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Employee Mental Illness: Managing the Hidden Epidemic

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Abstract

While the high prevalence of mental illness in workplaces is more readily documented in the literature than it was ten or so years ago, it continues to remain largely within the medical and health sciences fields. This may account for the lack of information about mental illness in workplaces (Dewa et al. Healthcare Papers 5:12–25, 2004) by operational managers and human resource departments even though such illnesses effect on average 17 % to 20 % of employees in any 12-month period (MHCC 2012; SAMHSA 2010; ABS 2007). As symptoms of mental illness have the capacity to impact negatively on employee work performance and/or attendance, the ramifications on employee performance management systems can be significant, particularly when employees choose to deliberately conceal their illness, such that any work concerns appear to derive from issues other than illness (Dewa et al. Healthcare Papers 5:12–25, 2004; De Lorenzo 2003). When employee non-disclosure of a mental illness impacts negatively in the workplace, it presents a very challenging issue in relation to performance management for both operational managers and human resource staff. Without documented medical evidence to show that impaired work performance and/or attendance is attributable to a mental illness, the issue of performance

management arises. Currently, when there is no documented medical illness, performance management policies are often brought into place to improve employee performance and/or attendance by establishing achievable employee targets. Yet, given that in any twelve-month period at least a fifth of the workforce sustains a mental illness (MHCC 2012; SAMHSA 2010; ABS 2007), and that non-disclosure is significant (Barney et al. BMC Public Health 9:1–11, 2009; Munir et al. Social Science & Medicine 60:1397–1407, 2005) such targets may be unachievable for employees with a hidden mental illness. It is for these reasons that this paper reviews the incidence of mental illness in western economies, its costs, and the reasons why it is often concealed and proposes the adoption of what are termed 'Buffer Stage' policies as an added tool that organisations may wish to utilise in the management of hidden medical illnesses such as mental illness.

Keywords

Mental illness – Policy – Stigma – Human resources

Introduction

The apparent lack of knowledge and policies to deal with hidden mental illness in workplaces is both staggering and disturbing as organisations become increasingly focussed on being innovative and forward planning in order to remain competitive in the global economy. Given that mental illnesses affect on average 17 % to 20 % of employees in any 12-month period (MHCC 2012; SAMHSA 2010; ABS 2007) depending on which measure is used, and that most affected employees conceal mental illnesses (Rüsch et al. 2010; Barney et al. 2009), both managers and human resource staff are often unaware of the prevalence of mental illnesses in their workplace (Dewa et al. 2004), and that large numbers of affected employees keep such conditions hidden (Corrigan et al. 2010; De Lorenzo 2003). In addition to this, there are currently no strategies in the literature to deal with cases of hidden employee mental illness that may be impacting negatively on performance and/or attendance (Dewa et al. 2004; De Lorenzo 2003). As a consequence, employees with a hidden mental illness and concurrent workplace issues such as impaired performance and/or attendance will be at a significant disadvantage to able-bodied staff if they are placed on a performance improvement plan that has the capacity to result in termination. Rather than reviewing the issue of moving towards better acceptance of mental illness so that more employees choose to divulge they have such illnesses, this paper takes the position that until societal views change, it is more important to focus on the issues at hand, and the fact that most employees with a mental illness will choose to remain silent. Hence, this paper will commence by reviewing the high prevalence of mental illness in workplaces and its

effects on fitness for work, the reasons why employees choose to conceal mental illness, and how, in the absence of widespread employee disclosure of mental illness, human resource staff and operational managers can, nonetheless, seek to manage hidden mental illnesses by adding to their performance management policies a proposed series of policies termed "Buffer Stage" policies.

The issue of managing hidden mental illness is grounded in the premise that a problem does not need to be visible for it to be tackled, but rather its outcomes need to be felt and considered unacceptable in order to take action. In the case of mental illness, its high prevalence shows that in workplaces it can range on average from 17 % (SAMHSA 2010) to 20 % (Dewa et al. 2004; ABS 2007) in any 12-month period, depending on which data set one uses and which country one examines. In terms of self-disclosure in the workplace, public and self-imposed stigma and concern about career damage serve to effectively reduce its disclosure (Rüsch et al. 2010; Barney et al. 2009; Quinn et al. 2004; Link et al. 2004; Hickie et al. 2004; De Lorenzo 2003; Glozier 1998). As will be reviewed in this paper, mental illness can significantly impact on job performance and employee attendance (Kessler et al. 2009; Dewa et al.2004). However, while the issue of widespread employee concealment is known (Rüsch et al. 2010; Barney et al.2009), the question of how to manage hidden mental illness receives little if any attention (Baldwin 2004). Some researchers seek to address the issue by suggesting that employers could embark on mental health screening (Sorensen et al. 2012). However, screening involves the use of a questionnaire so employees who are concerned about disclosure have the potential to fabricate their answers.

The acceptance of hidden illness per se is perhaps something that a manager and human resource (HR) staff can suggest is not in their province if it is not raised by an employee. However, studies show that concealment of mental illness is more common than its disclosure, as is the case for a number of other chronic illnesses (Munir et al. 2005). Meanwhile, the World Health Organisation (WHO 2005) points out that the costs of mental illness are too high to be ignored as it has multiple cost loadings within each affected organisation and the wider community.

In terms of policy options to assist organisations in developing appropriate strategies for the accommodation and care of employees with mental illness, WHO (2005) and similar country specific organisations

have developed a range of policies even where countries have not legislated in this area (NIMH 2012; AHREOC 2010a: MHCA 2010; WHO 2005; WHO 2004). The same is true of policies to reduce stigma and to curtail causal factors within workplaces that may create or exacerbate mental illness (WHO 2005). But there is nothing in place that seeks to manage hidden mental illness despite the fact that research shows that employees with a mental illness are more likely to adopt deliberate concealment of such conditions (Corrigan et al. 2010; Munir et al. 2005; Hickie et al. 2004; Druss et al. 2001), resulting in hidden cost burdens when absenteeism and reduced performance arise from concealed mental illnesses rather than other factors such as poor work ethic (De Lorenzo 2003).

