Demerouti's research by demonstrating how leaders may exacerbate or prevent loss spirals for employees. Obstructing managers may allow resource loss spirals to continue (either intentionally or inadvertently) or may even exacerbate a resource loss spiral by causing increased psychological distress. They may do so by invalidating employees' mental health challenges or manifesting stigma around mental health, further diminishing employees' personal resources. Accommodating managers may make somewhat minimal or reluctant efforts to make employees aware of initiatives and/or educate employees about how to access them, essentially 'ticking the box', and then leave employees to seek out initiatives when they choose. However, this study's results suggest that if an employee is experiencing a resource loss spiral, this minimal level of leadership may not be as helpful as the leader may think. Instead, such leadership may even act as a barrier to participation because the employee is unable to escape their resource loss spiral without active help from a leader. Promoting leaders may be in the best position to shift the circumstances into a gain spiral by noticing employees' psychological distress early on, identifying suitable resources or initiatives, making employees aware of them, and encouraging employees to utilise them, therefore acting as an enabler to participation.

Work Pressures and Expectations

This study's results highlight that employees' *work pressures and expectations* act as barriers to participation and that these pressures and expectations may be both objective/extrinsic or subjective/intrinsic. These findings address a significant gap in the existing literature as past studies have failed to distinguish between objective, organisationally imposed, and more subjective, self-imposed work pressures and expectations. This gap exists despite numerous calls in the literature for the need to make such a distinction (Bakker & Demerouti, 2018; Frese & Fay, 2001; Grawitch et al., 2018; Laurence et al., 2016). This distinction is considered necessary because past studies that have not determined the source of work pressures and expectations have reported inconsistent findings regarding work characteristics and work outcomes (Fried & Shirom, 1984; Laurence et al., 2016; LePine et al., 2004). For instance, while organisationally imposed work pressures can lead to stress and burnout, intrinsic, self-imposed work pressures can result in increased performance and job satisfaction (Laurence et al., 2016). The present study offers empirical evidence of the distinction between extrinsic and intrinsic work pressures and expectations. More specifically, it provides richly detailed descriptions of employees differentiating between the work pressures and expectations

imposed by the organisation and their perceptions of how they are sometimes responsible for creating their own work pressures and expectations and putting up their own barriers to participation in wellbeing initiatives. Identifying the source of employees' work pressures and expectations is crucial in understanding whether it is objective boundaries or employee perceptions that may impede or enhance their participation in mental wellbeing initiatives.

Although the term 'objective work pressures' was derived inductively from the data, it is akin to Demerouti et al.'s (2001) 'job demands' in Job Demands-Resources (JD-R) theory. Job demands are defined as "those physical, social, or organisational aspects of the job that require sustained physical or mental effort and are therefore associated with certain physiological and psychological costs (e.g., exhaustion)" (p. 501). Job demands include elements such as physical workload, time pressure, recipient contact, physical environment, or shift work. Given the similarity of constructs, 'work pressures' will henceforth be referred to as 'job demands' as it is a widely recognised term in the literature.

While extant research on barriers and enablers to participation in wellbeing initiatives has identified some objective barriers, such as a lack of time, the time investment needed to participate in these initiatives, unfavourable work schedules, and time and work pressures, none of these studies distinguish between real and perceived job demands and expectations (Gulliver et al., 2010; Lakerveld et al., 2008; Person et al., 2010; Rongen et al., 2014; Spence, 2015). Further, Bakker and Demerouti (2018) have noted that an important problem in existing JD-R literature is that the vast majority of studies follow an overly simplistic stimulus-response model by assuming that employees passively react to work conditions (objective), neglecting how employees can actively influence their own work conditions (intrinsic). Similarly, Laurence et al. (2016) have noted that historically, measures of job demands or work stress have been based on the assumption that the demands are imposed by the organisation, without studies explicitly identifying the organisation as the source of stress. Laurence et al. have also argued that many previous studies have failed to distinguish between organisation-imposed overload (OIO) and self-initiated overload (SIO) and that these constructs should be separated based on the source of overload; the organisation or the self. Frese and Fay (2001) have mentioned that, "researchers have shown hardly any interest in how people influence their work situation to make it more or less stressful, and they usually treat such influences as error variance" (pp. 137-138). In a similar vein, Grawitch et al. (2018) called for more research to examine whether, and to what degree, workplace telepressure (an employee's urge to respond

quickly to work-related messages via email, phone, or other information and communication technologies) is a true external pressure, or a self-imposed pressure. The present study provides detailed descriptions of how employees may respond to organisationally imposed job demands and expectations or influence their own work conditions, affecting their participation in wellbeing initiatives. Without understanding the source of employees' job demands and expectations, it is unclear whether objective organisational factors or intrinsic individual factors need to be addressed in order to enhance participation. For instance, does an employee have a high workload that prevents them from participating in mental wellbeing initiatives, or are they a high-performer who is over-committed to the task, such that they set unrealistically high expectations of themselves and thus create their own barriers to participation?

