

**The Impact of Workplace Mental Health Support Method Usage on Mental Health
Stigma within the Workplace.**

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Abstract

The rise in mental health awareness within the New Zealand workforce has stimulated the increased availability of Employee Assistance Programmes (EAPs) and much debate around the use of mental health days to cope with mental health issues. At the same time mental health stigma is still present within the New Zealand workforce. The present study aims to explore whether the usage of such support methods can lower workplace mental health stigma, along with the role past experience with such support methods plays on mental health stigma. In order to investigate the impact of support method usage on mental health stigma, 253 working adults in Christchurch based organisations were presented with three scenarios, involving a colleague disclosing a mental health issue to the participant along with what support method the colleague was using to cope with their mental health. Each of the three scenarios differed in the method of support used (EAPs, mental health days, or the non-usage of a support method (presenteeism)). Participants then rated their agreement with common assumptions of workplace mental health stigma across the three scenarios. Agreement with all assumptions of workplace stigma were lower in the scenarios where the colleague was using an EAP or mental health day. The effect of past experience with EAPs or mental health days on workplace mental health stigma proved inconclusive. These findings suggest that disclosing the method of support one uses to cope with their mental health issues could reduce the mental health stigma felt towards that individual within the workplace.

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Introduction

The Broader Context of Mental Health within Present Society

Current mental health statistics from the western world paint a bleak picture. Statistics from the past 10 years show an increasing trend in reported mental health issues present within a country's population (See: Paterson, et al, 2018; AIHW, 2018; Mental Health Foundation, 2016). New Zealand shows similar mental health statistics, with the largest statistical report coming out of the government's 2018 mental health report: *He Ara Oranga*. Within the New Zealand population, 3 to 5 percent of adults are in the severe need category of mental health issues/illness, and 16 to 17 percent of adults are between mild to moderate and moderate to severe need (7 percent and 9 percent respectively) (Paterson, et al, 2018). In the past 10 years there has been a 73 percent increase in the number of individuals accessing mental health or addiction services, along with a 50 percent increase in the number of prescriptions for mental health-related issues (Paterson, et al, 2018). Recent statistics show that 176,320 individuals accessed mental health services, or 3.6 percent of the New Zealand population in 2017 (Ministry of Health, 2019).

Looking at our closest neighbour, Australia, there are similar trends. Estimations based on the 2016 population found 730,000 people (2 to 3 percent of the population) had a severe mental health disorder, 1.5 million (4 to 6 percent of the population) had a moderate disorder, and 2.9 million (9 to 12 percent of the population) had a mild mental health disorder (Australian Institute of Health and Welfare (AIHW), 2016). Of the Australian population, 45 percent of people (between the ages of 16 and 85) were estimated to be impacted by a mental health disorder during their lifetime (AIHW, 2018). The statistics from Australia show that the prevalence of mental health issues across all levels within the Australian population mirror that seen within the New Zealand population. As such, it is not an issue unique to New Zealand, but prevalence statistics are only a portion of the wider picture,

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The cost of mental health and addiction in New Zealand tops \$12 billion a year; this is equal to 5 percent of gross domestic product (GDP). In 2016/2017 the New Zealand public health sector spent \$1.4 billion on mental health and addiction services (Paterson, et al, 2018). During the same period Australia spent \$9.1 billion on mental health services (AIHW), 2018). These values appear to show similar spending on mental health when taking into account the population sizes of the two nations. Of the \$1.4 billion spent in New Zealand, \$1.3 billion was spent targeting less than 3 percent of the population (Paterson, et al, 2018).

This study intends to approach mental health stigma in the more specific environment of the workplace. The above text provides the wider context of mental health within New Zealand, alluding to the prevalence seen within our population. As this is such a broad issue the study is narrowed to focus on the impact of mental health stigma within the workforce, specifically, the stigma associated with current mental health support methods found within New Zealand workplaces, and the potential impact they can have on mental health stigma.

Mental Health Stigma

Mental health issues/illness can be utterly detrimental to an individual and their life. However, upon diagnosis or disclosure to those around them, some individuals may face an equally detrimental issue: mental health stigma. Erving Goffman (1963) provided one of the most widely used definitions of stigma: “an attribute that is deeply discrediting... that reduces someone from a whole and usual person to a tainted discounted one” (p. 3). A resulting stigmatised individual will be perceived as having a “spoiled identity”, disqualifying the stigmatised individual from receiving full social acceptance from the wider community/society (Goffman, 1963, p. 3). Mental health stigma is prevalent across the western world (Corrigan, 2016), but it is not just seen in uninformed members of the general public; it is also seen in well trained health care professionals (Ahmedani, 2011; Corrigan,

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2000; Sharac, McCrone, Clement, Thronicroft, 2010). It is not only direct behaviour that can fuel stigma, as language associated with mental health is also stigmatised and can result in increases in stigma or stereotypes when used (Paterson, et al, 2018). As such, mental health stigma is an issue that can embed itself within multiple aspects of society, making it that much more difficult for individuals to cope with their mental health illness/issue.

Specifically, within New Zealand mental health has a legacy of shame and stigma which is a major barrier to those with such illnesses seeking help (Paterson, et al, 2018).

There are multiple adverse consequences of mental health stigma toward those with such illnesses. An individual may see decreased employment and housing opportunities, and a reduction in income as a direct result of these issues (Penn & Martin, 1998; Peterson, Pere, Scheehan, 2007; Sharac, et al, 2010). Decreased employment opportunities can have a great effect on society as it can decrease productivity and increase benefit payments towards mentally ill individuals. Stigma can also cause delays in help-seeking for mental health issues resulting in a worsened condition upon first point of care and, in turn, increased costs of care (Sharac, et al, 2010). Increased family stress, conflicting public opinion, and lack of acceptance in a community apply greater pressure on those with mental health issues. The resulting pressure can cause internalisation of mental health stigma (Penn & Martin, 1998; Peterson, Pere, Scheehan, 2007; Sharac, et al, 2010). Internalised stigma can result in additional mental health issues such as depression and anxiety, lower self-esteem, and the adoption of secrecy and withdrawn coping behaviours (Penn & Martin, 1998).

A study conducted within New Zealand found similar trends of discrimination/stigma towards mental health issues from family and friends, employers and colleagues, and mental health services (Peterson, Pere, Sheehan, 2007). Almost half of the approximately 750 participants reported having fears of discrimination. One third had problems with employment, and one fifth reported discrimination from financial institutions upon disclosing

mental health issues. Mental health stigma is therefore an issue that impacts many aspects of an individual's life, potentially making it that much more difficult for them to cope with their mental health.

How Can Stigma Manifest in Society?

Weiner (1985) proposed Attribution Theory: that the attribution of personal responsibility to a negative event directly impacts the responses/behaviour the person will exhibit towards an individual in a negative event. If the responsibility is perceived to be that of the individual directly involved in the event, then an observer (another person) will react with anger and decrease their helping behaviour while increasing punishment. However, if the responsibility is not perceived to be that of the individual then an observer's response is often that of pity and a desire to help (Corrigan, et al, 2007; Weiner, 1995). The origin of mental health is largely biological or genetic, although other people can often see an individual's mental health illness/issue as within their own control/responsibility (Ahmedani, 2011). However, this is not the case, as biology and genetics are in most cases completely out of the control of an individual. Yet, as it is deemed controllable, it is seen as a lack of personal effort on the part of the individual if it cannot be controlled (Ahmedani, 2011). These same assumptions have even been found within children: if it is believed that a child is responsible for their mental illness then other children responded with anger and less pity toward the said child (see: Corrigan, et al, 2007). Fear and avoidance were also found due to perceived danger of those with mental illness (Corrigan, et al, 2007).

There are multiple models in present literature that act as working explanations of how mental health stigma becomes prevalent within a population. One such model is the social cognitive model. Social cognitive theory was first posed by Albert Bandura in 1986 and has been widely adapted across multiple psychological fields. The model has seen large use across the wider area of stigma/self-stigma as a means to explain the cognitive process in

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which stigma can manifest (Corrigan, 2000; Corrigan, et al, 2007; Dagnan & Waring, 2004). Social cognitive model has three factors: discriminative stimuli or signals, in which an individual can pick up on in a given situation; cognitive mediators or stereotypes, yielded by the signal' and behaviour or discrimination, where action is taken against the stereotyped signal (Corrigan, 2000, 2002). An example of the social cognitive model applied to mental health stigma would be as follows: a person is seen talking to themselves in a public place (signal). It is inferred that that person is mentally ill as it is a stereotypical symptom of a mental health illness (stereotype). At the same time the stereotype that people with mental illness are “crazy” and/or “irrational”, and therefore, are dangerous may also be applied (Corrigan, et al, 2007). This notion that mentally ill individuals are dangerous has historically been perpetuated by media, thus strengthening such stereotypes within a population (Angermeyer & Matshinger, 1997). Once the stereotypes are applied, actions will be taken to avoid or remove that person or potentially to avoid all people with mental illness (behaviour). Another example could include attribution of responsibility and the responses seen within Attribution Theory (Wiener, 1985): that the mental health issue/symptoms are the individual's own fault due to a lack of responsibility/effort to seek help (stereotype). The stereotype then exhibits a behavioural response that is often discriminatory in nature: avoid that individual or provide little to no help to that individual (discrimination) (Corrigan, 2000, 2002). The example situations can easily occur countless times in a given day across a multitude of social situations, including workplaces, schools, and even in homes. The repetition of such situations and behavioural responses across large areas of society can further reinforce the stereotype's use and acceptance of stigmatised behavioural responses, resulting in the discrimination and stigmatisation of an individual with mental health issues.

Workplace Mental Health/Well-being

Prevention is a consistent theme throughout New Zealand, Australia, and the United Kingdom's (UK) latest mental health reports. This theme is also strongly tied to organisations and the workplace. Workplaces are proposed to be one of the better areas to promote understanding and prevention of mental health issues (Paterson, et al, 2018). It may be logical to assume that a public or more widespread prevention initiative and/or anti-stigma initiative would be better as it can reach the whole population, however, in practice this does not seem to be the answer as public initiatives have low/uneven uptake (Szeto & Dobson, 2010). Workplaces, while not able to reach vast amounts of people, can reach a smaller subset of the population with far greater success which in turn may actually reach more people than a public initiative. All staff can be required to engage in workplace initiatives, as they can be a part of training and/or professional development, and far more intensive in length and context than any other kind of initiative (Szeto & Dobson, 2010).

However, workplaces may also be one of the greatest initiators of mild to moderate mental health issues across the western world due to the ever-increasing stressful nature of employment (Paterson, et al, 2018). Workplace stress can occur in a variety of ways but is often the result of a perceived imbalance between the demands and the resources available to cope with those demands (Guarinoni, et al, 2013). Other causes include lack of control over work and a lack of support from colleagues and management. It was suggested within European Union nations back in 2013 that stress needs to become a priority within health and safety frameworks (Guarinoni, et al, 2013). It is not only physical hazards but “mental hazards” (such as stress) that need to be addressed within the workplace in order to maintain employees' health and safety.

In the narrower context of workplaces, the *Wellness in the Workplace Survey* (2019 & 2017) found that in 2018 New Zealand lost 7.4 million working days (collectively) due to

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absence, totalling a loss of \$1.79 billion. In 2016 the numbers were 6.6 million days lost at a cost of \$1.51 billion. The average rate of absence annually per employee is 4.5 to 5 days, with the typical costs of an absent employee having remained stable across the past two years at \$600 to \$1000 per year (Southern Cross Health Society & BusinessNZ, 2019, 2017). In 2016 the median total annual cost for an organisation with 50 to 99 employees was \$54,000 and \$691,000 for organisations with 100 or more employees. However, these associated costs have significantly increased in two years with the 2019 report showing the median cost to businesses with 50 to 99 employees is now sitting at \$113,732 and for businesses with 100 or more employees the median cost is now \$1.8 million. Stress and anxiety are an ever-increasing issue within New Zealand workplaces. Between 2014 and 2016 there was a net 22.9 percent increase in general stress and anxiety levels within workplaces (Southern Cross Health Society & BusinessNZ, 2019). When specifically looking at organisations with more than 50 employees the net increase in stress was larger again (30.5 percent). Forty-six percent of employees still turn up to work despite being sick. Reported stress felt by employees has had a net increase of 23.5 percent from 2016 to 2018. In this period, businesses with more than 50 employees reported a greater increase than that of businesses with fewer than 50 employees, with increases of 31.3 percent and 16 percent respectively (Southern Cross Health Society & BusinessNZ, 2019). Non-work-related mental illnesses (depression, anxiety, and stress) have increased by 12.6 percent from 2016 to 2018, and work-related mental illness has increased by 15.8 percent in the same period. The recent workplace wellness reports have shown potentially alarming increases in workplace mental health related issues and costs across a relatively short time period of two years.