It is therefore imperative that organisations recognise the high prevalence of mental illness in their workplace, its costs, why most employees choose to conceal such illnesses, and the concurrent importance of adopting policies to deal with hidden mental illness. Currently, when an employee's performance or attendance falls as a consequence of hidden mental illness, operational managers and HR staff members often have no option but to carry out employee control measures such as a performance improvement plan (Selden and Sowa 2011; Balser and Stern 1999a, b). This is standard management and HR practice which is taught and reinforced in university and college teaching materials and textbooks. It is also standard practice when HR staff members have no formal means of knowing if mental illness is the cause of an employee's poor performance and/or attendance. Yet, as will be shown, mental illness is often associated with impaired decision-making (Harvard 2010; WHO 2003b) and high levels of self-imposed stigma (Lagerveld et al. 2010; Plaisier et al. 2010; Haslam et al. 2005; WHO 2005; WHO 2004), hence it is also true to state that such employees are making career-changing decisions while they are undergoing significant deficits in their cognitive function. Consequently, this paper proposes that in addition to existing HR policies that deal with performance management, that consideration be given to adopting what have been termed "Buffer Stage" policies that have been devised by this author for use prior to the adoption of formal performance improvement plans. The purpose of Buffer Stage policies is to provide an added instrument to the performance management toolkit in recognition of concealed mental illness that may impact on employee performance and/or attendance. These policies will be reviewed after the reasons for their adoption have been discussed.

The Prevalence of Mental Illness

According to WHO (2003a), mental illnesses in the workplace are a major contributing factor to both absenteeism and reduced employee productivity. Kessler et al. (2009) note that studies of mental illness for individual countries conducted by WHO World Mental Health (WMH) surveys, and a host of comparative studies and literature reviews, consistently show that mental illness is common globally, with anxiety disorders having the highest incidence, followed by mood disorders (a collective term for anxiety and affective disorders such as depression and bi-polar disorder). In particular, findings from the WMH surveys agree with other notable studies in this field (Kessler et al. 2009; Hilton et al. 2008) showing that lifetime prevalence for any anxiety illness is approximately 16 % on average, while in relation to a 12-month prevalence, the figures are approximately 11 % on average; with mood disorders such as depression having been found to average approximately 12 % (Kessler et al. 2009). The Australian Bureau of Statistics (ABS 2007), in its comprehensive national survey of mental illness, found that lifetime prevalence of common mental health conditions (CMHC), namely anxiety disorders, affective disorders (e.g. depression) and substance use disorders (e.g. substance use disorders and harmful alcohol use and dependence), is on average 45.5 %. In short, mental illness is not the province of small cohorts of people, but instead afflicts close to one in two people directly at some stage in their life, and depending on which data set one reviews, on average a fifth of employees in any twelve-month period (SAMHSA 2010; ABS 2007; MHCC 2012; WHO 2005; Dewa et al. 2004).

In its five-country examination of mental health more than 10 years ago, the International Labour Organisation (ILO 2000) found that mental illness, and depression in particular, resulted in higher levels of absenteeism and other associated costs than other illnesses. In terms of actual absenteeism from depression alone, the report found that in the US some 200 million working days were lost each year (ILO 2000). In a further study, it was estimated that absenteeism has risen sharply as a consequence of soaring levels of mental illness that have been due in part to globalisation and innovations to communication (ILO and WHO 2000). Recent research suggests that the US may have the highest number of persons with a mental illness (Weiss 2005). In a 2008 report about costs of mental illness to industry, the Organisation for Economic Cooperation and Development (OECD 2008, p.4) reported that "Mental health problems are the second largest category of occupational ill-health after musculoskeletal problems, and work-related mental health problems are a leading cause of sickness leave and disability in OECD countries".

The 2008 OECD report, which was based on comparable mental illness data in Europe, also found that 25 % of all disability claims were due to mental illness (OECD 2008). In relation to depression alone, the report estimated that some 21 million persons in 28 European countries experienced this illness, resulting in associated costs of 118 billion Euros annually (OECD 2008). Similarly, Wittchen and Jacobi (2005) found that 27.4 % of persons in the European Union (EU) aged 18 years to 65 years had experienced at least one mental illness in the previous 12 months.

In a French study concerning an on-going longitudinal survey of a cohort of workers from a national electricity and gas company (Niedhammer et al. 1998) the researchers found that in 1995 significant numbers of the 12,555 subjects employed, resorted to taking longer and more frequent periods of sick leave when decision latitude in their work was low. Surprisingly, the same study also found that lack of social support caused male employees to take more sick leave days off from work. Despite the findings of such studies, Hilton et al. (2008) found that almost one in five senior managers surveyed in relation to the effect of mental illness on employee performance believed that it had no causal bearing at all. This would appear to reflect the fact that most managers are unaccustomed to receiving semi-regular employee disclosures of mental illness rather than ignorance. Moreover, while issues such as stress and burnout are increasingly reviewed in management and HR education courses and textbooks, mental illness is often not even mentioned (De Lorenzo 2003).

In a pertinent survey of the prevalence of mental illness in both the community and workplace spheres, the ABS (2007) found that CMHC had similar rates of incidence, namely 20.3 % in the community and 20 % in workplaces. Data in Table 1 shows there is little variation in the prevalence of mental illness between full and part-time employees, with anxiety disorders having the highest incidence.

Table 1

Persons aged 16–85 years with a common mental health disorder (Common mental health disorders consisted of the following: anxiety disorders: panic disorder, agoraphobia, social phobia, generalised anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder; affective disorders: depressive episode, dysthymia, bipolar affective

disorder; substance use disorders: harmful alcohol use, alcohol dependence, drug use disorders.) in a 12-month period by labour force status, Australia, ABS 2007 (%)

Labour market status	Anxiety disorders	Affective disorders	Substance use disorders	All mental health disorders[a]
Employed	14.2	5.7	6.0	20.3
Full-time	13.4	5.5	6.0	19.3
Part-time	15.7	6.1	5.8	22.1
Unemployed	17.5	15.9	11.1	29.4
Not in the labour force	14.5	6.5	2.9	18.6

ABS (*2007*), National Survey of Mental Health and Wellbeing, by Persons and Proportions, Cat. No. 4326.0. [a]The total (All Mental Health Disorders) refers to persons with any mental health disorder, not the sum of each category. As large numbers of persons have more than one mental health disorder (co-morbidity) this is reflected in the data for each individual CMHC, but not in the total for All Mental Health Disorders, where individuals with one or more disorders are counted once