In addition to evidencing this distinction, the present study helps explain the role of leaders in reducing job demands by moderating the degree to which organisationally imposed and self-imposed job demands and expectations act as barriers to participation. While the role of the leader has been discussed in the literature (Dimoff & Kelloway, 2017; Eisenberger et al., 2002), past studies have failed to fully explain the significant role that leaders can have in influencing employee job demands and expectations. Promoting leaders may try to reduce or moderate employees' objective job demands such as time pressures, workload, or deadlines in order to remove these barriers and enable employee participation. Conversely, obstructive leaders may not take action, meaning that objective barriers remain in place. A promoting leader may also reduce or moderate self-imposed job demands and expectations. Such leaders may be best equipped to recognise signs of stress, burnout, workaholism, or other behaviours that may suggest that employees' perceptions of their managers' expectations or own performance expectations of themselves are self-imposing barriers to participation. A promoting leader may make an effort to address these (possibly inaccurate) perceptions that drive an employee's behaviour in order to enhance participation. Leaders do not have the agency or power to completely get rid of organisation-imposed or self-imposed job demands and expectations, nor would employees necessarily want them to remove healthy pressure and challenge in their work. However, the results of the study suggest that leaders have some ability to limit the extent to which these pressures negatively influence employee participation.

Initiative Specific Factors

This thesis argues that leaders can help moderate the degree to which *initiative specific factors* inhibit employee participation. While extant research has identified a lack of awareness, knowledge, or accessibility, and the inconvenient locations of initiatives as barriers to participation, such studies have made little or no mention of the role that leaders can play in addressing these barriers (Dillon et al., 2020; Gulliver et al., 2010; Hunt & Eisenberg, 2010; Person et al., 2010; Spence, 2015). This study extends the present understanding by proposing that leaders have some ability to address and mitigate implementation, promotion, and coordination barriers. It is argued that promoting leaders may act on staff feedback about initiative availability (i.e., initiatives dropping off) or initiatives having unintended negative associations (such as plying staff with excessive sugar or creating unnecessary plastic wastage) and take steps to improve the aspects that dissuaded employee participation in the past. Leaders may also increase employee awareness of wellbeing initiatives, employee knowledge of how to participate, and seek feedback on the communication of mental wellbeing initiatives. This finding aligns with Dimoff and Kelloway (2016, 2019) and Ito and Brotheridge (2003) who have noted that leaders' knowledge of individual employees, the organisation's policies, resources, and initiatives put leaders in a good position to be able to recognise when employees need mental wellbeing resources, help to identify and make employees aware of suitable resources, enable employee access to resources, and even encourage resource use. As previously mentioned, it is argued that promoting leaders who are more likely to have well-developed mental health literacy and provide high levels of support may be best equipped to take such actions. Finally, leaders must ensure that there is continuity of service and fairness around wellbeing across the organisation and work to overcome specific role constraints that impede employee participation.

Most of the initiative specific factors identified in this research, such as initiative *availability* or *geographic location*, are relatively axiomatic and well canvassed in the literature, and therefore do not warrant detailed further analysis. Such factors may also always exist as barriers to employee participation because the availability, timing or geographic location of certain initiatives simply may not work for some employees regardless of other individual factors. While leaders have *some* influence over initiative specific factors, they have limited agency or ability to remove such barriers.

Limitations and Opportunities for Future Research

Inevitably, this study has some limitations that should be considered. First, the study's findings are limited to the context within which it was conducted and are therefore not necessarily generalisable to a wider population. Generalisability will always be influenced by context, and this study does not attempt to account for every possible contextual influence that may have affected interview participants' thinking or behaviour. For instance, the factors found to influence employee participation in this study may potentially be moderated by contextual influences in the organisation such as the relocation of offices or changes in leadership. However, as Johns (2006) has argued, no study is able to fully account for and describe all potential contextual factors that may affect participants. This limitation is mitigated by the fact that this study has never claimed generalisability and in fact has repudiated it. Instead, it has been argued that the study's findings may be transferable to similar contexts if the reader considers them so, or valued for particularisation (Eckstein, 1975; Lincoln & Guba, 2002; Stake, 1995).