Seventy-four percent of the UK population has reported feeling stressed to the point of it becoming overwhelming and leaving them unable to cope (Mental Health Foundation, 2018). When a stressor becomes overwhelming due to it becoming too frequent and/or too

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intense then the resulting stress becomes chronic/long term stress (distress) which has negative impacts on health (both physical and mental). (Mental Health Foundation, 2018; Vamhove, et al, 2016; Bowen, Edwards, Lingard, Cattell, 2014). Any situation within the workplace that an employee finds threatening or does not have the adequate ability to address will result in distress for the employee (Bowen, et al, 2014; Guarinoni, et al, 2013). In the UK and United States of America, 40 percent of all absenteeism is related to workplace stress/mental health issues (Prater & Smith, 2011). Workplace performance is also negatively impacted by distress, due to conflicts with organisational commitment and job satisfaction (Robertson, Jansen Birch, & Cooper, 2012; Van De Voorde, Paauwe, & Van Veldhoven, 2012). Frequent areas of stress found within the UK working population included: a lack of balance between effort and reward and lack of control, and demands of task versus control to manage task (Mental Health Foundation, 2018).

Mental Health Support Methods within Workplaces

In the following sections, methods of support for mental health issues used within New Zealand workforces will be discussed. A brief description of each method is provided.

Employee Assistance Programmes (EAPs)

The majority of New Zealand organisations offer Employee Assistance Programmes (EAPs) that are designed to directly reduce mental health related issues within the workplace (Human Resources Institute of New Zealand (HRINZ), 2019). Employee Wellbeing Programmes (EWPs) are also readily used across the western world, targeting specific areas of employee wellbeing via intervention-like programmes, such as: mindfulness training, resilience training, and more general wellbeing initiatives. However, as these are used in a broad manner and often tailored to each workplace, the focus will be put on EAPs as they remain relatively consistent. EAPs provide counselling and consulting services that focus on the prevention and/or remediation of issues in the workplace that can impact on mental

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health. They are often external to an organisation and freely available to all employees within an organisation, with those employees using it remaining anonymous to the employer (HRINZ, 2019; Compton, & McManus, 2015; Sieberhagen, Els, & Pienaar, 2011; Kirk, & Brown, 2003).

Within New Zealand EAP services are provided within approximately 80 percent of organisations with 50 or more employees, while only 32.5 percent of organisations with under 50 employees offer EAP services to their employees (Southern Cross Health Society & BusinessNZ, 2017). A review of Australian EAPs across 44 organisations (approximately 50,550 employees) found that EAPs provide great benefits to an organisation as they improve employee morale and relations, reduce stress, and result in a reduction of sick leave and absence (Kirk, & Brown, 2003). However, many organisations failed to have a method of evaluation that they could use to keep track of their effectiveness. Research shows the potential effectiveness of EAPs within organisations, but often appeared to be implemented as a blanket method without tracking their effectiveness, as if they were trying to “do the right thing” or to associate with humanistic concerns (Kirk, & Brown, 2003). In the context of New Zealand, there appears to be limited funding for EAPs, with only a small number of counselling sessions being funded (around three sessions) (Paterson, et al, 2018). This results in middle income earners being unable to continue to afford counselling even if it is available to them (Paterson, et al, 2018). As such this leaves the majority of income earners within New Zealand unable to afford continued counselling. The addition of EAP services within workplaces allows for greater reach of mental health/wellbeing services to those in need. However, within New Zealand there are factors (funding, reach of services, longevity of support) that are limiting EAPs from being utilised to their full potential.

Mental Health/Well-being Days

The UK Mental Health Foundation made a number of recommendations in their 2018 report on workplace stress, with an overarching recommendation of physical and psychological hazards being treated equally in the workplace. Mental health days were recommended as a mandatory response to reduce stress to employees (Mental Health Foundation, 2018). It was suggested to the European Union nations in 2013 that stress needs to become a priority within health and safety frameworks (Guarinoni, et al, 2013). However, mental health days currently find themselves in a grey area of implementation and usage as they are not formally offered by most organisations across New Zealand (Paterson, et al, 2018). It appears there is the same gap in policy, with the recent Health and Safety at Work Act 2015 referring to mental health once in the entirety of the 189-page piece of legislation: on page 19, Part 1 Section 16, where it states, “health means physical and mental health”. Based on this, when one is reading the legislation, they could deduce that every instance of the word “health” encompasses mental health, however, one would be hard pressed to determine how mental health applies to the majority of the policies within the Act. Therefore, within New Zealand workplaces there appears to be a lack of policies around mental health and the prevention of its instigating factors.

The UK Mental Health Foundation also suggested the implementation of a minimum of two mental health days in the public sector, as 45 percent of the population currently uses sick leave/annual leave for mental health days while providing an alternative excuse for either absence. This issue is seen in workplace stress research, as sick leave and absenteeism have been associated with distress within the workplace (Vamhove, et al, 2016; Bowen, et al, 2014). Perhaps the usage of an alternative excuse for absence is to some degree the result of stigma towards one’s mental health, an observation that is resonated by Paterson and his colleagues (2018) in New Zealand’s mental health report (He Ara Oranga).

A Perceived Lack of Support Method Usage: Presenteeism

Presenteeism is the act of attending work when one is ill (Johns, 2010). Although the individual is present at work their performance is often impaired due to a health issue (Cancelliere, Cassidy, Ammendolia, & Cote, 2011). Presenteeism can result in greater losses of productivity than absenteeism (Johns, 2010), with estimated costs of presenteeism being 1.8 times more than absenteeism (Cooper, & Dewe, 2008). Some research has stated the cost associated with presenteeism may be much higher, five to ten times higher than absenteeism, depending on the GDP/economic status of the country (Evan-Lacko & Knapp, 2016). Countries with higher GDP had a greater association between presenteeism and fears of job loss, however, if the fear of losing a job was purely due to depression, the individual was more likely to be high in absenteeism (Evan-Lacko & Knapp, 2016; Lack, 2011). High stress is often a contributing factor to presenteeism, along with poor relations with co-workers (Canellienre, et al, 2011). Stigma can also play a large role in presenteeism as individuals feel prejudice, fear, and/or internal/external pressures to work (see: Evans-lacko & Kanpp, 2016; Garelick, 2012; Hanisch et al, 2016; Lack, 2011; Prater & Smith, 2011). Individuals may also lack the knowledge of symptoms and therefore turn up to work in a compromised/subpar state (Hanisch, et al, 2016). Presenteeism is seen to increase with age and be higher in females (Lack, 2011).

Presenteeism has been associated with high achieving/responsible individuals, as well those who are conscientious/driven, self-critical and self-doubting (Garelick, 2012). These traits are often seen in those in high end careers, such as: doctors, lawyers, and senior managers, or jobs where the individual feels others are highly reliant on them (Garelick, 2012; Prater & Smith, 2011). The associated traits in moderation are manageable and often useful, however, when taken to the extreme or compounded with other issues, such as stress,

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or external factors (e.g. work-life balance) (Prater & Smith, 2011), those individuals are at greater risk of presenteeism (Garelick, 2012).

Presenteeism is not an outright negative action, as it also increases in workplaces where mental health is more accepted and disclosed. This is often due to the helping culture/support services directly available through the workplace as well as reduced stigma leading to more acceptance of those individuals with mental health issues (Evans-Lacko & Knapp, 2016). Mental health awareness is associated with decreased presenteeism, however, if there is a culture of presenteeism within workplaces individuals will feel as though they have to turn up to work (Cooper, & Dewe, 2008; Johns, 2010).

Within New Zealand, presenteeism may be, in part attributed to the “she’ll be right” attitude (an idiom that whatever is wrong will right itself with time) that is so famously associated with this country. Furthermore, there is a culture of picking yourself up and keeping on moving forward as an individual or a collective, an attitude that is often seen in the wake of disaster or tragedy in New Zealand. These attitudes felt in large scale issues may also be felt in lesser situations at the individual level, and as such provide some reasoning for the use of presenteeism within New Zealand.

Workplace-Related Mental Health Stigma

Although there are many mental health-based services readily available in most workplaces, mainly in the form of EAPs, there are barriers which prevent people from accessing them. One of the greatest barriers is that of mental health stigma and its many forms within organisations. Stigma can be seen as a ‘destructive plague’ on workforces around the world and often leaves individuals with mental health issues in an uncomfortable situation when it comes to work and the attitudes of other employees (Stuart, 2004; Wilkerson, 2003). Fear of damaging one’s career results in individuals not disclosing mental health issues to their employer (Dewa, 2014). Stigma results in a harsh return to employment

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that is often met with hostility and reduced responsibility (Stuart, 2004). Colleagues have been found to attribute concerns of safety and reliability of employees to a mental health issue (Dewa, 2014). Those with mental health issues can have a reduced quality of work-life as a direct result of stigma (Stuart, 2004).

Those with mental health issues often report decreased employment opportunities, and as such reduced personal income (Penn & Martin, 1998; Sharac, et al, 2010). Common issues felt as the result of stigma within the workplace upon disclosure of mental health issues include losing out on promotions, difficulty with supervisors, and co-workers avoiding them or treating them abnormally (Peterson, et al, 2007). Individuals who experience mental health issues such as depression may self-stigmatise as their state of mind is suffused with pessimism (Garelack, 2012). This can often result in the individual having negative views around employers and health services which results in a lower likelihood of seeking help and/or increased absenteeism.

Kurpa and his colleagues (2009) analysed over 500 Canadian documents from a diverse range of stakeholders and interviews with 19 key informants to develop an understanding of stigma towards mental health within the workplace. They found five key assumptions that underlie the stigma towards people with mental illness in the workplace. The first assumption is that persons with mental illness lack the competence required to meet the considerable task requirements and social demands at work. The second is that people with mental illnesses are dangerous or unpredictable in the workplace. The third assumption is that mental illness is not a legitimate illness, with the fourth being that working is not healthy for people with mental illness. Lastly, there is the assumption that providing employment for people with mental illness is an act of charity (Krupa, Kirsh, Cockburn, & Gewurtz, 2009). These same assumptions are seen in similar work by Pescosolido and her colleagues in 2013, who asked participants about their thoughts towards individuals with

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depression or schizophrenia. Individuals who exhibited stigma often reported perceptions of danger, treatment resulting in lasting carryover issues, exclusion of individuals with mental health issues, prejudice towards them, and socially distancing themselves from those with mental health issues (Pescosolido, Medina, Martin, & Long, 2013). In order to combat stigma, one must first identify what is causing the stigma, which in this case involves looking at the assumptions that underlie mental health stigma. This may help in the structure and implementation of anti-stigma initiatives. Furthermore, identifying the strength or prevalence of these assumptions may aid in identifying the major causes and areas that are heavily misinformed or misunderstood by the population.

Workplace mental health stigma can be explained using the social cognitive model in a similar way to the example given earlier. An individual in the workplace is seen to be exhibiting characteristics which are stimuli to other people who interpret said stimuli as a mental health symptom/issue such as stress/fatigue, lack of performance/ability, or burnout. The stimulus then has stereotypes or stigma attached to it, such as that the workplace is not somewhere an individual with mental health issues should be, or that the individual lacks the competence required to meet the considerable task requirements and social demands at work (Krupa, et al, 2009). These stereotypes then lead to behavioural changes in those around the individual, which could include avoidance, loss of responsibility, losing out on promotions, and/or segregation from social groups/activities (Corrigan, 2000; Penn& Martin, 1998; Pescosolido, et al, 2013; Peterson, et al, 2007).

Support Initiative Related Stigma

EAP utilisation often allows an organisation to evaluate whether or not the service is successful and cost effective. The higher the utilisation of EAPs the better the returns in terms of savings and benefits to employers (McRee, 2017). Effective utilisation (returns outweigh the costs) of EAPs within American organisations has been stated as 5 percent of

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employees using the counselling services (see; McRee, 2017; Butterworth, 2001; Every & Leong, 1995). However, 5 percent is at the upper end of utilisation values within American organisations, with some at less than 1 percent (McRee, 2017). Within the UK workforce, EAP utilisation averages at 5 percent of employees within an organisation (UK Employee Assistance Professionals Association, 2016). A major barrier to the use of EAPs services is the stigma that surrounds them, a stigma that is linked to the more general stigma towards mental health (Milot, 2019; Butterworth, 2001). Stigma surrounding EAPs has multiple views stemming from different areas of a workplace, the views/culture of the workplace, self-stigma, job security and flow on effects, and how other employees may view them.