The hidden nature of mental illness means that when issues such as absenteeism and reduced employee productivity arise among employees with a mental illness, disclosure is difficult in the face of inadequate management knowledge (Munir et al. 2005; Hickie et al. 2004; Druss et al. 2001). However, when employees with a mental illness are not forthcoming about the true reasons for poor performance and/or attendance, managers invariably look to familiar explanations such as poor work ethic to account for such employee outcomes. In the case of absenteeism, causal explanations such as job satisfaction and group norm theories have been the predominant schools of thought to explain absenteeism, despite the fact that when tested,they often fail to be proven outside particular workplaces (De Lorenzo 2003; Harrison and Martocchio 1998; Smith et al. 1995; Vroom 1986). Nonetheless, the 2007 ABS survey of mental health and wellbeing (ABS 2007) attributes days absent from one's normal role as a consequence of mental illness. Meanwhile specific research studies and literature reviews in this area show that without the inclusion of mental illness, causal models of explanation for absenteeism are seriously impaired (Dewa et al. 2004;

Goetzel et al. 2004; De Lorenzo 2003; Kessler et al. 2001; French and Zarkin 1998).

Fitness for Work: The High Costs of Presenteeism and Absenteeism

In considering the effect of mental Illness on the question of employee fitness for work, the issue of cognitive and other disease specific deficits on employee performance and/or attendance arises. That is, to what extent do CMHCs negatively affect employee outcomes in the workplace? As will be demonstrated by reviewing several conditions, mental illness can have multiple effects on employee health including cognitive impairment (Harvard 2010; Seymour 2010; Druss et al. 2001). When translating this to particular workplace issues, employees may find their performance and/or attendance affected (Dewa et al. 2004; Goetzel et al. 2004). Mental illness can also have an effect on presenteeism; that is employee performance that often mimics absenteeism as employees attend work but their output is substantially diminished by inability to undertake their normal duties due to illness or some other factor that is typically concealed (Ashman and Gibson 2010). In addition to issues surrounding fitness for work are considerations in relation to safety in the workplace (AHREOC 2010b). That is, to what extent may mental illness affect an employee's ability to attend to their work in a manner that allows them to take due care in relation to safety? These questions are made all the more noteworthy when such illnesses are purposefully hidden as operational managers have nothing to inform them when seeking to determine why employee work outcomes start to decline.

In reviewing the issues of fitness for work and safety in the workplace, it is pertinent to note that estimates of the duration of mental illness vary greatly, although in the case of anxiety disorders, the data suggests that most persons will have at least a six-month period of duration before the condition resolves itself (NIMH 2012). The effect on work performance and/or attendance for employees with these conditions can be significant, particularly when their symptoms are difficult to manage and spill out into the workplace with behaviours that may normally be attributed to persons of poor work ethic rather than illness (Harvard 2010; NIMH 2012; De Lorenzo 2003).

In their review of self-reported answers to the "Wellness Checkpoint", a health risk assessment questionnaire of nearly 200,000 employees in Canada, Europe, Latin America and the United States, Allen et al. (2010) found that 175 persons reported taking sick leave to manage symptoms of depression. Meanwhile, nearly 23 % of respondents reported experiencing mild to severe depression, while 41 % reported high levels of presenteeism. In other words, while poor attendance was significant in this study, the effects of depression on employee output via presenteeism appears to show a more substantial impact in the workplace, particularly in relation to employee performance. As a consequence, good employee attendance needs to be measured against possible presenteeism, as attendance alone does not guarantee effective employee performance or engagement. Hence, as a stand-alone measure, absenteeism can be misleading (Seymour 2010).

In relation to employees who sustain moderate to severe depression, a 2010 study shows that such persons miss work more often than non-depressed employees each month (Birnbaum et al. 2010). Seymour (2010) notes that in Britain at least 40 % of sick days are attributable to employees requiring sick leave to cope with a CMHC and that depression and anxiety take their toll with rising levels of presenteeism. Moreover, Seymour (2010) also notes that in considering self-reported work-related illness data, a fifth of employees with a CMHC note that workplace practices have either contributed or caused their mental illness.

As Druss et al. (2001) note, absenteeism in respect of depressed employees appears to be the outward sign of an even more costly loss from underperformance. According to these researchers, the stigma of mental illness is likely to be the reason why underperformance is higher than absenteeism, as underperformance is:

> *… expected to be particularly likely when an employee is reluctant to report an illness or believes the illness would not be regarded as a legitimate reason for missing work. The perceived stigma associated with depressive disorders may thus result in a high proportion of hidden costs to employers that are not readily evident from health or disability claims data. … For employers … much of the value in treating depression may lie in the potential to improve work outcomes* (Druss et al. 2001, p. 733).

The Druss et al. (2001) study, which was carried out over 2 years and surveyed 6,239 employees across three organisations, found significant levels of absenteeism and reduced performance, particularly in respect of employees who had depression. Moreover, for every lost day of work the study found that on average depressed workers had significantly lower levels of performance when they were able to attend work (Druss et al. 2001), further demonstrating that absenteeism data can be misleading in the face of presenteeism as a means of dealing with mental illness.

A recent Harvard (2010) study of 34,622 employees across ten organisations found that depression was the most costly illness in terms of paid pharmaceutical and medical costs from a group of twenty-five conditions, while anxiety was the fifth most costly condition. However, along with findings from equivalent studies, it was estimated that indirect costs such as reduced attendance and presenteeism were far more costly (Harvard 2010).

Even on a modest scale, the effects of disclosed and estimated mental illness on workplace costs in relation to reduced attendance and compromised performance via presenteeism is not in dispute, but rather a question of how individual cases manifest in the workplace (Dewa et al. 2004; Begg et al. 2007; De Lorenzo 2003 and 1999). In terms of productivity, research shows that as an aggregate measure, the effect of mental illness in workplaces confers a heavy cost burden (Kessler et al. 2009).

It is pertinent to note that medical evidence shows that persons with a CMCH can incur significant deficits in attempting to undertake their normal work duties (Harvard 2010) which contributes to presenteeism. According to a 2010 Harvard medical paper, it was noted that behaviours of employees with mood disorders (i.e. anxiety and affective disorders) often exhibit the following patterns in the workplace:

> *nervousness, restlessness, or irritability—and in physical complaints, such as a preoccupation with aches and pains. In addition, employees may become passive, withdrawn, aimless, and unproductive. They also may be fatigued at work, partly as a result of the mood disorder or because they are having trouble sleeping at*

night. Depression may also impair judgment or cloud decision making (Harvard 2010, p. 2).