Second, there is the potential that participants' actual experiences were not accurately reflected by what they reported in the interviews due to self-reporting biases such as social-desirability, recall bias, or stigma around mental health and illness (Althubaiti, 2016). Interviewee responses may have been shaped by the participant's desire for social approval, lack of comfort in discussing an often stigmatised subject, or by the participant's ability to recall past events. However, most of the interview questions did not focus on past events but instead asked about current factors that influence employee participation, limiting the potential for retrospective bias. Further, there is no reason to suspect that participants were not truthful or intentionally withheld relevant information in the interviews. On the contrary, in retrospect, participants shared more than I anticipated about their mental wellbeing and personal lives. This openness may have been due to self-selection, whereby only those who wanted to talk about mental wellbeing participated in the study. Given that participation in this study was entirely voluntary, it is possible that participants shared similarities or had a common motivation for participating. However, as previously mentioned, the various opinions and perspectives that participants held on mental wellbeing in the workplace assured me that participants did not display similar characteristics. In addressing this potential limitation, I also ensured I met Tracy's (2010) criteria for quality qualitative research. In particular, I attempted to achieve sincerity through self-reflexivity, vulnerability, honesty, transparency, and data auditing in

order to be open about, and minimise my potential biases and foibles, as well as remarking on the joys and mistakes of the research. This study recommends that future research also uses Tracy's criteria.

Third, although I set out to collect data using observation, in retrospect the nature of the topic did not lend itself well to observations outside of the interview setting, as the decision to participate in mental wellbeing initiatives is typically experienced internally (in one's mind), rather than expressed overtly. Future research is encouraged to consider alternative ways to capture observational data. It may seek to use observation methods to study actual manifestations of *obstructing, accommodating,* or *promoting* leadership behaviours in the workplace. This observational data may enrich the existing conceptualisation of these behaviours. While I do feel that observations made in interviews offered useful insights, further observations outside of the interview setting, perhaps more proximally to wellbeing initiatives, may have enriched the data further and captured more than was possible with the methods used in this study.

Finally, given that the importance of leadership was unanticipated in this study, I did not set out to measure managers' mental health literacy. Due to the fact that mental health literacy emerged as a potentially important factor that influences employee participation in mental wellbeing initiatives, future research is encouraged to consider methods to measure managers' actual mental health literacy. Such information may inform appropriate training and education approaches based on manager's current needs and levels of knowledge.

Future research is also encouraged to consider examining *factors* that influence employee participation in mental wellbeing initiatives, as opposed to continuing to divide them into separate categories of *barriers* and *enablers*. Extant research has consistently examined participation in terms of these two separate categories (Dillon et al., 2020; Gulliver et al., 2016; Mellor & Webster, 2013; Rongen et al., 2014). Although this study initially set out to explore barriers and enablers in the same way, the data showed that this can be restricting in the sense that one factor can potentially be both a barrier or an enabler, depending on how it is managed within a particular organisation. For instance, while Person et al. (2010) reported 'lack of awareness' as a barrier, this study reports 'awareness' neutrally to illustrate that it can positively or negatively influence employee participation, depending on the situation. This thesis argues that it is often the leader who influences whether an employee experiences a factor

as problematic or perceives it to encourage and enhance participation. Employee participation in mental wellbeing initiatives is a dynamic, intricate phenomenon that cannot be divided into two separate categories of barriers and enablers. Future research could explore how factors, such as leadership, may positively or negatively influence employee participation. Doing so will provide a greater understanding of how factors can be experienced uniquely for different individuals.

Practical Contributions

The study's findings have important practical implications for organisations attempting to enhance sustained employee participation in workplace mental wellbeing initiatives. First, the identification of factors that influence employee participation can be practically useful for organisations trying to understand why some employees experience certain factors as problematic while others do not.