One of the most common concerns individuals have around EAP utilisation is that other employees will find out that they are receiving counselling (Attridge, et al, 2010; Butterworth, 2001). Individuals fear that their use of EAP services will be held against them in some way, whether that is as a personal flaw or work impairment issue (Attridge, et al, 2010). This fear may be further permeated by the misunderstanding individuals have about what services EAPs provide. Many believe services are purely focused around mental health issues; however, this is not so. EAP services extend to areas of stress management, work-life balance, financial planning, and overall mental wellness (McRee, 2017; Attridge, et al, 2010). This stigma can result in reduced usage of EAPs even in the event of distressing personal problems (Milot, 2019). Further, individuals may fear raising issues with the stigma itself with their colleagues as it may bring about negative views from co-workers towards the individual, allowing the stigma to go unaddressed by employers and/or employees.

Presenteeism Mental Health Stigma

Stigma associated with presenteeism follows similar trends to that of EAP stigma and of course general mental health stigma. Individuals fear that they will be marginalised and mistreated if they come forward with mental health issues or take time out to deal with such

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issues (Attridge, Bennett, Frame, & Quick, 2009; Hanisch, et al, 2016; Szeto & Dobson, 2010). Regardless of whether there are real acts of discrimination or not, individuals anticipate discrimination if they do not turn up to work (Hanisch, et al, 2016). This discrimination is often believed to manifest in negative opinions of managers towards the individual, loss of career opportunities, and/or loss of job. These concerns fuel an individual to attend work even when they are compromised (Hanisch, et al, 2016; Prater & Smith, 2011). These are essentially the same issues that relate to EAP and the stigma around their utilisation: individuals fear that their mental health issue will impact their employment, or they are ashamed to seek the help in the first place.

It is possible that similar stigma occurs around the usage of mental health days, however, there is currently a lack of research around mental health days. The stigma felt towards EAPs aligns with that seen towards mental health issues and illness. The current study endeavours to explore stigma associated with each of these support methods along with the potential stigma associated with presenteeism among the New Zealand workforce.

Mental Health Stigma and Past Experience with Mental Health Issues

With the increasing prevalence of mental health issues within the western world it is a fair assumption that there is a portion of the population with past experiences with mental health issues and a wide variety of support methods. Research on past experience with mental health issues is focused around those who work with mentally ill patients, or have previously had mental health issues/illness. However, research into mental health stigma in individuals who have past experience with mental health issues and/or services is mixed, with a vast amount of factors contributing to different outcomes. For example, one study found that participants that had previously had comfortable/positive experiences with mental health services had lower stigma toward mental health services (Corrigan, et al, 2014). Antipathetic and distancing attitudes towards those with mental health issues were found to decrease in

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individuals with past experience with mental health issues, however no differences were found between different mental health disorders (Angermeyer & Matschinger, 1996). Past personal experience was also associated with increased trust of those with mental health issues being given social responsibility or placed in social situations (Trute & Loewen, 1978). However, the interaction of past experience with individuals with mental health issues and mental health stigma towards others has been found to be influenced by multiple additional factors, such as age and sex (See: Hayward & Bright, 2009). Mental health stigma can be widely found within practitioners within the mental health field (Corrigan, 2000; Penn & Martin, 1996), with stereotypes being reinforced within those who are there to help with mental health issues (Corrigan, 2000). Greater support for mental health funding has been found in those with personal or family experience of mental health issues (Thompson, et al, 2002). In opposition to experience with mental issues is 'social distancing', which aligns with stigmatised views of mental health. Such views have an association with age and 'traditional values' towards health care, all of which have been shown to prefer less funding for mental health care when compared to physical care (Schomerus, Matschinger, Angermeyer, 2006; Sharac, et al, 2009). Therefore, those with past experience do not exhibit the same levels of stigma and distancing behaviours commonly seen within those who lack any experience with mental health issues.

Although the research on past experience with mental health is primarily focused around the issue itself and not support services, past research does show that those with past experience exhibit less stigma than those without experience. Therefore, past experience with mental health support methods within organisations may result in lower stigma towards such support methods. As there is not substantial research on this topic, the current study will also explore the impact of past experience using workplace mental health support methods/services on stigma assumptions towards such methods.

What is Missing from Current Research?

From the above information it is certain that there is a mental health crisis across the western, if not the entire, world. Prevention is underdeveloped, and employers can provide one of the greatest platforms for prevention, education, and normalisation within the workplace. The current New Zealand government in 2019 announced a “wellbeing budget” with a sizable portion of the budget (\$1.5 billion) targeted at mental health and addiction. Stigma occurs within all areas of society, from family and home life, workplaces, and even within mental health care (Corrigan, 2016).

Workplaces are said to be one of the greatest places to implement mental health-based initiatives and educate the population (Szeto & Dobson, 2010). However, workplaces may also be one of the most damaging places for stigma to exist, as they can potentially cause serious psychological and mental harm, loss of employment and income, and feelings of isolation from society for those with mental health issues/illness. Therefore, gaining a better understanding of mental health stigma within workplaces is vital to improve the health of those impacted by mental health stigma and give greater direction to future initiatives targeting mental health and its stigma. Within New Zealand workplaces there is limited research on mental health stigma, more specifically, what the current climate of perception towards mental health is, as well as how current support methods are viewed by a working population. There is also limited research as to whether past experience with the support methods further reduces mental health stigma towards them.

There are multiple theories that try to describe the underlying mechanisms generating mental health stigma within a population. These theories stem from multiple areas of the wider topic of stigma and provide solid groundwork for further exploration and development.

The Current Study

Attribution theory states that a person's behaviour towards an individual experiencing a negative event is based on the person's perception of whether the individual is responsible for the negative event. If the individual is perceived to be responsible for the negative event then a person's response is more likely to be of anger, reduced willingness to help, and punishment, rather than pity and willingness to help the individual. A common stigmatising assumption is that mental health issues are caused by the individual and/or caused by their biology or genetics (Ahmedani, 2011). In turn, the individual is also deemed to be responsible for their mental illness/mental health issue and its control (Ahmedani, 2011; Corrigan, 2000; Corrigan, et al, 2007). If the individual does not have their mental health "under control" then it is considered to be the result of lack of effort on the individual's part (Ahmedani, 2011). Therefore, if an individual is seen to be using support methods to cope with their mental health, it may be possible to reduce the stigma one might receive as they are seen to be taking responsibility and putting in effort to "control" their mental health. Perception of the overall benefit of each support method may play a major role in a person's view of each support method and of the individual. If a person has past experience with mental health support methods, their stigma associated with attribution of responsibility and effort could be further reduced by having experienced it themselves.

The current study intends to capture current mental health stigma towards individuals with mental health issues and any stigma associated with support methods used to cope with such issues within a New Zealand based working population sample. Based on attribution theory (Weiner, 1985) and the role of perceived effort on an individual's part to reduce/avoid a negative event, it is hypothesised that the use of a support method by an individual to cope with their mental health issue will reduce a participant's mental health stigma towards that individual.

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***Hypothesis 1:** Participants' responses will agree less with the items based on assumptions of workplace mental health stigma in the EAP scenario and mental health day scenario when compared to the presenteeism scenario.*

Analysis for Hypothesis 1 will also provide insight and data on any stigma that may exist towards any of the support initiatives commonly used within the New Zealand workforce.

It is also hypothesized based on research into past experience with mental health issues that participants with past experience using either support method will have lower stigma towards the individual in the scenario.

***Hypothesis 2:** Participants with past experience using EAP services or mental health days will agree less with the workplace stigma items based on assumptions of workplace stigma when compared to those without past experience.*

In order to test these hypotheses a survey will be provided to participants regarding mental health support methods and their view towards and past experience with such support methods. In order to explore any mental health stigma that may be present within the sample, work by Corrigan (2000) using social cognitive theory (Bandura, 1986) in regard to mental health stigma and attribution theory (Weiner, 1985) will be used to develop a scenario of mental health within the workplace in which a participant may apply stereotypes of stigma to. The survey contains three scenarios of an individual disclosing mental health issues to a colleague (the colleague will be the participant), along with the support method (EAP services, mental health days, or presenteeism) they are using to help cope with the issue. Participants' responses to items regarding stigma assumptions across the three scenarios will be compared in order to determine if stigma is reduced based on support method usage.

Figure 1 outlines the intended steps a participant will take as they respond to the survey based on social cognitive theory. The scenarios intend to place participants on the

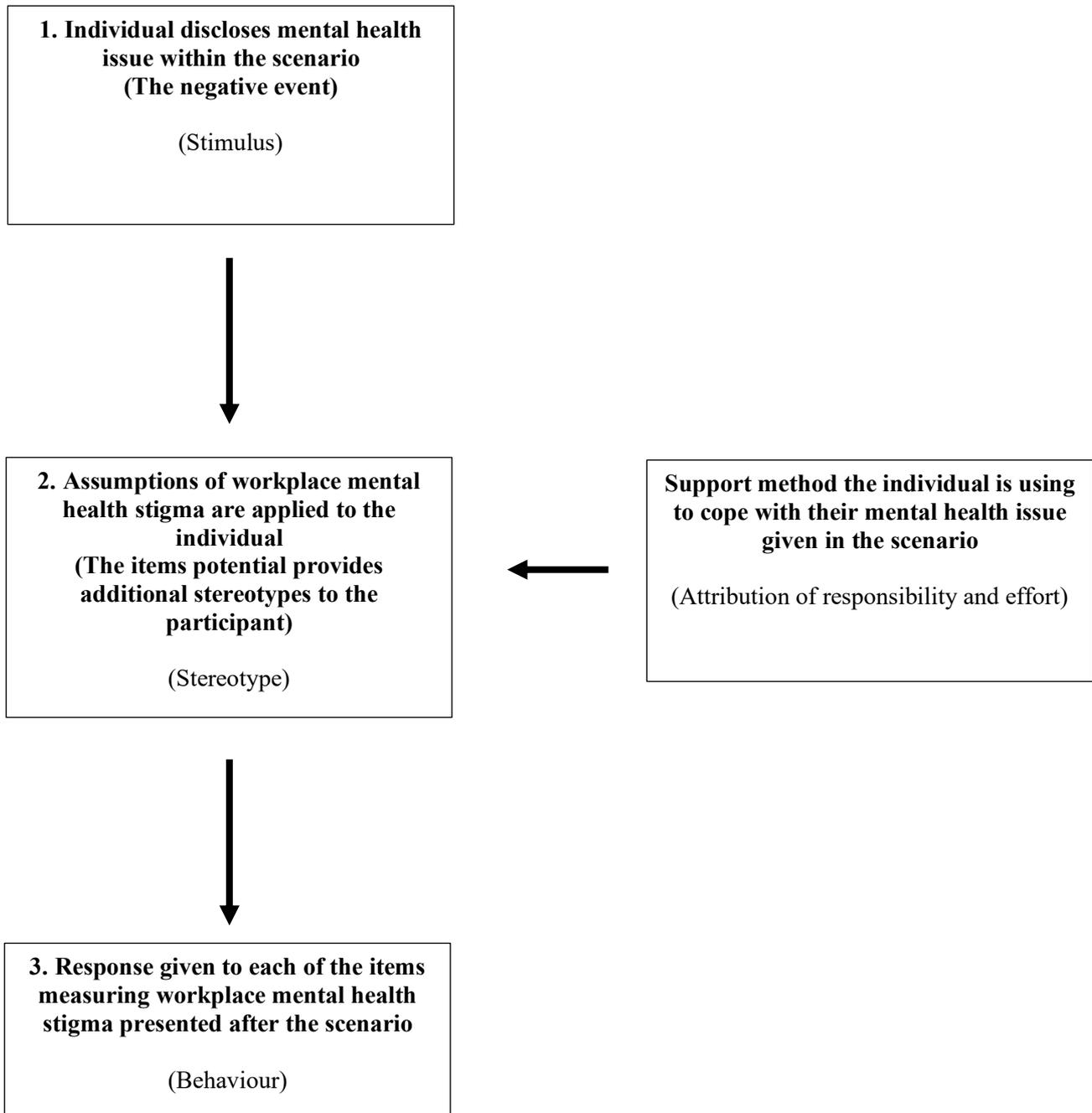
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“pathway” of social cognitive theory, with the individual disclosing a mental health issue acting as the first step, the *stimuli*. The second step will be how the participant applies *stereotypes* to the stimuli. Items are provided to measure the stereotypes based on the assumptions that underlie workplace mental health stigma presented in Kurpa, et al, (2009). At this time attribution theory will also play a role in how the participant responds, depending on whether they attribute responsibility to the person for their mental illness (this is the negative event) or to external circumstances. This assumption may act as an additional stereotype to any mental health stigma the participant has. The support method the individual is using to cope with their mental health issue is intended to see if it can reduce stigma and the attribution of lack of effort on the individual's part to cope with the mental health issue (negative event). The responses a participant gives to each scenario will act as the *behaviour*, the final step in social cognitive theory. The third scenario will use presenteeism as opposed to a support method in order to see if the addition of a support method and perceived effort on the individual's part is playing a role in the social cognitive process. Presenteeism along with the addition of the individual appearing stressed (additional stimuli) based on attribution theory could lead participants to perceive a lack of effort on the individual's part and strengthen negative perception towards the individual. The responses a participant gives to each scenario will act as the *behaviour*, the final step in social cognitive theory.