In addition to nervousness, fatigue and greatly reduced concentration levels, employees with a mood disorder may also "require constant reassurance about performance. Sometimes, as with depression, physical symptoms or irritability may be noticeable" (Harvard 2010, p. 3). Given this, when an employee's anxiety disorder is highly symptomatic, in its early stages, or difficult to manage, work performance for such persons will almost certainly be compromised (Allen et al. 2010; Birnbaum et al. 2010; Seymour 2010). When this impacts on safety in the workplace, the possible outcomes can be even more serious. In relation to bipolar disorder (an affective disorder), WHO utilised an employee questionnaire to establish fitness for work, finding that 28 days were lost on average to sick leave and 35 days to lost productivity each year for each affected employee (Harvard 2010).

In their examination of the extent to which depression impacts on attendance, performance and presenteeism, Adler et al. (2006) found that deficits in all three areas tend to vacillate depending on the severity of symptoms. However, in comparison to other illnesses, mental illness can impose greater costs. For instance, in reviewing the productivity of 93 employees with rheumatoid arthritis, 286 employees with diagnosed depression and a control group of 193 employees without a mental or other illness, Adler et al. (2006) found that employees with depression had the highest level of reduced productivity for tasks involving cognitive skills. However, in respect of physical work, the cohort with rheumatoid arthritis had the highest level of reduced productivity, with the depressed employees having the second highest deficit in productivity (Adler et al. 2006). Meanwhile, in a review of the prevalence and effects of depression in the United States, Kessler et al. (2003), p. 3095) found that "Major depressive disorder is a common disorder, widely distributed in the population, and usually associated with substantial symptom severity and role impairment".

Specific studies reveal that severe depression in heavy goods vehicle drivers is responsible for collisions or near misses in a twenty-eight-day testing period in a study undertaken by Hilton et al. (2009). The same study also found that alcohol used to manage symptoms of depression reached levels of alcohol blood content as high as 0.08 % which is higher than most levels of legally permissible driver levels (Hilton et al. 2009). In

relation to absenteeism, Hilton et al. (2010) found that blue collar workers were more likely than white collar workers to respond to "psychological distress" by taking sick leave, at a staggering rate of 18 %. However, both groups in this study suffered diminished work output or presenteeism in dealing with the symptoms of mental illness.

In one US organisation, the associated health care costs and days of lost productivity for depressed employees, was far in excess of other leading health conditions (Druss et al. 2000). As Druss et al. (2000) found, the health bill for this large organisation of 15,153 employees, was higher for depression, than for the other top three leading ailments. As with many other US companies, health coverage is often factored into add-on costs, and 1995 records for health care treatment of employees with depression was on average $5,415 per annum, far higher than the costs for hypertension and other high cost ailments (Druss et al. 2000). Days lost due to illness were similarly far higher for depression, with a mean 9.86 days per annum, taken for sick leave (Druss et al. 2000). This excludes other costs, such as underperformance, and reduction in quality of work for those with severe depression.

In terms of actual impact on employee work function, both anxiety and depression are closely correlated with reduced performance, presenteeism and reduced work attendance (Hilton et al. 2010; Haslam et al. 2005). Research indicates that while both anxiety and depression impact negatively on work performance, depression appears to have a heavier impact and is more likely to result in higher levels of reduced work performance (Plaisier et al. 2010). This is not surprising as depression can severely compromise cognitive functioning resulting in normal work tasks becoming more difficult and laboured (Lagerveld et al. 2010; Adler et al. 2006).

Common symptoms of most anxiety disorders include; poor sleep, fatigue, short-term memory problems, persistent fear/agitation in relation to a specific or general matter/person, inability to function normally, and for some, panic attacks (Matlin 1995). Some studies have found that stress and anxiety have tended to become interchangeable, due to the popular use of stress as a catch all for fears, anxieties, and poor coping skills (Seppala 2001; De Lorenzo 1999). In terms of the costs of anxiety, Greenberg et al. (1999) utilised data from the US National Comorbidity Study to estimate that the annual cost of anxiety disorders in that country was US$42.3 billion in 1990.

As with stress, insufficient job control and decision latitude are associated with higher incidence of anxiety in the workplace, and other forms of mental distress (Griffin et al. 2002). With the trend towards flatter organisational structures, the heightened level of responsibility imposed on most employees as middle management roles disappear may leave some employees feeling overwhelmed (Schaubroeck et al. 2001). For employees who lack self-reliance, flatter organisational structures not only have the capacity to cause psychological distress, they can also result in a range of physical illnesses (Schaubroeck et al. 2001). For instance, it has been found that the greater an employee's responsibility and workload is, the more likely it is for that employee's immune system to be compromised which in turn has the capacity to make them more susceptible to upper respiratory illnesses such as colds and influenza (Shaubroeck et al. 2001).

Alongside other forms of mental illness, anxiety disorders respond well to social support in the workplace, as this acts as a buffering, or protective element for sufferers (Weinberg and Creed 2000; Singh et al. 1991). Singh et al. (1991) found that not only does social support positively improve well-being; it also serves to ease the symptoms of those with anxiety and other mental conditions bringing greater relief to the sufferer, particularly when it includes the support from the employee's supervisor.

While the deficits experienced by large numbers of persons with a mental illness are recognised and articulated in psychiatric and related health literature, the same cannot be said within the management literature where disparate studies are fewer in number (De Lorenzo 2003). Bilsker (2006, pp. 61–62) elaborates on this by stating; "The time is right to make substantial changes in the way that the health care and occupational domains collaborate to manage workplace depression . . . We need to establish a bridge between mental health care and the workplace. . . . most individuals being treated for common mental disorders continue to attend work, although often with a lower level of effectiveness."