Second, based on the study's findings, it is recommended that organisations offer leadership training that focuses specifically on enhancing mental health literacy. Dimoff and Kelloway (2019) have noted that leader-focused workplace mental health training is a catalyst for employee resource-utilisation. An Australian mental health charity, SANE, carried out a survey in 2013 and found that 95 percent of respondents believed that their managers required significantly more education and skills-based training on mental health issues and how to handle them in the workplace (HRD, 2014). Dimoff et al. (2015) found that after attending a three-hour Mental Health Awareness Training (MHAT), leaders experienced long-term improvements in mental health knowledge, reduced stigma, confidence, and promotion intentions for mental health-related activities and resources. Potential training content for leaders could include knowledge-building around mental health and wellbeing, as well as skills-based training to improve leaders' confidence and ability to recognise signs of mental ill-health, have mental wellbeing-related conversations, or referring and encouraging employees to access suitable initiatives or resources. Mental health literacy training would not require managers to diagnose and intervene in employee mental health issues, but instead to support employees to find suitable resources or initiatives and encourage their participation. In the present study, some managers expressed concerns about being expected to be a manager, counsellor, educator, and sounding board. Mental health literacy training could help mitigate

these concerns and reassure managers that they are not required to take on overwhelming responsibility in the mental wellbeing space.

Third, senior managers are encouraged to role model participation in mental wellbeing initiatives. The data showed that role modelling participation was the single most encouraging behaviour that leaders could exhibit to enhance employee participation. This positive advocacy demonstrates to employees that initiatives have value, that they do not need to remain silent about mental health and wellbeing, and that they too can make time to engage in wellbeing activities. Beginning with the CEO, organisations are encouraged to establish what senior leaders enjoy doing to maintain their mental wellbeing and make this visible to employees to inspire them to follow suit with activities that personally appeal to them. Role modelling may help to address issues around leaders not enacting espoused values and employees' perceived inaction of managers.

Fourth, it is recommended that organisations establish metrics to measure the success of efforts to enhance employee participation. For instance, an organisation could run all staff surveys every quarter or year and measure actual participation percentages, employee wellbeing, job satisfaction, retention, sickness absence, and other potentially relevant indicators of wellbeing outcomes. Such metrics may validate the organisation's efforts in focusing on employee wellbeing by highlighting the benefits to the individual employee and the organisation's increased productivity and profitability.

Finally, in addition to offering mental wellbeing initiatives, this study recommends that organisations embed wellbeing activities into their culture, work environment, and overall fabric of the organisation through day-to-day practices in order to cultivate a genuine culture of wellbeing. For example, some participants expressed a desire for managers to begin a meeting by asking teams how they are coping with workloads or stress, as opposed to focusing only on work or performance related conversations. Employees also suggested concluding a meeting on a positive note by having staff write down or share something that they are looking forward to, or introducing daily prompts on the intranet to get staff thinking about their mental wellbeing. These small actions create subtle wellbeing cues which help to normalise wellbeing activities and may help decrease the perception that some staff members have of wellbeing being 'faddish' or 'fluffy'. Creating a culture of wellbeing in the workplace supports employee

wellbeing in its own right, reduces the need for significant investments in wellbeing events and resources, and creates an environment more conducive to participation in wellbeing initiatives.

Concluding Remarks

This study has explored the factors that influence employee participation in workplace mental wellbeing initiatives. In doing so, it has contributed to the academic literature in several ways. First, this study has addressed a gap in the extant literature around why there is low employee participation. It has identified that participation is influenced by 1) leadership, 2) organisational context, 3) perceived value, 4) remaining silent, 5) work pressures and expectations, and 6) initiative specific factors. This study is a response to numerous calls in the literature for a more exploratory, qualitative, in-depth analysis of this phenomenon. It supplements previous quantitative studies by providing a richly detailed, emic understanding of how and why these factors influence employee participation. Second, this study has highlighted the significant role that leaders have in influencing whether an employee experiences a factor as problematic or believes it encourages and enhances participation. Third, this study has demonstrated that the organisational culture and work environment provides the underlying foundation or overall conditions that make employee participation possible: extant research has typically neglected to consider changing the organisational system in which wellbeing initiatives are to be embedded. This study has also identified the critical contextual factors necessary to create an organisational context that is conducive to employee participation. Fourth, this study has identified an important gap in the existing literature by evidencing that job demands and expectations may be organisationally imposed or self-imposed, a distinction that is crucial in understanding what factors impede or enhance employee participation. Fifth, this study has contributed to extant research by revealing that a factor can be both a barrier or an enabler, depending on the situation. The study's findings provide theoretical and practical recommendations that can be used to enhance sustained employee participation and inform directions for future research to build on. Ultimately, this study hopes to contribute to the normalisation of mental wellbeing in the workplace and calls for others to do the same.