In the survey information will also be gathered regarding mental health day usage and disclosing behaviour around using them. The information on mental health day usage is intended to provide some insight into current usage of mental health days and whether they appear to be being abused in any way as they are often stereotyped as such.

Figure 1.

The social cognitive process of the scenarios used within the survey.



Method

Participants

Organisations were initially approached by their EAP provider, via emails that were sent to organisation directors or the heads of health and safety departments. In total 15 organisations were initially contacted by the EAP provider, with five organisations indicating that they would participate within the time allocated for data collection. The five organisations covered a range of industry including: construction, agriculture and meat production, agricultural research, engineering, and retail (supermarkets). Additional emails were exchanged between researchers and the five organisations to outline details of the research and its associated procedure, after which the organisation sent basic information regarding the study and a survey link to its employees. Upon completion of the survey participants were given the opportunity to enter a prize draw to win one of ten \$50 vouchers. This was also used as an incentive for participation.

Two additional organisations outside of the EAP providers client base and the city of Christchurch were contacted in an attempt to widen the generalisability of the findings. However, both organisations declined to be involved due to concerns for their staff or with the research itself, despite initially indicating enthusiasm to be involved.

Two-hundred-and-fifty-three individuals provided responses to the survey however, this included individuals who opened the survey but did not answer any questions. Therefore, participants that responded to the items were 228 part-time or full-time employees of multiple Christchurch based organisations across different sectors, including: 102 male and 126 females. The mean age of participants was 39.5 years old (SD = 13.2). Ninety-five participants (42 percent) indicated that they were in a managerial position, and participants on average had been with their current employers for 8.54 years (SD = 8.56) years. Of the 228 participants, 164 responded as New Zealand European, 19 as Māori, 12 as Asian, 2 as

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Middle Eastern/Latin American/African, and 30 as others which included a wide range of responses.

Materials

Participants responded to 39 items in the survey titled “Perceptions of Workplace Mental Health Initiatives in the NZ Workforce” (see Appendix A). It consisted of items developed in collaboration with the EAP provider organisation, as well as items developed by the researcher. The survey was split into eight main sections: demographics, support initiative scenarios, general mental health, interaction with support initiatives, and on-site staff support (EAP Providers’ Services). A 5-point Likert scale, where 1 = strongly disagree and 5 = strongly agree, was used when responding to items used within the scenario portion of the survey. The survey took between 10 and 20 minutes to complete.

An initial question asked individuals to write what came to mind when they read the term “EAP”, followed by a brief definition of EAPs so participants were familiar with the terminology before the scenarios were presented. The support methods were presented to the participants via neutral scenarios where the participant was instructed to imagine a scenario where they are told by a colleague that they are using a support initiative to cope with an undisclosed mental health issue. These scenarios were intended to be very similar in context and neutral in the fact that the individual approaches the participant and does not specify what their mental health issue was. The neutral nature of the scenario and consistent format intended to remove as much bias towards any one support method as possible, as well as reduce any potential stigma that may arise through a specific mental health issue/illness. Each scenario began with the following: *“Please read the scenario below and rate to what extent you agree or disagree with the following statements based on this scenario only”* to alert individuals to the change in scenario before answering the items. Each scenario was

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presented directly below the statement. The scenarios were randomised to reduce any ordering effects. The scenarios are as follows:

EAP - While at work you are told by a colleague that they are currently using the company's employee assistance programme (EAP), the EAP provides anonymous counselling to any employee that seeks it. You are told that this is due to the colleague currently having issues with their mental health.

Mental Health Days - While at work you are told by a colleague that they are currently taking mental health days as a part of their own annual/sick leave, on days where they do not feel they are able to work due to reasons other than physical illness. You are told that this is due to the colleague currently having issues with their mental health.

Presenteeism - While at work you are told by a colleague that they are currently feeling stressed and are not performing to their normal standards. However, they still turn up to work each day. You are also told that the colleague is currently having issues with their mental health.

Seven items were presented after each scenario in a randomised order each time and six of the items are based on three of the five assumptions of stigma (Krupa, et al, 2009) that are further supported by separate work by Pescosolido, et al (2013). For the assumption that people with mental health issues in the workplace lack the competence required to meet the considerable task requirements and social demands at work, items were created around performance expectations (Performance), social demands (Social Interaction), and benefits (Social Benefit). In regard to the assumption that people with mental illnesses are dangerous or unpredictable in the workplace, items were created around health and safety of the individual and others (H&S-Self, H&S-Others) and the unpredictability of one with a mental health issue (Unpredictability). The benefits of the support initiative for the individual (Helpfulness) is the seventh item presented with each scenario. The following section on

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more general mental health stigma used the following stigma assumptions: mental illness is not a legitimate illness, working is not healthy for people with mental illness, and providing employment for people with mental illness is an act of charity. These assumptions were split into four items with the wider scope of employers in mind. Each item used a 5-point Likert scale where 1 = strongly disagree and 5 = strongly agree.

The section on experience with mental health support methods was split into two subsections, EAPs and mental health days, in order to gain information for the between-subject variables. Each subsection consisted of three questions asking if the participant's organisation offered the initiative, and whether a participant had intentions to and/or had used either initiative in the past. Two further questions were asked if a person indicated they had taken a mental health day, as to the reason for the mental health day and their explanation to an employer for their absence. Reasons for mental health days were then coded into six broad categories based on key words in a participant's response: Bereavement, Burnout/Exhaustion, Mental Health Illness/Issue, Needed a Break, Stress, Work-Life Balance/Family. Explanations for their absence were coded into two categories: the same as their reason for taking a mental health day or provided an excuse.

The final section of the survey was not directly related to this study but part of a wider collaboration between an EAP provider and the researchers centred around evaluating the services provided by Workplace Support to its clients. This section focused on the specifics of Workplace Support's services and intentions to utilise their services. However, this data is not used within any analysis of this research.

Procedure

Information regarding the background of the research and a survey link were sent to each organisation (see Appendix B). This email was then distributed to employees of each organisation in multiple ways. Two organisations chose to post the information and survey

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link on their employees Facebook group, a further two organisations forwarded the email to their employees work emails along with a message of support, and one organisation posted the information on an internal forum page. Employees could then access the online survey via the link provided and complete the survey where and when they wanted to. The survey could be completed on a PC/laptop or a cell phone/tablet. The survey took between 10 and 20 minutes on average to complete. Once the survey was complete participants were asked if they would like to be taken to a separate survey to enter a prize draw as an appreciation for their participation.

Each organisation had their own survey link which remained open for two weeks and after one week the organisations provided a prompt/reminder to complete their survey that was sent out on its respective platform.

Design

The research is exploratory in nature but employs a repeated measure design with within-subject and between-subject factors. Within the survey there are three near identical scenarios which are used for the within-subject factor, each scenario differs in the support method the individual is using to cope with their mental health. Participants' responses to the seven items are compared across the three scenarios. The between-subject factors are participants past experience/usage with the support methods, EAPs and mental health days, in his or her own working life.

Results

Within-Subject Analysis

The within-subject analysis utilises repeated measures ANOVAs to analyse the effect of each of the three scenarios (EAPs, mental health days, and presenteeism) on seven assumptions that underlie stigma within the workforce. Data exclusions were conducted by a listwise deletion, resulting in a sample of 184 (72.7 percent) of the original sample having

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complete data and that could be included in the within-subjects analysis. Means and standard deviations for the helpfulness variable and six stigma assumptions across the three scenarios can be found in Table 1. Appendix C provides correlations for all variables used within the following analyses.

Table 1.
Means and standard deviation for participant's responses for stigma assumption items across the three scenarios

Variable	Scenario		
	EAP	Mental Health Day	Presenteeism
Helpfulness	4.22 (.70) N = 187	3.66 (1.1) N = 184	2.80 (1.2) N = 195
Stigma Assumptions			
Performance	2.49 (1.1) N = 186	2.81 (1.1) N = 184	3.15 (1.1) N = 194
Social Interaction	2.52 (1.0) N = 187	2.72 (1.1) N = 184	2.83 (1.0) N = 195
Social Benefit	3.73 (.85) N = 187	3.45 (.92) N = 183	3.69 (.79) N = 195
H&S-Self	2.78 (1.1) N = 187	3.16 (1.1) N = 184	3.62 (.95) N = 195
H&S-Others	2.47 (1.1) N = 187	2.61 (1.1) N = 184	3.11 (1.1) N = 194
Unpredictability	2.88 (1.0) N = 187	3.08 (1.0) N = 184	3.44 (.90) N = 195

Note. All items were measured on a 5-point likert scale with 1 = strongly disagree and 5 = strongly agree.

The condition of sphericity was tested across the seven variables using the Mauchly's Test of Sphericity, where in order to meet the assumption of sphericity for a repeated measures ANOVA values must be non-significant at the .05 level. Only four of the seven items returned non-significant values: social interaction, $\chi^2(2) = .463, p = .793$, social benefit, $\chi^2(2) = 5.53, p = .063$, H&S-Self, $\chi^2(2) = 5.48, p = .064$, and unpredictability, $\chi^2(2) = .159, p = .924$. The variables of helpfulness, performance, and H&S-Others all produced significant results ($p < .05$) for Mauchly's Test of Sphericity and therefore, violated

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the sphericity assumption. As such, further analysis of these variables will use the Greenhouse-Geisser test as it is a more conservative test accounting for the violation. ANOVAs that return significant results (reject the null hypothesis) will use Fisher's Least Significant Difference (LSD) as a post hoc test to compare the difference in means between scenarios.

For the variable of Helpfulness, there was significant main effect of the independent variable of the scenario, ($F(1.85, 322) = 104, p = .000, \eta_p^2 = .375$). This can be considered as a large effect as it is above the cut-off of .14, which signifies a large effect (Miles & Shevlin, 2001; Cohen, 1988). LSD post-hoc test shows that perceptions of the helpfulness of the support method were significantly higher in the EAP scenario ($M = 4.22; SD = .703$) when compared to the mental health day scenario ($M = 3.669; SD = 1.05; p = .007$) and the presenteeism scenario ($M = 2.76; SD = 1.24; p = .000$). Further to this, a significant difference was found between the mental health day scenario and presenteeism scenario ($p = .000$). This result supports Hypothesis 1, and shows participants perceived EAP services to be more helpful to the individual when compared to mental health days and presenteeism.

The variable of performance showed a significant main effect of the independent variable ($F(1.85, 320) = 32.478, p = .000, \eta_p^2 = .152$). This can be considered as a large effect as it is above the cut-off of .14 (Miles & Shevlin, 2001; Cohen, 1988). LSD post-hoc test shows that the perceptions of individuals' inability to meet performance requirements of work was significantly lower in the EAP scenario ($M = 2.51; SD = 1.08$) when compared to the mental health day scenario ($M = 2.80; SD = 1.14; p = .007$) and the presenteeism scenario ($M = 3.21; SD = 1.14; p = .000$). Further to this, a significant difference was found between the mental health day scenario and presenteeism scenario ($p = .000$). This evidence supports Hypothesis 1. Peoples' stigma towards an individual, in this case around the ability of the

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individual to meet performance requirements in the workplace, was lowest in the EAP scenario and highest in the presenteeism scenario.

The variable social interaction showed a significant main effect of the independent variable ($F(2, 348) = 8.61, p = .000, \eta_p^2 = .047$). This can be considered as a small effect as it is just above the cut-off of .04 which signifies a small effect (Miles & Shevlin, 2001; Cohen, 1988). The LSD post-hoc test shows that the perception of the individual's inability to manage social interaction at work was significantly lower in the EAP scenario ($M = 2.53; SD = 1.02$) when compared to the mental health day scenario ($M = 2.74; SD = 1.05; p = .007$) and the presenteeism scenario ($M = 2.85; SD = 1.02; p = .000$). However, there was no significant difference between the mental health day scenario and presenteeism scenario ($p = .173$). This evidence supports Hypothesis 1. Peoples' stigma towards an individual, in this case around an individual's ability to handle social interaction within the workplace, was lowest in the EAP scenario and highest in the presenteeism scenario.

The variable social benefit showed a significant main effect of the independent variable ($F(2, 346) = 7.65, p = .001, \eta_p^2 = .042$). This can be considered as a small effect as it is just above the cut-off of .04 which signifies a small effect (Miles & Shevlin, 2001; Cohen, 1988). Social benefit has the smallest effect size across all seven variables in this analysis. The LSD post-hoc test shows that the perception of the benefit of workplace social interaction for individuals was significantly lower in the EAP scenario ($M = 3.70; SD = .851$) when compared to the mental health day scenario ($M = 3.46; SD = .918; p = .000$), however there was no significant difference seen between the EAP and presenteeism scenario ($M = 3.64; SD = .793; p = .395$). There is a significant difference between the mental health day scenario and presenteeism scenario ($p = .008$). This results does not support Hypothesis 1 as there was no significant difference between the EAP scenario and presenteeism scenario.