Non-Disclosure of Mental Illness

According to Rüsch et al. (2010, p. 60), "People with a mental illness are among the most stigmatised groups in western societies" with

stigmatising behaviours being knowingly or unknowingly legitimised through structural and work processes. Similarly, persons who view themselves as stigmatised are more likely to accept discrimination which adds to further condone such actions and at the same time to make self-disclosure a less attractive option (Rüsch et al. 2010). Moreover, persons who have a mental illness are more likely to view themselves as stigmatised and shameful than persons who do not have a mental illness (Corrigan et al. 2010).

In a pertinent study by Munir et al. (2005) which examined the extent to which employees managed chronic illnesses, and whether they disclosed such illnesses in their workplace, questionnaires were sent to all 5,000 employees of a university in the United Kingdom. Employees were asked to report if they had a chronic illness, specifically; depression and anxiety, arthritis, diabetes, musculoskeletal pain, migraine, heart disease, irritable bowel disease and any other non-listed chronic illness, and to specify measures taken in relation to self-management of their illness and whether they disclosed their illness in the workplace. The study had a response rate of 44 % or 2,200 completed questionnaires, of which 34 % of respondents, or 748 employees, reported having at least one chronic health condition.

In nearly 90 % of cases, employees with a reported chronic illness had received a formal medical diagnosis (Munir et al. 2005). From the group of 748 employees who reported having a chronic illness, 49.8 % chose not to disclose their illness and 26 % chose to only partially disclose their condition to a line manager in the workplace if it was necessary for treatment and accommodation purposes. That is, just over three quarters of employees with a chronic illness made the choice to either not disclose their illness, or to only partly disclose features of their illness where necessary. Only 24.2 % of employees with a chronic illness chose to fully disclose their illness to their line manager and to detail how their illness affected them in carrying out their duties. The three highest chronic illnesses reported by employees in this study were depression and anxiety 16.9 %, asthma 13.1 % and musculoskeletal pain 12.9 % with diabetes at 5 % having the lowest number of employees listing this as a formal chronic illness (Munir et al. 2005).

It may appear foolhardy to conceal an illness that is both legitimate and has the potential to significantly impair employee outcomes, but studies confirm this practice (Hickie et al. 2004; Glozier 1998). In addition to

issues of personal privacy that may influence the decision to disclose, mental health illnesses suffer from the added burden of significant stigma (Rüsch et al. 2010). According to Corrigan et al. (2010, p. 907), "Public stigma robs people with mental illnesses from rightful opportunities related to work and other important life goals".

Stigma among persons with a mental health illness has been found to have a number of peculiar features. Stigma in relation to sustaining a mental illness is prevalent among the psychiatric community and a host of other health professions (White et al. 2006; Hickie et al. 2004; Glozier 1998). A particularly poignant study revealed high non-disclosure rates among psychiatrists in order to avoid stigma which they knew to be widespread within their profession (White et al. 2006). It has also been found that, employees returning to work after suffering mental illness may face social exclusion (Glozier et al. 2006; White et al. 2006), while most persons with a mental illness often endure significant shame and low self-esteem that is aggravated by social exclusion (Baldwin and Marcus 2006; Link et al. 1999).

There are also a host of erroneous views attributed to the behaviours of persons with a mental illness, often wrongly associating higher levels of violence upon persons who have a mental illness (Elbogen and Johnson 2009). Studies also show that persons who do not have a mental illness may fear being stigmatised by associating with persons who have a mental illness (Kulik et al. 2008). Such beliefs, while mistaken, serve to foster lower levels of social contact from persons who do not have a mental illness, which can also manifest in blatant social exclusion (Kulik et al. 2008). Where social rejection or marginalisation occurs in response to illness, it is hardly surprising that persons who sustain a mental illness are less likely to wish to reveal their condition in the workplace.

In relation to shame and feelings of low self-worth (Rüsch et al. 2010) concealment of a mental illness may represent a logical strategy. In the workplace, employees with a mental illness may even go to great lengths to appear to be fit and healthy such that when they take sick days to deal with their hidden illness, they may appear to be lacking in credibility if they fabricate an alternative and more "acceptable" illness to account for regular use of sick leave (De Lorenzo 2003). It is interesting to note how effortless the strategy of deliberately concealing a mental illness can be as the following account of an employee with a mental illness illustrates, "I don't think anyone I'd ever met would say that I wasn't a happy

optimistic person. I'd never, never bring anything bad to work, never sound unhappy, nothing, and so it was all very well hidden, and I still hide it now." (Barney et al. 2009, p.3).

Managing Mental Illness in the Workplace: Disclosed and Hidden

As has been noted, mental illness is pervasive at both the community and workplace level. Common mental illnesses have the capacity to affect a person's ability to both attend and undertake their work role in the same manner as would be the case if they were fit and well. In relation to ease of disclosure of mental illness, studies show that shame, stigma, and fear of career damage, serve to significantly reduce the number of employees who disclose they have such an illness. Some studies suggest that the rate of free and willing disclosure for any chronic illness may be as low as only one in four employees (Munir et al. 2005). For those employees who choose to disclose, most countries have disability legislation in place to deal with this, some better than others. However, for the larger group of employees who come to work with a mental illness, their silence places them in a unique category, unprotected and being managed as though they were fit and able. In this section, a review of common remedies for employees who disclose they have a mental illness will be reviewed. This will be followed by a proposed system of policies to deal with hidden mental illness.

Managing Disclosed Mental Illness

In its comprehensive review of strategies and legalisation to deal with mental illness WHO (2003b p.2) notes that "Mental health legislation is essential because of the unique vulnerabilities of people with mental disorders" which includes stigma, marginalisation and poor decision-making. Despite this, in nearly a quarter of all countries there is no legislation to assist persons with a mental illness, while in countries that have adopted legislation to deal with disability deriving from mental illness, such legislation can vary considerably (WHO 2003b). Moreover, in countries which have enacted detailed statutes to assist employees who choose to disclose that they have a mental illness, there is no guarantee that their policies are sufficiently comprehensive (WHO 2003b). A review of three legislative remedies from the US, UK and Australia, highlight the variability between such policies.

In the United States the American Disabilities Act (ADA), which was enacted in 1990, serves to protect the rights of persons with a medically substantiated disability. Organisations with 15 or more employees are specifically banned from engaging in any form of discrimination in relation employees in paid employment who are medically evaluated as being disabled under the Act (USDJ 2005). The ADA also ensures that persons with a mental illness can obtain reasonable accommodation, including flexible work hours in order to undertake their duties (USEEOC 2008). However, employee disclosure of mental illness is a requirement, and for workplaces with fourteen or fewer employees the ADA does not require employer accommodation of employees with a medically substantiated mental illness.