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Appendices

Appendix A: The Five Ways to Wellbeing

Appendix B: Invitation to Participate

Understanding Barriers and Enablers to Participation in Wellbeing Initiatives

My name is Sarah Little, and I am a postgraduate student at the University of Canterbury currently working on a research project for my thesis. [Organisation] is kindly participating in this project as my chosen case study.

You are invited to participate in this research study exploring the barriers and enablers to employee participation in workplace mental wellbeing initiatives. Barriers can be defined as obstacles or circumstances that prevent employees participating in mental wellbeing initiatives, while enablers include factors that facilitate or encourage participation.

The interview should take between 30-60 minutes and will focus on your thoughts, perspectives, or experiences with wellbeing initiatives in your workplace (regardless of whether you have participated in any wellbeing initiatives or not). The study does not address your personal mental wellbeing and there are no right or wrong answers.

While [Organisation] is supporting the study, all data collected during interviews will be strictly confidential and no identifying information will be disclosed in the thesis or any summary reports provided to [Organisation]. Each interview will be assigned a code to remove identifying information, and you will have the opportunity to edit or omit anything you said in the conversation if you choose. Please see the information sheet attached for more information about your confidentiality and data security.

If you are willing to participate in this research project, please contact me via email on sarah.little@pg.canterbury.ac.nz. Interviews will take place at a venue and time that is convenient to you and do not have to take place at [Organisation].

If you have any further questions, please do not hesitate to ask. I look forward to hearing from you.

Kind regards,

Sarah Little

Appendix C: Information Sheet for Interview Participants

Department of Marketing, Management and Entrepreneurship
Telephone: +64 3 3693710
Email: sarah.little@pg.canterbury.ac.nz
Date: 15/07/2020
HEC Ref: HEC 2020/73

Exploring Barriers and Enablers to Employee Participation in Mental Wellbeing Initiatives: Information Sheet for Interview Participants

My name is Sarah Little, and I am a postgraduate student at the University of Canterbury currently working on a research project for my thesis. The purpose of my research is to explore the barriers and enablers to employee participation in workplace mental wellbeing initiatives. Barriers can be defined as obstacles or circumstances that prevent employees participating, while enablers include factors that facilitate or encourage participation. In recent times there have been various unsettling events that can have a potentially negative impact on one's mental wellbeing such as the Canterbury earthquakes, mass shootings, and the current COVID-19 pandemic. However, participation rates in workplace initiatives aimed to promote and support mental wellbeing tend to be low. I am wanting to understand if employees know about such initiatives in their workplace and what they think the programmes are about, if they have had any personal experience with these services, how easy it is to access them and so on.

If you choose to take part in this study, your involvement in this project will be to take part in an interview with the researcher for approximately 30 – 60 minutes. It is important to note that the research is concerned with exploring participation in mental wellbeing initiatives and does not focus on your personal mental wellbeing.

The interview will be audio recorded with your consent to ensure accurate data analysis. I will transcribe the interview to ensure your confidentiality. The only people that will have access to your data will be the researcher and the researcher's supervisors.

Participation is voluntary and you have the right to withdraw at any stage without penalty. You may ask for your raw data to be returned to you or destroyed at any point. If you withdraw, I will remove information relating to you. However, once analysis of raw data starts on October 15th, it will become increasingly difficult to remove the influence of your data on the results. The transcript of your interview will be sent to you via email, and you will have one week to review and amend the transcript if you so desire.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: your identity will not be made public. To ensure anonymity and confidentiality, your name will be replaced with a pseudonym and all data will remain confidential and will be stored in a password-encrypted file and any documents will be locked in a secure office at the University of Canterbury. The audio

recordings will be destroyed after transcription, and the transcriptions and other data is required to be securely stored in the research supervisor's office for a period of five years and then it will be destroyed. The thesis document will not identify any participants or organisations; these will remain confidential. A thesis is a public document and will be available through the UC Library.

Please indicate to the researcher on the consent form if you would like to receive a copy of the summary of results of the project.