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This suggests equal assumptions of stigma. However, the mental health day scenario was perceived as lower than both EAPs and presenteeism.

In terms of the health and safety risk to the individual (H&S-Self), the variable showed a significant main effect of the independent variable ($F(2, 348) = 45.7, p = .000, \eta_p^2 = .208$). This can be considered as a large effect as it is above the cut-off of .14 (Miles & Shevlin, 2001; Cohen, 1988). The LSD post-hoc test shows that the perception of health and safety risk to the individual was significantly lower in the EAP scenario ($M = 2.81; SD = 1.07$) when compared to the mental health day scenario ($M = 3.13; SD = 1.10; p = .007$) and the presenteeism scenario ($M = 3.64; SD = .953; p = .000$). Further to this, a significant difference was found between the mental health day scenario and presenteeism scenario ($p = .000$). This evidence supports Hypothesis 1. People's stigma towards an individual, in this case around the health and safety risk the individual poses to themselves, is lowest in the EAP scenario and highest in the presenteeism scenario.

When looking at the health and safety of other employees within the workplace (H&S-Others), the variable showed a significant main effect of the independent variable ($F(1.85, 334) = 32.5, p = .000, \eta_p^2 = .157$). This can be considered as a large effect as it is above the cut-off of .14 (Miles & Shevlin, 2001; Cohen, 1988). The LSD post-hoc test shows that perceptions of the health and safety risk the individual poses to other employees within the workplace was not significantly different in the EAP scenario ($M = 2.51; SD = 1.05$) when compared to the mental health day scenario ($M = 2.62; SD = 1.11; p = .084$). However, perceptions were significantly lower in the EAP scenario when compared to the presenteeism scenario ($M = 3.11; SD = 1.06; p = .000$). Further to this, a significant difference was found between the mental health day scenario and presenteeism scenario ($p = .000$). This evidence supports Hypothesis 1. People's stigma towards an individual, in this case around the health

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and safety risk the individual poses to others, is lower in the EAP scenario and highest in the presenteeism scenario.

The unpredictability of the individual within the workplace (unpredictability) showed a significant main effect of the independent variable ($F(2, 348) = 30.3, p = .000, \eta_p^2 = .148$). This can be considered as a large effect as it is just above the cut-off of .14 (Miles & Shevlin, 2001; Cohen, 1988). The LSD post-hoc test shows that perceptions towards the unpredictability of the individual within the workplace were significantly lower in the EAP scenario ($M = 2.88; SD = 1.04$) when compared to the mental health day scenario ($M = 3.10; SD = 1.04; p = .005$) and the presenteeism scenario ($M = 3.74; SD = .902; p = .000$). Further to this, a significant difference was found between the mental health day scenario and presenteeism scenario ($p = .000$). This evidence supports Hypothesis 1. People's stigma towards an individual, in this case around the unpredictability of the individual within the workplace, is lower in the EAP scenario and highest in the presenteeism scenario.

Overall, there are main effects across all seven variables in the repeated measures ANVOAs. These results support Hypothesis 1, in that the support method an individual with a mental health issue uses creates a difference in the stigma assumptions of those around them in the workplace. The EAP scenario provides the lowest perceptions of stigma across all six items, while the presenteeism scenario provides the highest stigma assumptions. Mental health days appear to act as the middle ground in terms of stigma response as it was consistently found to be between the two scenarios.

Between-Subjects Analysis

For Hypothesis 2, the between-subject effect of past experiences with support methods (taking a mental health day, EAP usage) and its interaction with the helpfulness variable and six stigma assumptions within each scenario is tested via a two-way repeated measures ANOVA. The effect of past experience will be analysed via tests for interaction

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effects between each scenario and past experience. Main effects will also be tested to see if those with past experience differ in their response regardless of the effect of the scenario. Levene's test of equality of error variances were conducted for all ANOVAs. No significant results were returned from these tests, therefore the assumption of homogeneity of variance is met. Table 2 provides the descriptive statistics for past experiences with support initiatives. Frequency of EAP past usage data was gathered by asking the number of times a participant has used such services in the past five years. For the between-subjects analysis, all participants with any experience were grouped together regardless of how many times they have used an EAP service. All other items were asked as a question with yes, no, or do not know as response options. Within the sample, only 27.4 percent (31 participants) of the 113 participants who responded to the EAP usage question have used an EAP service in the past five years. For participants who responded to the item of past experience with mental health days, 45.3 percent (78 participants) of the 172 participants have taken a mental health day for any reason. Of note, all organisations in the sample provided EAP services to their employees, despite this 6.1 percent of participants did not know this. None of the five organisations formally provided mental health days as its own form of leave yet 12.2 percent of the sample believed they were provided mental health days.

Table 2.
Frequency and percentage of participants past support method usage and knowledge of support method availability

Item	N	Yes
Have you used an EAP service in the past five years?	113	31 (27.4%)
Have you ever taken a mental health day for any reason?	172	78 (45.3%)
Are EAP services offered through your workplace?	181	170 (93.9%)
Does your organisation provide mental health days?	180	22 (12.2%)

Note. All participants were part of organisations that currently provided EAP services to their employees.

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The results of the repeated measures ANOVA for the interaction effect of both between-subject variables on the variable of helpfulness (perceived helpfulness of the support method to the individual) found no interaction effect between EAP usage and the three scenarios ($F(1.85, 222) = 2.02, p = .108, \eta_p^2 = .020$). No main effect was found between past experience when looking at EAP usage and participants response to the helpfulness variable. Participants with experience using EAP services showed no statistically significant difference in their responses to the helpfulness of the support method across the three scenarios when compared to those without experience ($F(1,111) = .02, p = .887, \eta_p^2 = .000$).

When looking at results for past experience taking a mental health day, there is no interaction effect between past experience and responses to the helpfulness variable across the three scenarios ($F(1.85, 317) = 4.78, p = .011, \eta_p^2 = .027$). There appears to be no main effect of past experience with mental health days on participants' responses to the helpfulness variable. Participants with past experience taking a mental health day show no statistically significant difference in responses to the helpfulness of the support method across the three scenarios when compared to those without experience ($F(1,171) = .461, p = .545, \eta_p^2 = .002$). With these results in mind for the variable of helpfulness, Hypothesis 2 is not supported. There was no interaction effect of past experience with support methods across the three perceived helpfulness of the support methods across the scenarios. Further to this, there is no main effect of past experience on participants' responses across the scenarios when responding to the helpfulness variable.

The results of the repeated measures ANOVA for the interaction effect of both between-subject variables on the variable of performance (perceived ability of the individual to meet the performance expectations of the job based on support method) found no interaction effect between EAP usage and the three scenarios ($F(1.85, 220) = .759, p = .460, \eta_p^2 = .007$). No main effect was found between past experience when looking at EAP usage

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and participants' responses to the performance variable. Participants with experience using EAP services showed no statistically significant difference in responses to the ability of the individual to meet performance expectations of work across the three scenarios when compared those without experience ($F(1, 110) = .078, p = .781, \eta_p^2 = .001$).

When looking at past experience taking a mental health day, there is no interaction effect between past experience taking a mental health day and responses to the performance variable across the three scenarios ($F(1.86, 316) = 2.39, p = .097, \eta_p^2 = .014$). There is a main effect of past experience with mental health days on participants' responses to the performance variable. Participants with past experience taking a mental health day show statistically significant different responses to the ability of the individual to meet performance expectations of work across the three scenarios when compared those without experience ($F(1, 171) = 12.6, p = .000, \eta_p^2 = .069$). This can be interpreted as a small effect size (Miles & Shevlin, 2001; Cohen, 1988). The effect shows that those with past experience taking a mental health day appear to agree less with the idea that the individual will be unable to meet the performance expectations across all three scenarios when compared to those who have no past experience taking a mental health day. With these results in mind for the variable of performance, Hypothesis 2 is not supported. There is no interaction effect of past experience with support initiatives and any of the three scenarios when participants are responding to the perceived ability of the individual to meet the performance expectations of work.

The results of the repeated measures ANOVA for the interaction effect of both between-subject variables on the variable of social interaction (perceived ability of the individual to meet the social interaction of work based on support method) found no interaction effect between EAP usage and the three scenarios ($F(2, 222) = .336, p = .715, \eta_p^2 = .003$). No main effect was found between past experience when looking at EAP usage and participants' responses to the social interaction variable. Participants with experience using

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EAP services showed no statistically significant difference in participant responses to the ability of the individual to meet social interaction expectations of work across the three scenarios when compared those without experience ($F(1,111) = .351, p = .555, \eta_p^2 = .003$).

When looking at past experience taking a mental health day, there is no interaction effect between past experience taking a mental health day and responses to the social interaction variable across the three scenarios ($F(2, 342) = .816, p = .443, \eta_p^2 = .005$).

Participants with past experience taking a mental health day show statistically significant different responses to the ability of the individual to meet social interaction expectations of work across the three scenarios when compared those without experience ($F(1,171) = 16.0, p = .000, \eta_p^2 = .086$). This can be interpreted as a medium effect size (Miles & Shevlin, 2001; Cohen, 1988). The effect shows those with past experience taking a mental health day appear to agree less with the idea that the individual will be unable to meet the social interaction expectations across all three scenarios when compared to those who have no past experience taking a mental health day. With the above results in mind for the variable of social interaction, Hypothesis 2 is not supported. No interaction effect was found between past experience with support initiatives in the three scenarios and participants' responses to the perceived ability of the individual to meeting social interaction expectation of work.

The results of the repeated measures ANOVA for the interaction effect of both between-subject variables on the variable of social benefit (perceived benefit of the social interaction work provides to the individual) found no interaction effect between EAP usage and the three scenarios ($F(1.75, 222) = .435, p = .621, \eta_p^2 = .004$). No main effect was found between past experience when looking at EAP usage and participants' responses to the social benefit variable. Participants with experience using EAP services showed no statistically significant difference in responses to the benefit of social interaction at work to the individual

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across the three scenarios when compared to those without experience ($F(1,111) = 1.49, p = .224, \eta_p^2 = .013$).

When looking at past experience taking a mental health day, no interaction effect between past experience taking a mental health day and responses to the social benefit variable across the three scenarios was found ($F(1.93, 340) = 1.64, p = .196, \eta_p^2 = .010$). There was no main effect of past experience with mental health days on participants response to the social benefit variable. Participants with past experience taking a mental health day show no statistically significant different responses to the perceived benefit of social interaction of work to the individual across the three scenarios when compared to those without experience ($F(1,170) = .040, p = .841, \eta_p^2 = .000$). With the above results in mind for the variable of social benefit, Hypothesis 2 is not supported. There is no interaction effect of past experience with support initiatives and any of the three scenarios when participants are responding to the perceived benefit of the social interaction work provides to the individual.

The results of the repeated measures ANOVA for the interaction effect of both between-subject variables on the variable of H&S-Self (perceived risk to the individuals own health and safety within the workplace) found no interaction effect between EAP usage and the three scenarios ($F(2, 222) = .530, p = .589, \eta_p^2 = .005$). No main effect was found between past experience when looking at EAP usage and participants response to the H&S-Self variable. Participants with experience using EAP services showed no statistically significant difference in participant responses to the perceived risk to the individuals own health and safety within the workplace across the three scenarios when compared those without experience ($F(1,111) = .610, p = .436, \eta_p^2 = .005$).

When looking at past experience taking a mental health day, there is no interaction effect between past experience taking a mental health day and responses to the H&S-Self variable across the three scenarios ($F(2, 342) = 1.05, p = .210, \eta_p^2 = .009$). There is no main

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effect of past experience with mental health days on participants' responses to the H&S-Self variable. Participants with past experience taking a mental health day show no statistically significant different responses to the perceived risk to the individual's own health and safety within the workplace across the three scenarios when compared to those without experience ($F(1,171) = .519, p = .024, \eta_p^2 = .029$). With the above results in mind for the variable of H&S-Self, Hypothesis 2 is not supported. There is no interaction effect of past experience with support initiatives and any of the three scenarios when participants are responding to the perceived risk to the individual's own health and safety within the workplace.

The results of the repeated measures ANOVA the interaction effect of both between-subject variables on the variable of H&S-Others (perceived risk the individual poses to other employees' health and safety at work) found no interaction effect between EAP usage and the three scenarios ($F(1.85, 220) = .759, p = .460, \eta_p^2 = .007$). No main effect was found between past experience when looking at EAP usage and participants' responses to the H&S-Others variable. Participants with experience using EAP services showed no statistically significant difference in participant responses to the perceived risk the individual poses to other employees' health and safety at work across the three scenarios when compared to those without experience ($F(1,111) = .039, p = .843, \eta_p^2 = .000$).