In the United Kingdom, the Disability and Equality Act (commonly referred to as the Equality Act) was enacted in 2010 and as is the case with the ADA, provides for reasonable accommodation and protection from discrimination for persons evaluated medically as having a disability that has a duration of at least 12 months (DLS 2010). In the case of persons who have a mental illness of less than 12 months, the Equality Act does not come into play.

In Australia disability protection is offered by the Disability Discrimination Act (DDA) of 1992 and provides for accommodation of persons with a physical or mental disability (AHREOC 2010a). The Act, which aims to remove discrimination against persons with a disability, specifies that employers must accommodate any disability where the employee in question is the best person for the job (AHREOC 2010a). As with the American ADA and Britain's Equality Act, the DDA also requires employee disclosure via medical substantiation.

While each of these legislative protections exists to assist persons with a mental illness, or other disability, they each require employee disclosure and medical substantiation before legislative remedies become available. Furthermore, WHO (2003b) notes that variability in legislative remedies is a fact of life that needs to be changed over time, with many countries still leaving employees unprotected by legislation. Nonetheless, WHO (2003b) does not tackle the issue of non-disclosure, seeking instead to concentrate almost exclusively on accommodation for employees who

reveal they are ill, or on policies that seek to remove factors that may aggravate or cause mental illness, namely overwork and bullying.

In recognition of increasing mental health disability in the community, the Mental Health Council of Australia (MHCA), in support of the United Nation's move to enact a Convention of the rights of persons with a Disability (MHCA 2010), argues that such a convention is needed to tackle a range of issues, chief of which is stigma which even in the face of exemplary legislation requires employees to overcome their reluctance to disclose. However, such proposals fall short of recommending that policies be enacted in anticipation of stigma when it acts to silence a person from disclosing their illness, particularly in countries where there is legislative protection.

WHO (2005) suggests that in addition to fulfilling legislative requirements, organisations have a responsibility to implement policies that work to prevent stress build up that can lead to mental illness. Organisations are strongly encouraged to carry out surveys to establish the extent of mental illness in their workplace and to perform risk assessments to assist in establishing any existing or potential risks in the work environment that may lead to a deterioration in mental health for any employee (WHO 2005). The development of a vision statement detailing each organisation's commitment to maintaining a healthy workplace, along with relevant policies, objectives and action plans is also viewed as a necessary process for organisations that are committed to dealing effectively with mental illness (WHO 2005).

The use of anti-stigma campaigns that seek to reduce the silence surrounding mental illness are also useful strategies with initiatives such as the Canadian MHCC (2012) and similar programs in New Zealand, England, USA and Scotland (Queensland Alliance 2012) working to reduce stigma surrounding mental illness. The availability of workplace ready policies from organisations such as WHO (2005) and similar organisations (NIMH 2012; AHREOC 2010b: MHCA 2010) serve to further assist organisations towards putting together practical and workable policies in the workplace to reduce stigma in relation to mental illness, policies for the effective management of employees with a mental illness, and strategies designed to reduce possible causes and exacerbations of mental illness in the workplace.

In the case of employees who make the decision to conceal their mental illness from both their operational manager and HR staff, several issues arise. As decision-making for such employees is often impaired (WHO 2003b), employees with a hidden mental illness are a potential risk to themselves and others if they are required to use machinery, or to make decisions that impact on the safety of others (Hilton et al. 2009; Hilton et al. 2008). If their symptoms make it difficult for them to undertake their work as they normally would, any decline in work quality or output will expose them to conventional HR policies, namely performance management policies (Selden and Sowa 2011; Balser and Stern 1999a, b). This will also be the case for persons whose attendance or behaviours alter significantly as a consequence of mental illness.

In other words, short of being mind-readers, operational managers and HR staff currently have no universally established policies in place to deal with hidden illness, and are within their rights to do nothing. However, doing nothing does not remove the problem of the silent epidemic of mental illness. Instead it adds another layer of obfuscation to an already clear and present problem which is why this author has developed Buffer Stage policies. They have been formulated as an added tool in the current performance management toolkit, and are not proposed to replace conventional policies in this area.

When an employee is unable to achieve their normal work performance and/or attendance requirements, whatever the cause, their operational manager will often attempt to ascertain via an informal meeting if the employee can account for this sudden change (Selden and Sowa 2011; Balser and Stern 1999a, b). At this juncture, the employee's operational manager will be on a fact-finding mission, seeking to establish if there are contributing factors for the reduced performance and/or attendance that can be quickly remedied, for instance, inadequate training, unknown issues in the workplace, personal issues and so forth. Alternatively, the employee's manager may be required to follow a series of formal meetings with HR staff in attendance, or may choose this path out of personal preference. Cunningham et al. (2004) also raise the issue of manager competency, finding in their case studies of employees with chronic illness that often managers were inconsistent in their management with many lacking the required training to follow due process. Nonetheless, many organisations have a prescribed series of

steps for guiding HR staff, operational managers and employees through a scripted process of performance management polices with the objective of formulating a plan to improve performance in stages, often referring to this as a performance improvement plan (for instance; OCPE 2012, Indiana State University 2012; London Development Agency 2005).

At this juncture, whether this is at the informal or formal first stage of a performance management process, shame and stigma will often act to silence employees from divulging that they have a mental illness (Rüsch et al. 2010; Munir et al. 2005; Hickie et al. 2004; Glozier 1998). As a consequence, once a performance improvement plan is drawn up with the understanding by the operational manager and HR staff that the employee has not disclosed a health or other issue; specific work targets will be set in place and checked against actual performance at prescribed dates. Unless employees reveal at some stage that they have a mental illness, or any other illness, failure to meet prescribed targets will be viewed as an inability to achieve performance improvement plan requirements, that is, insubordination which may result in termination.