The project is being carried out as a requirement for the Degree of Master of Commerce in Management by Sarah Little under the supervision of Dr. Russell Wordsworth, who can be contacted at russell.wordsworth@canterbury.ac.nz and secondary supervision of Dr. Sarah Wright, who can be contacted at sarah.wright@canterbury.ac.nz. They will be pleased to discuss any concerns you may have about participation in the project.

The research questions should not cause mental or emotional distress. However, if the conversation causes you to become upset the interview can be stopped immediately. There are a range of resources you can access to support your mental wellbeing, such as the following:

- **All Right?**

https://www.allright.org.nz/
E-mail: hello@allright.org.nz
Free call or text 1737 any time, 24 hours a day. You can also call Lifeline on 0800 543354 or text HELP to 4357.

- **Mental Health Foundation of New Zealand**

https://www.mentalhealth.org.nz/get-help/in-crisis/helplines/
Depression and anxiety help: 0800 111 757 or free text 4202 (to talk to a trained counsellor about how you are feeling or to ask any questions)
Anxiety help: 0800 269 4389 (0800 ANXIETY)

- **Depression and Anxiety**

https://depression.org.nz/contact-us/
Text: 4202
Phone: 0800 111 757

- **Ministry of Health**

https://www.health.govt.nz/your-health/services-and-support/health-care-services/mental-health-services/mental-health-services-where-get-help
Free call or text 1737 any time.
Talk to a trained counsellor or call:
The Depression helpline – 0800 111 757
Alcohol drug helpline – 0800 787 797
Gambling helpline – 0800 654 655
Healthline – 0800 611 116 – to get help from a registered nurse 24/7.
Lifeline – 0800 543 354
Samaritans – 0800 726 666

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz). If you agree to participate in the study, you are asked to complete the consent form and return to Sarah Little via email or in person at the interview.

Appendix D: Consent Form for Interview Participants

Department of Marketing, Management and Entrepreneurship
Telephone: +64 3 3693710
Email: sarah.little@pg.canterbury.ac.nz

Exploring Barriers and Enablers to Employee Participation in Mental Wellbeing Initiatives:
Consent Form for Interview Participants

- ☐ I have been given a full explanation of this project and have had the opportunity to ask questions.
- ☐ I understand what is required of me if I agree to take part in the research.
- ☐ I understand that participation is voluntary, and I may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achievable.
- ☐ I understand that any information or opinions I provide will be kept confidential to the researcher, and researcher's supervisors and that any published or reported results will not identify the participants or the organisation. I understand that a thesis is a public document and will be available through the UC Library.
- ☐ I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years.
- ☐ I understand the risks associated with taking part and how they will be managed.
- ☐ I understand that I can contact the researcher Sarah Little (sarah.little@pg.canterbury.ac.nz) or her supervisor Dr. Russell Wordsworth (russell.wordsworth@canterbury.ac.nz) or secondary supervisor Dr. Sarah Wright (sarah.wright@canterbury.ac.nz) for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)
- ☐ I consent to the interview being audio recorded.
- ☐ I would like to review the transcript of this interview.
- ☐ I would like a summary of the results of the project.
- ☐ By signing below, I agree to participate in this research project.

Name:_____ Signed:_____ Date:_____

Email address (for report of findings, if applicable):_____

Please return to Sarah Little via email or return at the interview.

Appendix E: Follow-Up Interview Questions

- *You mentioned_____earlier, can you explain that to me a little further?*
- *Can you tell me what you mean by_____?*
- *You discussed_____earlier, can you tell me a little bit more about how that influences your participation in wellbeing initiatives?*
- *Can you think of an example of_____?*
- *Can you tell me about a time where_____?*
- *How did you experience_____?*
- *Are there any other factors that you can think of that influence your participation in wellbeing initiatives?*
- *Is there anything else you would like to discuss today?*

Appendix F: Human Ethics Committee Approval

HUMAN ETHICS COMMITTEE
Secretary, Rebecca Robinson
Telephone: +64 03 369 4588, Extn 94588
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2020/73

4 September 2020

Sarah Little
Management, Marketing and Entrepreneurship
UNIVERSITY OF CANTERBURY

Dear Sarah

The Human Ethics Committee advises that your research proposal "Exploring Barriers and Enablers to Employee Participation" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your emails of 20th August and 1st September 2020.

Best wishes for your project.

Yours sincerely

Dr Dean Sutherland
Chair
University of Canterbury Human Ethics Committee