When looking at past experience taking a mental health day, there is no interaction effect between past experience taking a mental health day and responses to the H&S-Others variable across the three scenarios ($F(1.86, 316) = 2.39, p = .097, \eta_p^2 = .014$). There is a main effect of past experience with mental health days on participants' responses to the H&S-Others variable. Participants with past experience taking a mental health day show statistically significant different responses to the perceived risk the individual poses to other employees' health and safety at work across the three scenarios when compared to those without experience ($F(1,171) = 7.04, p = .009, \eta_p^2 = .040$). This can be interpreted as a small

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effect size (Miles & Shevlin, 2001; Cohen, 1988). The effect shows that those with experience appear to agree less with the idea that the individual will pose a risk to the health and safety of employees within the workplace across all scenarios, when compared to those who have no experience with mental health days. With the above results in mind for the variable of H&S-Others, Hypothesis 2 is not supported. There is no interaction effect of past experience with support initiatives and any of the three scenarios when participants are responding to the perceived risk the individual poses to other employees' health and safety at work.

The results of the repeated measures ANOVA for the interaction effect of both between-subject variables on the variable unpredictability (perceived unpredictability of the individual within the workplace) found no interaction effect between EAP usage and the three scenarios ($F(2, 222) = .866, p = .422, \eta_p^2 = .008$). No main effect was found between past experience when looking at EAP usage and participants' responses to the unpredictability variable. Participants with experience using EAP services showed no statistically significant difference in responses to the perceived unpredictability of the individual within the workplace across the three scenarios when compared those without experience ($F(1, 111) = .157, p = .693, \eta_p^2 = .001$).

When looking at past experience taking a mental health day, there is no interaction effect between past experience taking a mental health day and responses to the unpredictability variable across the three scenarios ($F(2, 342) = 1.16, p = .214, \eta_p^2 = .007$). There is no main effect of past experience with mental health days on participants' responses to the unpredictable variable. Those participants with past experience taking a mental health day show no statistically significant difference response to the perceived unpredictability of the individual within the workplace across the three scenarios, when compared those without experience ($F(1, 171) = 3.08, p = .081, \eta_p^2 = .018$). With the above results in mind for the

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variable unpredictability, Hypothesis 2 is not supported. There is no interaction effect of past experience with support initiatives and any of the three scenarios when participants are responding to the perceived unpredictability of the individual within the workplace.

Overall, the results of the between-subjects analysis show that there is no interaction between past experience with support methods and responses to the six stigma assumption items across the scenarios. Therefore, there is no evidence to support Hypothesis 2. Main effects appear within three of the six stigma assumption items. However, this was only when using past experience with mental health days.

Mental Health Day Usage

Participants who indicated that they had taken a mental health day in the past were presented with two additional questions asking why they took a mental health day and what reason the participant provided to their employer regarding their absence. Of the 78 participants who indicated they took a mental health day, 77 provided a reason for their mental health day and 73 provided the reason they gave to their employer. Table 3 provides the frequencies of responses given for the reason for a participant taking a mental health day. Categories were based on common words and/or phrases found within participants' statements. The largest group of responses were related to stress felt through work (stress was often accompanied with feelings of being overwhelmed). Simply needing a break from work covered a large portion of responses and was often the result of workload and/or conflict with workmates. Within mental health illness/issues the most common response was depression and/or anxiety. Burnout and exhaustion were classified as separate to that of stress as participants did not use these terms in the same statements. The majority of work-life balance issues consisted of family and relationship issues that needed time to be addressed. Bereavement was the smallest of the response groups and was always due to the loss of someone close to the individual.

Table 3.

Common responses participants gave behind their reason for taking a mental health day

Common Responses	Frequency
Bereavement	4 (5.2%)
Burnout/Exhaustion	10 (13%)
Mental Health Illness/Issue	14 (18.2%)
Needed a Break	17 (22.0%)
Stress	22 (28.6%)
Work-Life Balance/Family	10 (13%)

Note. $N = 77$. Categories were based on key words within participants' statements.

The reason participants gave to their employer/those they work closest with consists of two groups: those who told the truth around their absence and those who provided an alternative excuse. Twenty-six (35.6 percent) participants told the truth and/or said that their absence was a mental health day. Some participants stated that they had a good relationship with those around them and this made it easier to disclose the truth. However, 47 (64.4 percent) participants gave an alternative reason to those they work closest with. Frequent reports of “feeling sick” or that they had a physical injury/illness were given to employers rather than a mental-health-based reason. It was also stated by some participants that their mental health day and the reason for taking it was none of their employers’ business and therefore they did not need to know.

Discussion

The aim of this study was to identify if people's mental health stigma based on assumptions found within the workplace can differ based on the support method an individual is using to cope with his or her mental health issues. The study also sought to identify whether having past experience with the support methods affected people's mental health stigma based on assumptions found within the workplace. In order to explore these aims participants completed a 15-minute survey. Thirty-nine items measured agreement with assumptions that underpin work-related mental health stigma across three fictional scenarios involving different support methods: EAPs, mental health days, and presenteeism.

Hypothesis 1 proposed that the use of a support method by an individual to cope with their mental health issue will lower agreement with mental health stigma assumptions towards that individual by participants. Hypothesis 1 was tested by repeated measures ANOVAs, which returned significant differences between the three scenarios across all seven items. The direction of the differences matched that of Hypothesis 1, as mean responses for the EAP scenario were consistently lower in agreement with the stigma assumption statements when compared to those in the mental health day and presenteeism scenarios. The largest effect size was found within the helpfulness variable ($\eta_p^2=.375$), which far exceeded any other effect sizes found within the analysis. This suggests that the support methods are not perceived equally by participants and EAP services are perceived as the most helpful of the two support methods for coping with mental health issues. It is possible that the perceived helpfulness of each support method plays a role in how participants responded to the stigma assumption items. However, the data within this study cannot support this idea as correlations between the helpfulness item and the six other items show no significant notable correlations (see Appendix C). The idea of perceived helpfulness of support methods interacting with

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mental health stigma appears to be beyond the scope of this study but may warrant future investigation.

A similar trend of mean responses were found throughout the six stigma assumption items, as the lowest means were consistently found in the EAP scenario. Lower means signify a lack of agreement with the stigma assumptions and therefore, lower mental health stigma towards those using EAP services. These means fall within the “somewhat disagree” range of responses (mean approximately 2.0 to 2.5). As such, participants to some extent disagree with the idea that the individual in the scenario will struggle with workplace performance requirements, the social interactions within a working environment, maintaining their own and others health and safety in the workplace, and be unpredictable within the workplace. These findings align with the rationale for Hypothesis 1, suggesting that the perception of effort by the individual to cope with their mental health issue, via a support method, could potentially reduce negative assumption towards that individual around mental health within the workplace. Individuals with mental health issues are often of the belief that their use of EAP services will be held against them and result in them being marginalised and/or mistreated, a belief that is supported by research (See: Attridge, et al, 2010; Hanisch, et al, 2016; Milto, 2019; Szeto & Dobson, 2010). While an individual may still experience stigma based on their mental health issue, the current results would suggest that on average those working around the individual will have lower levels of stigma towards them, provided the individual discloses any support methods they are using along with their mental health issue.

The mean responses in the mental health day scenario were significantly higher than the EAP scenario across all seven items. However, mean responses were still significantly lower in the mental health day scenario when compared to the presenteeism scenario. Means for the seven items within the mental health day scenario sat within a middle ground of 2.6 to

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3.2 on the 1 to 5 response scale. When compared to the other two scenarios in terms of structure and perceived effort, mental health days sit somewhere between the two. While not seeking professional help as in an EAP service, it can still be perceived as actively approaching one's mental health issue in order to cope. The difference seen in mean responses in the EAP and mental health days scenario suggests that support methods are not equal in their effect on mental health stigma. However, disclosure of the use of a support method to cope appears to be perceived more positively than taking no action towards one's mental health issue. This favours the underlying rationale that being seen to be taking responsibility and action towards mental health reduces stigma. There are a variety of potential reasons why there is a difference between the mean response for each support method, including the perception of effort required for each method, participants 'faith' in the ability for support methods to help the individual cope, or an interaction with the stigma towards each support method. This is another area which needs further investigation beyond this study. It is possible that the results are impacted by the change in public perception towards mental health days, as it is only in recent years that mental health days have become a topic of serious debate in the media and suggested for use by mental health foundations (see: Mental Health Foundation, 2018; Paterson, et al, 2018).

Mean responses for the presenteeism scenario match the expectations of Hypothesis 1, as responses showed greater agreement with the stigma assumptions. Further to this, the presenteeism scenario reported the lowest mean for helpfulness ($M = 2.8$). Mean responses for the six items based on stigma assumptions were above 3.0, apart from the variable of social interaction which was slightly below ($M = 2.8$). These results are consistent with the rationale of perceived responsibility and effort by the individual impacting mental health stigma. It is stated in the presenteeism scenario that the individual appears to be taking no action to help cope with their mental health issue, in direct contrast to the other scenarios.

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However, the scenario is unique as it states that the individual is feeling stressed and is not performing to their normal standards. This statement had negative connotations suggesting the individual was performing and acting in an impaired/negative way, which was not present in the other two scenarios. It is possible that the addition of those statements may have had an impact on participants responses, leading them to see this scenario from a negative perspective. The addition of those symptoms was intended to align with research, as individuals who engage in presenteeism often have impaired performance due to health issues (Cancelliere, et al, 2011). The result that stigma assumptions were most negative for the presenteeism scenario may be contradictory to the intentions of those who engage in presenteeism. It has been found that individuals engaging in presenteeism do so out of fear that they will be marginalised and mistreated if they come forward with mental health issues or take time out to deal with such issues (Attridge, Bennett, Frame, & Quick, 2009; Hanisch, et al, 2016; Szeto & Dobson, 2010).

Of note, the social benefit variable did not show a significant difference between mean responses in the EAP scenario and presenteeism scenario, but both scenarios were significantly higher than mean responses in the mental health day scenario. Means for all three scenarios were above 3.0, putting them within the neither agree nor disagree range but heading towards the somewhat agree response (4.0). These results suggest that participants perceive the social interaction of work to be of some benefit to the individual no matter what scenario the individual is in. Social interaction has been shown to benefit individuals with mental health issues in many areas, including: acceptance and belonging in society, gaining self-esteem, and reducing stress (Honey, 2004). Social interaction and maintaining employment are seen as a key part in mental well-being for New Zealanders (Paterson, et al, 2018). However, when looking at participants reasons for taking a mental health day, there are a large number of individuals who were stressed by work and/or needed a break from

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work. Some participants cited their colleagues/managers as the reasons they were stressed and needed a break. Therefore, it is possible that there is an association between taking mental health days and having work-related social issues. This may explain why participants rate the benefit of social interaction lower in the mental health day scenario.

Hypothesis 2 proposed that participants with past experience using either support method will have lower stigma towards the individual across all scenarios. Contrary to Hypothesis 2, it appears that participants' past experience did not play a role in their response to any of the seven items across the three scenarios. No interaction effects were observed between past experience with EAP services or taking a mental health day for any reason and the scores on any of the scenarios. Significant main effects were found between past experience using mental health days and the variables of performance ($\eta_p^2 = .069$), social interaction ($\eta_p^2 = .064$), and health and safety of others ($\eta_p^2 = .040$). These results show that individuals with past experience of taking mental health days agree less with the stigma assumptions regardless of the scenario, however responses for each scenario in both groups follow a similar gradient across the scenarios (lowest values in the EAP scenario and the highest in the presenteeism scenario). No differences were found between those with past experience of EAP and those who did not in any of the study variables. Past research (see: Corrigan, et al, 2014; Angermeyer & Matschinger, 1996; Trute & Loewen, 1978) has found an association between past personal experience with mental health issues and a reduction in mental health stigma. However, in one study for individuals to have lower stigma toward mental health services they had to report having had comfortable/positive personal experiences with previous mental health services (Corrigan, et al, 2014). Individuals who had past personal experience with mental health issues respond with fewer negative attitudes towards others with mental health issues. The present study also found no interaction between past personal experience and the mental health disorder the individual had

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(Angermeyer & Matschinger, 1996). Similar findings are found in the reported levels of trust towards persons with current mental health issues, engagement in areas of social activity and responsibility, as individuals with past personal experience with mental health issues show higher levels of trust towards people currently suffering from mental health issues, when compared to people without experience (Trute & Loewen, 1978). Past experience interacting with an individual suffering from mental health issues can reduce one's stigma in later events. However, the relationship was heavily influenced by multiple additional factors, such as age and gender (Hayward & Bright, 2009). Research on past experience with mental health issues predominantly focuses on those who work with mentally ill patients, or have previously had mental health issues/illness themselves. This limits the crossover between the past research findings and the findings within this study. In saying that, this study does have a unique strength as it focuses on a 'normal' population's interaction with mental health stigma. The take home findings from past research (Corrigan, et al, 2014; Hayward & Bright, 2009; Angermeyer & Matschinger, 1996; Trute & Loewen, 1978) appear to show that the more experience/exposure an individual has with mental health, the less likely they are to stigmatise mental health issues/illness. Similar results were found within this study when focusing on past experience of taking mental health days and the variables of performance, social interaction, and the health and safety of others. However, stigma was not measured in a general context within this study as it was tied to the three scenarios. This limits the usability of these findings, suggesting the need for future research into the broader context of past experience of workplace mental health/support methods and a working population.