Buffer Stage Policies

Given the high prevalence of mental illness in workplaces, and in respect of the high non-disclosure rate of these illnesses, this author proposes that workplaces take this into consideration by reviewing their current performance management policies. Currently, standard HR management policies suggest that there is no alternative but to move to a performance management plan if the employee gives no reason for any unacceptable performance and/or attendance (Selden and Sowa 2011; Balser and Stern 1999a, b). Both HR staff and operational managers are at liberty to implement their own policies to deal with suspected hidden illness, but the fact remains that there is no clear direction about how to proceed if the employee has a concealed illness. It is for this reason that the Buffer Stage policies have been devised. They have been formulated as an additional policy that may be used prior to formal utilisation of a performance improvement plan.

The nomenclature ‘Buffer Stage policies’ is, as its name demonstrates, intended as a means of introducing an interval of alternative policies prior to formal implementation and monitoring of a performance improvement

plan. In short, the intention is to insert a circuit breaker into an otherwise formal and sometimes difficult to resolve process of performance management when employees may have hidden mental illness, or any other hidden illness or issue that impacts on their performance and/or attendance. While they are conceptual, they are offered in the absence of any empirically tested alternative policies as a helpful aid to HR management staff.

These policies are designed to assist organisations from unintentionally placing employees with a hidden mental illness on a performance improvement plan that may not only be difficult to achieve, but which may further exacerbate an employee's ill-health. Buffer Stage policies allow employees the means of disclosing an illness confidentially to a designated member of HR, or to keep their illness hidden, while they are given the opportunity to avail themselves of reduced hours or a break in work for two to three months. It is argued that, for employees who come to work with a concealed mental illness, the opportunity to have reduced hours or a total break from work will allow them to better recuperate without having to disclose their illness, or to disclose it under strict conditions of confidentiality with HR. As WHO notes, impaired decision-making is a recognised feature of persons with mental illness (WHO 2003b). Along with deficits in cognitive functioning, as noted above, employees with a hidden mental illness are at a significant disadvantage when they are confronted with a performance improvement plan as the following account by "Betty", a senior project manager in her early 40s, who was subjected to performance management policies following a noticeable drop in her performance, illustrates (De Lorenzo 2003).

> *When I was asked to attend a performance management meeting with my manager and someone from HR I was immediately fearful that I would lose my job. I felt intense fear. I was also very angry that this was occurring. After pushing myself to deliver on some very unreasonably short deadlines for a year, I began to experience a great deal of tiredness and anxiety. After completing these projects my sleep became severely interrupted so that I would go to work feeling very tired and unable to concentrate. I also noticed that I was feeling insecure most of the time. The whole performance management thing felt like I was about to be punished severely and that my life was at risk. I know now that I was a little out of whack, but it sure felt at the time as though my life was about to be extinguished. The emotional pain of the whole thing was unbelievable.*

Around this time I was diagnosed as having anxiety and depression which appears to have been caused by my long work hours. Maybe that's why I was feeling all this fear about the performance management thing. . . . I took every step to avoid attending the meeting and ended up resigning a month later. I guess my manager's strange entrapment was the catalyst that caused me to leave. Maybe he didn't want to be seen as someone who was happy to impose long hours on his staff. Whatever the case, the thought of telling people I had anxiety and depression was something I just couldn't do.

In Betty's case, her operational manager did not seek to have an informal chat to review why her output had fallen, and instead moved straight to a formal meeting with HR to commence the preliminary stage of a performance improvement plan. While an informal meeting is not mandatory, Betty's manager showed a lack of due diligence and compassion that may have heightened her anxiety. In any case, as Betty states, she was not comfortable with disclosing her illness and resigned. For other employees who choose to stay with their organisation while they are placed on a performance improvement plan, the decision to not disclose can be equally difficult and may result in termination if their symptoms do not improve and they are unable to reach specified work targets. After outlining Buffer Stage policies below, Betty's case will be reviewed in consideration of how such policies may have assisted her and the organisation she worked for to better tackle her workplace issues.

In practice Buffer Stage policies would come into play whenever HR are notified by an operational manager that one of their employees has exhibited unacceptable work outcomes, for instance; poor work performance, increased absenteeism, unacceptable workplace behaviours and so forth. It is recommended that the following policies be inserted into an organisation's HR policy documents for use before formal performance management policies are enacted. They may also form the preliminary stage of performance management policies, for use prior to a performance improvement plan. In any event, in relation to 'workplace issues' that commonly invoke a performance improvement plan, in the case of Buffer Stage policies, workplace issues will constitute any unacceptable execution of an employee's role as outlined in their performance document. It is suggested that unacceptable workplace issues should be documented for a period of at least two months by the

employee's operational manager to substantiate what is taking place unless the employee's behaviours are so serious that they need to be rectified as quickly as possible, for instance, compromising staff safety or behaving in a manner that may cause serious harm to the business relationships of the organisation. After the manager has fully documented the employee's unacceptable behaviours, Buffer State policies would be rolled out as follows:

Buffer Stage One

The operational manager is requested to have an informal meeting with the employee to ascertain causes of unacceptable workplace issues. At this meeting, the manager notes that they have documented unacceptable workplace issues by the employee for 2 months, and provides him/her with a copy of the document they have prepared. The employee is then given an opportunity of explaining why this has taken place in an informal and supportive manner. If the employee does not disclose any causal factor that can be pursued without resource to a performance improvement plan, the operational manager writes up the results of the meeting and refers the matter to a designated member of HR who implements the next series of Buffer Stage policies, with a copy forwarded to the employee. As the issue has not been resolved, the matter proceeds to Buffer Stage Two. Included in this letter are all steps of the Buffer Stage policies for the employee to read and digest.

Buffer Stage Two

A member from HR who deals with Buffer Stage cases contacts the employee in question and meets with them to ask if they have any reasons that may account for their workplace issues. At this meeting, the employee is given the opportunity of disclosing any health or other issues confidentially to HR. If disclosure takes place, employees will be required to forward medical substantiation of their condition to the HR staff member. The matter can then remain in the hands of HR to deal with confidentially, and the operational manager can be informed that the matter has been investigated and the employee has substantiated an issue that will be kept confidential. At this stage the employee can be managed as any other employee with an illness, but will report inability to attend or undertake work to the designated member of HR, instead of

their operational manager. If the employee makes no disclosure of any cause to account for their unacceptable workplace issues, then the matter proceeds to Buffer Stage Three.