It is possible that the unexpected findings in relation to Hypothesis 2 were influenced by the sample variations, in particular the number of participants with past experience and the nature of their past experience versus the nature of the scenarios. Those with past experience using EAP services made up 27.4 percent (31 participants) of those participants who

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responded to the item on past experience. This percentage is high compared to the upper end of utilisation values within American and UK organisations, which is approximately 5 percent (McRee, 2017). However, if this number is compared to the number of participants that completed the survey (167), the percentage of usage is 5.4 percent, equalling that of McRee (2017). Based on these figures it is possible that the sample has high representation of EAP utilisation compared to the average population which may have distorted results. Past experience of taking mental health days was more even within the sample, with 45.3 percent (78 participants) of participants having experience. However, the reason for taking a mental health day varied greatly. Only 18.2 percent (14 participants) reporting a mental health illness as their reason for using mental health days. Therefore, for the majority of participants their experience with mental health days could be seen as more of a wellness or “well-being” issue than strictly a mental health illness/issue. The vast majority of past research has focused purely on experience with mental illness (See: Corrigan, et al, 2014; Hayward & Bright, 2009; Angermeyer & Matschinger, 1996; Trute & Loewen, 1978) and not with the wider areas of wellbeing. With this in mind, it is possible that participants did not associate their past experience in the areas of mental health to that of the scenario as the wording of the scenario is “... the colleague is currently having issues with their mental health”. The mental health issue in the scenario may be deemed as completely different to the issues the participants had leading to their own mental health days. This disconnect between the scenario wording and participants' own experiences may have led to a lack of interaction with one's past experience.

Finally, results for participants responses to the reasoning behind their mental health days shows that the majority of people use mental health days as a direct response to workplace issues. Stress, burnout, and “needing a break” accounted for 64 percent of participants' reasons for taking a mental health day, often stating issues of workload,

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colleagues, managers, and the overall pressure of deadlines as the tipping point for taking time off. Of more concern is the non-disclosure behaviour of the participants, with 64 percent of participants using an alternative excuse for their absence. The majority of participants using general “sickness” as their reason for absence. Workplace stress is not defined within New Zealand law; however, employers are obligated to monitor potential workplace stress and act accordingly to reduce stress where possible (Employment New Zealand, 2019). This may play a role in the non-disclosure of mental health days as there are no laws around their usage, and therefore employers are not obligated to provide any form of leave associated with such issues. Stress leave is a possibility for an employee at the discretion of their employer and often comes under sick leave (Employment New Zealand, 2019). Employment New Zealand suggests that any stress leave is negotiated between employee and employer, a task that may be difficult for employees, especially if they are already stressed as a result of work and/or the people around them (2019).

Implication and Application for this Study

The findings in this research may help to shed light on the aspects of current mental health stigma within the New Zealand population. It is only within the last few years that mental health and well-being has become a more widely accepted and talked about issue. The current government has released the first ever “well-being” budget targeted at improving the well-being of New Zealanders (Government of New Zealand, 2019), yet education on mental health is not as widely seen. The change in approach to mental health is a major shift in thinking from that of times past. Given the current cultural shift that is beginning to occur within New Zealand, insight into the current nature and prevalence of stigma within the New Zealand workforce may offer a unique understanding as to mental health as it is currently understood and received in workforces. This may highlight gaps or issues that need addressing. If an individual within a workplace is currently dealing with a mental health issue

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and decides to disclose this to work colleagues and/or their manager, it should be encouraged, based on this study, to not only talk about the issue but also to disclose any methods of support or coping that the individual is using in response to their mental health issue.

Disclosure has been shown in this study to reduce stigma assumptions across major areas of work resulting in less stigma towards the individual. This may prompt additional help and support from those employees around the individual. Further to this, it appears that the use of more clinical or professional healthcare around mental health results in the lowest stigma response. The increased structure and professional practice may aid in easing some worries in colleagues or those who work closely with an individual with mental health issues, due to its nature and/or trust in healthcare. Potential stigma is a barrier for individuals accessing mental health services and support methods (Attridge, et al, 2010; Butterworth, 2001; McRee, 2017). However, the results of this study show it is possible that stigma is actually reduced when one is using such services, compared to the stigma associated with no service use. As such, this study suggests that perceived barriers to accessing mental health services may be reducing in size, possibly as awareness and an accepting culture of mental health increases within New Zealand.

However, stigma does still exist within this sample. Mean responses sit around 3.0 on the response scale (neither agree nor disagree), with standard deviations of 1.0, leading a portion of the sample response to lean more towards agreeing with the stigma assumptions. Due to these results it is hard to determine the exact nature of mental health stigma within this sample. Therefore, more awareness and education are needed within the working population, with workplaces being an ideal place to implement initiatives to reduce stigma and educate the working population on mental health issues and well-being.

As past experience with EAP services and taking mental health days has minimal impact on participants' responses to each scenario, its implication is more limited. Due to the

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inconclusive findings in this study more research is needed in this area. The primary focus of this study was on the three scenarios and as such limited the usability of the data to the area of past experience. A more direct study of the relationship between past experience with these services and mental health stigma could result in more conclusive findings. Previous research on past personal experience with mental health issues and/or illness shows overall more positive attitudes and reduced stigma towards those with mental health illness/issues (See: Corrigan, et al, 2014, Angermeyer & Matschinger, 1996, Trute & Loewen, 1978). Therefore, this is positive evidence to support continued research in this area.

Regarding mental health days, this sample has been shown to mainly use mental health days as a response to stress and/or becoming overwhelmed/burnout by the workplace itself. Participants reported that they recognised that they were not able to work to the best of their abilities given their current state, and this included feeling that aspects of work were getting on top of them. As a result, participants felt a need to remove themselves from the workplace in order to reduce risk and/or the burden they were feeling. This again aligns with a trend found in research on mental health days and the cost of presenteeism to a workplace. Stress can have as greater negative impact on an employee's performance as that of a clinical mental health disorder (McRee, 2017), and employers need to recognise this to be able to act accordingly.

The results of mental health day usage suggest the following for New Zealand workplaces. Workplaces should give greater availability and acceptance towards mental health days as not one participant reported taking a mental health day because they could not be bothered going to work or would rather be doing some leisure-based activity. The survey itself was anonymous, therefore participants had no reason to not disclose such behaviour if it was present. Abuse of mental health days is often the concern with their usage. This concern was the reason given by one organisation for not wishing to take part in this study, believing

that if their employees had mental health days promoted to them, they would begin to use them to abuse their annual and/or sick leave. The amount of leave available to an employee is limited, so employees do not always have an endless supply to burn through. Therefore, it appears that individuals take mental health days for legitimate reasons and acknowledge their impaired performance if they were to stay at work. There is no evidence within this study to support the idea that employees would abuse mental health days for any reason. The findings of this study also highlight an issue with disclosure of mental health days. Participants more often than not gave an alternative excuse for their absence. This further muddies the nature of mental health days as they are taken in relative secrecy. If employees disclose their mental health day behaviour to their employer and it is more accepted, then an opportunity is opened up to address the issues within the workplace that are getting on top of or causing stress to employees. Without this disclosure it may be difficult for employers to notice the signs of stress-related issues and appropriately deal with them.

Limitations

No study is without limitations, and a large limiting factor of this research is the sample used and its defining characteristics. The sample size was 253, however only 184 participants provided useable data for the main analysis. The survey itself would have been distributed to between 500 to 800 individuals within five separate organisations. While the response rate is acceptable and well within expected numbers, it was limiting for the power of and the generalisability of the findings. It is possible that the nature of the research lowered the overall response rate of the survey. As mental health is a difficult and stigmatised topic, it is possible that this made people more hesitant to take part in the survey. In addition to this, approximately 60 participants began the survey, filling out the initial demographics section, but upon reaching items on mental health did not respond further. This could potentially have been due to the sudden change of topic from demographic items to mental

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health items. Two organisations declined to take part in the study due to the survey addressing mental health. One organisation feared the potential damage the survey may cause to those suffering from mental health issues, suggesting that "...some items may ironically affect their anxiety, and cause them to wrongly question our motives in assisting with the study". The other company felt that the survey made some of the managers who screened the survey feel uncomfortable and did not wish for their employees to experience the same feelings of discomfort. However, given the nature of this research it is near impossible to avoid such issues. Repeated exposure may be one of the only ways to increase normalisation of mental health discussion and as such cannot be reduced or avoided.

The distribution method for the survey was ultimately at the discretion of the individual organisations, with the researchers suggesting a preferred method of mass internal emailing. Two of the five organisations distributed the survey link via their workplace Facebook groups. This led to far lower response rates than that of two similarly sized organisations who distributed it throughout work emails and/or internal noticeboards. Those who saw the survey information and link on Facebook would most likely have done so outside of their working hours and/or within their own homes, potentially leading to less interest or time to complete the survey. In future, survey distribution would be best conducted via workplace emails and/or internal notice boards as this appears to have been the far superior method to reach participants and gain the greatest response rates.

All five organisations used within this study are from the greater Christchurch area. This limits the applicability of the research to the wider country, as Christchurch has been the centre of unique and devastating events within the past decade (most notably the March 15th terror attack in 2019 and the 2010 and 2011 earthquakes). As such, Christchurch citizens may pose unique views towards mental health that are not equally resonated in other areas of New Zealand. The participating organisations were limiting to the wider use of the findings as they

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all used the same EAP service provider and were under a specific EAP service offered by this provider. In total 15 organisations were contacted by the EAP provider to take part in the current research, however only five organisations were willing to participate within the given timeframe. Three additional organisations stated interest in the study but could not participate within the required timeframe of this study. Some of the 15 organisations provided reasons for not wanting to take part in the survey. These reasons included: oversaturation of surveys at work, that they are providing EAP services to their employees as per requirements and did not wish to engage in further activity, or that the timing of the research did not fit with their organisation. Attempts were made to contact organisations external to the university-EAP provider collaboration and Christchurch. However, only two organisations had formal correspondence regarding the research, and both declined to be involved due to the nature of the research. The organisations stated concern for their own employees' mental health if they took part, or that the research would “promote the abuse of annual/sick leave for reason of mental health days” and it was “not in the company’s best interest to inform their employees of such issues/reasoning.” Responses such as these highlight a greater limitation with mental health and well-being-based research within organisations, namely that some employers simply do not want to address issues of mental health and well-being within their workplace, believing that mental health and well-being is an issue that they are not to be involved in. This creates a barrier to workplaces and truly limited the potential reach of research within this area in New Zealand. Future studies should involve more organisations being approached across a much larger time period in the hope of recruiting more participant organisations. The scope of organisations contacted would also need to be broadened to reach a far larger area and more diverse range of industry. Conducting similar research in the coming years could result in a greater response rate as the population becomes more familiar and accepting of mental health and well-being issues.

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Five of the six items on stigma assumption are negatively framed, with the item assessing social benefit of the support method being the single positively framed item. The framing of questions/items may create unintended bias in the responses of participants (Gideon, 2012; Goldin & Reck, 2019). This limits the scope of stigma assumptions as they were not presented in a more neutral way, with both positively and negatively framed items for all of the assumptions. The use of mainly negatively framed questions was a result of concerns with the length, repetition, and complexity of the survey. The use of near identical scenarios and repeated items was to address the response rate of the survey and clarity of responses. It was speculated that it may confuse participants or in some way discourage them from continuing due to boredom. This concern was resonated by one organisation as they questioned the repetition and did not enjoy this aspect. However, a future survey could remove the items that come after the scenarios regarding support methods and their usage, in favour of more items on the stigma assumptions that allow positively and negatively framed statements to be used.

Future Research

The current study has shed light on issues of mental health within a specific area of the New Zealand population, however there is far more which could be expanded upon. Due to the lack of consistency in the past experience analysis, further research in this area should be conducted to gain a better understanding of the role that past experience plays in support methods and associated stigma. For instance, changing the phrasing in scenarios away from “mental health issues” towards that of the greater area of wellbeing may help participants better link the scenario to their own past experience with support methods. The results found within this study show positive responses towards support methods in terms of workplace stigma assumptions, however in a limited context (disclosure to a single neutral colleague). The next step to this research should involve further investigation into potential changes in

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scenario context. This would include investigating whether responses change if the individual is suffering from a different issue and not a “mental health issue”. Such different issues would include wellbeing issues, specific mental health illnesses, workplace stress, or work-life balance. Such changes in context could provide a much broader view on the nature of mental health stigma within the New Zealand workforce involving more contemporary issues and language currently being used within government and media.

Concluding Remarks

Mental health stigma is a major barrier for those with mental health/well-being issues and can place even more pressure on those already struggling with such issues. However, the results of this study shed some positive light on such a heavy issue and show that there is a potential shift in the perception of mental health within the workplace. Workplace stigma assumptions appear to change based on the support method an individual is using to aid in coping with a mental health issue. These results show promise that within a working population ideas and beliefs around mental health are shifting towards a better and more accepting stance. Past experience with support methods is somewhat grey in its interpretation within this study, not matching with results found in similar areas of research. This suggests the need for further research into the role of past experience on workplace stigma and past experience with support methods. Further research into the mental health stigma within the New Zealand population is needed to understand the changing dynamics that may be at play due to the increased conversations of mental health and well-being within this country. In all, greater conversation and education is needed if we are to better the mental health and well-being of all New Zealanders. However, this research shows a changing perspective that is moving towards a positive acceptance of individuals’ mental health and well-being. This is a change that will benefit the lives of all New Zealanders.

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Appendix A: Survey

Perceptions of Workplace Mental Health Initiatives in the NZ Workforce

My name is Scott Hallaway and I am working on a thesis for my Master of Science in Applied Psychology at the University of Canterbury. I am conducting research into people's perceptions around mental health support initiatives within the workplace and the challenges one might face when using these methods, as well as people's willingness to use such support initiatives.

Your organisation has been approached to take part in this study as a part of a collaboration between Workplace Support and the University of Canterbury. Workplace Support has discussed participation in this study with a broad range of their member organisations, who in turn has invited their staff to participate, as they believe you may have important input to provide for this study.

If you choose to take part in this study, you will be asked to complete a survey, asking you about mental health support initiatives in your workplace. The survey is anonymous, which means that your responses cannot be linked to you in anyway, and neither your organisations nor Workplace Support will know who has participated. Participation is voluntary and you are able to withdraw from the survey at any point by closing the survey tab.

The survey takes between 10 and 20 minutes to complete. It will ask you to answer a range of questions based on different workplace scenarios. Upon completion of the survey you will have the option of entering into a prize draw to win one of ten \$50 Westfield Vouchers. This will require you to provide us with your contact details, but this will be done in a separate survey, which is **not** connected to the original survey or your responses in anyway. Your contact information is confidential to the researchers.

The survey deals with aspects of mental health that some may find distressing. If you feel upset or distressed at any point during or after the survey there are places you can contact for support, for example the ones listed below.

Workplace Support

0800 443 445 or 03 366 4586
office@workplacesupport.co.nz

Need to talk? Free call or text 1737 any time for support from a trained counsellor.

For more general resources:

New Zealand Mental Health Foundation

<https://www.mentalhealth.org.nz/>

Your General Practitioner's office can also help.

The results of this project may be published, but you can be assured of the complete confidentiality of data gathered in this investigation: your identity will not be made public.

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To ensure anonymity and confidentiality, your identifying information (your email) is collected separately from your survey responses and cannot be linked back to your answers. Data will be securely stored on the university servers in password protected files, and on password protected computers. Only the researcher and supervisors will have access to the raw data. After five years, all raw data will be destroyed. A thesis is a public document and will be available through the UC Library.

The project is being carried out as a requirement for the completion of a Master of Science in Applied Psychology by Scott Hallaway under the supervision of Katharina Naswall who can be contacted at *Katharina.naswall@canterbury.ac.nz*. Katharina will be happy to discuss any concerns you may have about participation in the project.

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*).

By clicking the continue button, I indicate my agreement to participate in the project under the conditions outlined above.

To begin, we have some general questions about you. These questions help inform us on the overall group of people who participated in the survey. Your responses are anonymous, meaning they will not be linked to any identifying information about yourself.

Gender

- Male
 - Female
 - Gender Diverse
-

Age

Ethnicity

- New Zealand European
 - Māori
 - Pacific Islander
 - Asian
 - Middle Eastern/Latin American/African
 - Other _____
-

Industry Sector

Are you in a supervisor/managerial position?

- Yes
 - No
-

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How long have you been with your current employer?

End of Block: Demographic

What is the first thing you think of when you hear the term "EAP"?

EAPs (Employee Assistance Programs) provide counselling and consulting services that focus on prevention and/or remediation of issues which employees face within the workplace. These services are often external to an organisation and freely available to all employees within said organisation and remain anonymous to the employer

Please click continue to be taken to the next stage

The following section involves reading through a scenario and then answering a group of questions regarding the scenario.

There are three scenarios that are all similar in nature with the same group of questions each time. Please answer all questions for each scenario, make sure that your answers are specific to each scenario.

Please click continue to begin

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Please read the scenario below and rate to what extent you agree or disagree with the following statements based on this scenario only.

While at work you are told by a colleague that they are currently using the company's employee assistance programme (EAP), the EAP provides anonymous counselling to any employee that seeks it. You are told that this is due to the colleague currently having issues with their mental health.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
This method of coping with the mental health issue will be helpful to the colleague in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question lacks the required capability to meet performance requirements of the job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question lacks the required ability to meet the social interactions at work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The social interaction of work may benefit the colleague in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question presents a risk to their own health and safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question presents a risk to other employee's health and safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question may be unpredictable in the workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Please read the scenario below and rate to what extent you agree or disagree with the following statements based on this scenario only.

While at work you are told by a colleague that they are currently taking mental health days as a part of their own annual/sick leave, on days where they do not feel they are able to work due to reasons other than physical illness. You are told that this is due to the colleague currently having issues with their mental health.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
This method of coping with the mental health issue will be helpful to the colleague in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question lacks the required capability to meet performance requirements of the job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question lacks the required ability to meet the social interactions at work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The social interaction of work may benefit the colleague in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question presents a risk to their own health and safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question presents a risk to other employee's health and safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question may be unpredictable in the workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Please read the scenario below and rate to what extent you agree or disagree with the following statements based on this scenario only.

While at work you are told by a colleague that they are currently feeling stressed and are not performing to their normal standards. However, they still turn up to work each day. You are also told that the colleague is currently having issues with their mental health.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
This method of coping with the mental health issue will be helpful to the colleague in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question lacks the required capability to meet performance requirements of the job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question lacks the required ability to meet the social interactions at work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The social interaction of work may benefit the colleague in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question presents a risk to their own health and safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question presents a risk to other employee's health and safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The colleague in question may be unpredictable in the workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Please rate the following statements based on the extent to which you agree or disagree with them.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Mental health issues are an acceptable reason to take sick leave.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Individuals with a mental health issue are capable of continuing working.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The routine of work is helpful to an individual's mental health issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing employment to an individual with a mental health issues is something employers feel they must do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In this section we will ask you about any past experiences you may have had with mental health initiatives.

Does your organisation provide any EAP services to its employees?

- Yes
- No
- Do not know

Would you use EAP services for mental health issues if it was offered through your organisation?

- Yes
- No

How many times have you used EAP services in the past five years?

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Should organisations provide mental health days as another form of leave?

- Yes
- No
- Do not know

Does your organisation provide mental health days to its employees?

- Yes
- No
- Do not know

Have you ever taken a mental health day for any reason?

- Yes
- No

Display This Question:

If Have you ever taken a mental health day for any reason? = Yes

What was your reason for taking your mental health day?

Display This Question:

If Have you ever taken a mental health day for any reason? = Yes

What did you tell the people you work with the most was the reason for your absence?

Appendix B: Survey Information Email

Dear XXX,

As mentioned in Katharina's email last week about the research collaboration between Workplace Support and the University of Canterbury, here is the email we ask that you forward to staff. It includes some brief information and the link to the survey. I would appreciate if you could let me know when the survey has been distributed to your staff.

Many thanks,
Scott Hallaway

Hi,

My name is Scott Hallaway and I am working on a thesis for my Master of Science in Applied Psychology at the University of Canterbury. I am conducting research into people's perceptions around mental health support initiatives within the workplace.

Your organisation has been approached to take part in this study as a part of a collaboration between Workplace Support and the University of Canterbury.

If you wish to participate, you will find a link to the survey below. The survey itself takes around 10 – 20 minutes to complete and will ask you a variety of questions regarding mental health support initiatives in your workplace. The survey is anonymous and voluntary. Your responses cannot be linked to you in any way and you are able to withdraw from the survey at any point by closing the survey tab. At the end of the survey you have the option to enter in a prize draw for one of ten \$50 Westfield vouchers as a thank you for your time.

Here is the link to more information before taking you to the survey: XXX

We hope to have you on board,

Scott Hallaway

Master of Science in Applied Psychology
School of Psychology, Speech and Hearing
Telephone: [REDACTED]
Scott Hallaway
Email: scott.hallaway@pg.canterbury.ac.nz

Appendix C: Item Correlations

Table A. *Pearson Correlations for all variables present within the repeated measures AVONVA analysis*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	
1. Helpfulness (EAP)	-																							
2. Performance (EAP)	.01	-																						
3. Social Interaction (EAP)	.01	.62**	-																					
4. Social Benefit (EAP)	.24**	.08	.02	-																				
5. H&S-Self (EAP)	-.09	.55**	.48**	.08	-																			
6. H&S-Others (EAP)	-.07	.65**	.57**	.08	.61**	-																		
7. Unpredictability (EAP)	.01	.50**	.47**	.05	.66**	.56**	-																	
8. Helpfulness (Mental Health Day)	.15*	-.03	-.05	.03	-.11	-.02	-.09	-																
9. Performance (Mental Health Day)	.02	.58**	.37**	.14	.36**	.44**	.30**	-.09	-															
10. Social Interaction (Mental Health Day)	.02	.50**	.51**	-.03	.32**	.43**	.32**	-.03	.57**	-														
11. Social Benefit (Mental Health Day)	.26**	.16*	.01	.60**	.09	.12	.07	.09	.17*	.00	-													
12. H&S-Self (Mental Health Day)	.12	.44**	.44**	.02	.52**	.42**	.36**	-.12	.48**	.41**	.11	-												
13. H&S-Others (Mental Health Day)	-.02	.46**	.39**	.02	.39**	.61**	.37**	-.16*	.51**	.53**	.14	.55**	-											

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

Workplace Support Method Stigma

Table A. (Continued)

14. Unpredictability (Mental Health Day)	.11	.48**	.29**	.13	.39**	.46**	.52**	-.03	.60**	.57**	.22**	.45**	.57**	-									
15. Helpfulness (Presenteeism)	.06	.35**	.25**	.23**	.19**	.33**	.19**	.14	.29**	.20**	.18*	.16*	.27**	.29**	-								
16. Performance (Presenteeism)	.13	.41**	.22**	-.07	.29**	.18*	.24**	-.02	.34**	.26**	-.08	.23**	.11	.22**	-.02	-							
17. Social Interaction (Presenteeism)	.07	.47**	.48**	-.08	.34**	.33**	.29**	-.03	.35**	.47**	-.02	.29**	.33**	.25**	.12	.50**	-						
18. Social Benefit (Presenteeism)	.28**	-.02	.04	.54**	.02	.03	.04	.06	.06	.01	.43**	.11	.09	.12	.30**	-.21**	-.07	-					
19. H&S-Self (Presenteeism)	.08	.17*	.18*	-.02	.30**	.30**	.27**	-.03	.20**	.21**	-.06	.32**	.23**	.19*	-.14	.33**	.26**	-.04	-				
20. H&S-Others (Presenteeism)	.06	.27**	.24**	-.06	.32**	.44**	.27**	.02	.25**	.31**	.06	.32**	.47**	.31**	-.06	.33**	.37**	-.02	.56**	-			
21. Unpredictability (Presenteeism)	.04	.36**	.37**	.00	.36**	.42**	.49**	-.02	.34**	.41**	.04	.37**	.38**	.42**	-.04	.31**	.40**	-.07	.48**	.51**	-		
22. EAP Past Usage	.10	-.02	-.02	-.12	-.04	.04	.03	-.13	.06	.07	-.13	-.01	.07	.05	.05	-.07	.05	-.04	-.12	-.04	-.10	-	
23. Mental Health Day Past Usage	.02	.25**	.30**	.06	.13	.24**	.16*	-.20**	.27**	.23**	-.02	.19*	.18*	.11	.09	.10	.17*	-.08	.06	.04	.07	-.17	-

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).