Buffer Stage Three

When the employee provides no reason to account for unacceptable workplace issues, Buffer Stage policy advice to the HR staff member advises them to consider that the employee may or may not have a concealed illness. To deal with this possibility, such employees will be asked to meet with HR to review their situation prior to moving to a formal improvement performance plan. The employee in question will be sent a formal email from HR along with an attached letter outlining Buffer Stage Three options for them to select at the next meeting. The three Buffer Stage Three options that an employee can select are as follows:

Option A:

Reduced Hours with either two or three months of work at no more than 25 % of normal work hours at no expense to the organisation. Employees can utilise any unused annual leave for this option but are not permitted to undertake overtime during this period.

Option B:

A two or three months total absence from work at no expense to the organisation. Employees can utilise any unused annual leave for this option.

Option C:

Movement to a formal Performance Improvement Plan.

If we now apply Betty’s case to the outlined Buffer Stage policies, she would have been given an informal chat by her operational manager to

outline his/her concerns with reference to a two months documentation of workplace issues. At this meeting, Betty would be asked if she could account for the issues outlined so that the matter could be resolved. Betty would have the option of outlining her work pressures and how this impacted on her health. If the meeting was undertaken with sufficient care, she may have felt comfortable stating her health had become impaired as a consequence of long hours and short deadlines. If she were to choose to disclose nothing about her medical conditions, she would later receive an email from her operational manager detailing what had transpired at the informal meeting.

As Betty's manager would be required to write a letter outlining what was discussed, including an attached copy of the workplace issues outlined to her, and a full copy of the entire Buffer Stage policies, Betty is given a range of options to consider, rather than moving straight to a performance improvement plan that in her case caused her to feel extreme anxiety or "intense fear". She would be able to note that she could confidentially disclose her health issues with a designated member of HR, or could elect to move to lower work hours or to take a break from work. That is, rather than being consumed by "fear", the Buffer Stage polices would provide Betty and other similar employees with time to consider what to do. In this case, whether Betty would have disclosed her conditions to HR or not is unknown, but her decision to resign in order to avoid a performance improvement plan would most likely have been averted. In any event, Betty would have had breathing time and options to consider about how to best precede under the care of a well-trained HR person with people skills that operational managers may not possess (Cunningham et al. 2004).

Adoption and implementation of Buffer Stage policies involve no organisational cost apart from implementation costs for HR, and the possible employment of temporary staff to undertake short-term contract work for staff who are not working to full capacity or who elect to take a total break from work. As staff in the Buffer Stage have been assessed as having unacceptably low performance and/or attendance levels, the cost of employing temporary staff to undertake duties while staff are in the Buffer Stage are significantly mitigated by a return to normal performance and/or attendance by the use of fully functioning staff.

The possibility that employees without a hidden illness may utilise such policies is not ruled out. However, as Buffer Stage policies involve

reduced hours or a break from work at the employee's expense, adoption of these policies by fit and able employees will not impose a heavy cost burden to their employer. Moreover, once a Buffer Stage period has been served, whether the employee had a hidden illness or not, when such employees return to work, their performance and attendance will be measured and where employees continue to have work issues, the use of conventional performance improvement plans are now open for use.

In the case of employees with a hidden illness, the Buffer Stage offers a much needed break for such employees in order that they may return to normal duties in better health, or if their health is still below par, the interval of either reduced hours or a break from work will serve to allow them to make a less pressured decision about disclosure of their illness. For employees who have a hidden illness, the option of confidential disclosure to HR should remain as a viable option, again with the requirement that their illness be substantiated by a qualified medical practitioner.

Under conventional performance management policies, while they are often well thought out, they also have the potential to be ineffective, and at worst harmful when placed on the shoulders of employees suffering from a hidden mental illness as they offer no allowance for the existence of a hidden illness. Such persons may be struggling to attend work and may be unable to function at full capacity, so for them, the added move to performance management can be enough to push them over the edge. It is also short-sighted to not factor into HR policy, policies for dealing with hidden illness when the weight of research findings is that large numbers of employees choose to not disclose that they have a chronic illness. The following poignant comment from a person with bipolar disorder is instructive as the person concerned ponders whether or not to divulge an illness to their manager:

How can I explain to my boss how my bipolar illness sometimes affects my ability to get going in the morning? Up until now, I have kept my bipolar quiet, but after several instances of not making it to work till noon and being too ashamed to call, my supervisor is now completely furious and unwilling to accept anything less than me being there 10 min early. (AAM 2012)

Discussion and Conclusion

Close to one in two persons will be subjected to a CMHC during the course of their lifetime. In workplaces and the community, on average a fifth of all persons have a CMHC in any 12-month period. For some, such conditions will be their first and only encounter with such an illness, while for others they will re-experience these disorders or may even have a chronic state of ill-health with mental illness. Stigma and shame serve to silence people effectively so we do not often know when we encounter people with a mental illness. In the workplace, concealment of a mental illness when symptoms affect a person's ability to perform and/or attend work to their optimum level can result in them being subjected to formal counselling and the application of a performance improvement plan. However, when an employee's performance and/or attendance are compromised because of a concealed mental illness, such policies are unlikely to succeed. It is therefore proposed that organisations adopt Buffer Stage policies to ensure they are not unknowingly subjecting employees with a hidden illness to formal performance improvement plans that they are unlikely to effectively complete.

As concealment of mental illness and other chronic health conditions is high, HR policies need to factor this into their policy toolbox by recognising that employees with poor performance and/or attendance may be unwell and not insubordinate or lacking in work ethic. It is not enough to expect conventional remedies that require self-disclosure to be sufficient in dealing with the effects of mental illness in the workplace as the issue of stigma and concern about career damage have been shown to be widespread by sufferers of mental illness.

As has been stated above, while Buffer Stage policies are conceptual and not yet empirically tested, they nonetheless serve as a helpful means of assisting both HR staff and operational managers in introducing an alternative means of managing unacceptable employee performance and/or attendance rather than moving immediately to a performance improvement plan. By offering Buffer Stage policies in the form of flexible hours or a total break from work, along with the opportunity of confidentially divulging illness to a designated member of HR, as options prior to a possible formal performance management process, organisations will be proactive and innovative, rather than burying their faces in the sand of denial. Until societal stigma collapses, and most persons with a mental illness feel comfortable about revealing their illness

in the workplace, a change to performance management policies is overdue and necessary as a proactive system for dealing with employees who will persistently choose not to divulge they have a mental illness.

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