Sharing part of a letter I wrote on 08.04.15 to the service I worked in just before I broke down: My thoughts and recommendations on staff well-being and stigma from the point of view of a supervisor in this team. It was so important to give some of the reasons for breaking down back to the organisation at the time, rather than internalising all of it as my fault. Colleagues helped me realise this. I felt I needed to voice for the team, all of whom were struggling.

The recommendations I would like to make based on my experience

With my dual expertise in mental health (something that is actively recruited for and valued in the NHS) and as a clinician, I would like to put forward some advice to **the service** about some aspects of the Occupational Health process given my experience of it.

I would advise that all employees requesting an appointment or review with Occupational Health should be granted one where their primary concern around working to full capacity is due to their mental or physical health. In doing so, discussions about the type of work undertaken can be held in the context of holding the health issue in mind. Mental and physical health recovery is a dynamic process, and without allowing check in and updates, Occupational Health will run a rigid and inflexible service which does not mirror the reality of need or support in the workforce, nor therefore show that it fully values it. Reviews should be given where requested and this was not offered to me, and I feel that was wrong.

Occupational Health should have access to a clinical psychologist or psychiatrist to bring expert knowledge of mental health, individual formulation of need and recovery plans to the work environment. This includes ongoing conversations reviewing health progress within a transparent framework of what is possible regarding employment options.

I understand that the organisation has a bottom line to consider in employing individuals who are unable to perform to capacity in their jobs, but not being given a chance to discuss this with a health clinician when it is health related feels dismissive. Perhaps these issues can be more fully discussed between Occupational Health, HR and Managers. The joining between Occupational Health and HR needs to be made transparent to employees, so that options are understood about the possibilities of redeployment or alternative work should the employee be unable to return in their previous capacity.

Whether or not it is true, it seemed to me that **the service** had only a ‘statutory’ option of 4 weeks non-clinical time, with a return to clinical at week five, and no concession to individual differences, type of presenting problem or dynamic review, this does not follow classic recovery patterns. I understand that communicating at the outset of my return that I was unsure when I might be able to return to clinical work may have set up some difficult dynamic, but that should be independent of a valid and responsive clinical process at Occupational Health.

It needs to be said that there are organisational factors which impact on the ability for any individual to feel resourced to tolerate stress. The **service** has been through two years of new start up and a significant merger. I helped to support the service where I could through these changes, but the lack of clear policies, clinical governance and changes in management and supervision have caused stress which has made things much more difficult to manage. Others in

the team have also expressed their difficulty in coping during team meetings and through sickness. My breakdowns happened in the context of this unrest and uncontained time. Although I own my individual mental health needs and take responsibility for working them through, the stress that we have been working under had an impact on my resilience and ability to cope, and I feel this needs to be acknowledged by the organisation. An uncontained and under resourced team will leave workers feeling less able to hold and heal trauma in clients.

In feeling so dismissed, and the worries about competence rather than capacity that were voiced, gave me concern that HR may hold stigmatised ideas about mental ill health in clinicians. I have no evidence of this, but it feels important to say the experience of mental health in mental health clinicians is as common as in the general population as we are all human. Research tells us it is not synonymous with issues of competency unless there are stigma against mental health. The mental health episode should be treated and recovered from in parity with any physical health episode, and returns to clinical work should be thoughtfully graded in terms of type of task (clinical versus non-clinical) and type of case when ready to start (choosing by presentation, or intervention versus assessment). The clinician should be supported to think about the limitations in their practice until they feel well enough to take on clinical work again, there is a fine-grained difference between clinical and non-clinical tasks in terms of recovery pattern and capacity, we have integrity and stand by our ethical rules, and our assessment of this is to be trusted. Thinking through this could be supported in Occupational Health by a clinician with a good experience of mental health practice.

<u>Regarding stressed mental health teams…</u>

Clinical teams should be provided with adequate regular individual clinical supervision as well as the opportunity for a regular group reflective space. This is not to be conflated with team meeting times which are task and business focussed. The challenges of engaging fully with the difficulties of client's mental health means that reflective space is an essential and not a luxury to the successful holding of the work, and the wellbeing of the clinicians and in turn clients. Clinicians need space to partial out the projections of difficult emotions that they hold as part of the emotional healing process with the clients. Our working tools are not just our minds, but our emotions through working with projection, transference and counter-transference, this emotional quality to the work needs to be attended to to stay healthy.

Policies and procedures fit for clinical purposes are necessary to hold a team safely through providing their work and to describe standards and ways of practicing. During the growth of this team and the merger, these policies have not been updated and need to be.

One of the stressors for the team is that in **this community service**, the basic need of rooms within which to offer therapy is lacking. For those clinical cases where an independent space is essential from home or school in order to process difficult emotions, this needs to be looked at. These cases are often the young people rather than the children, and sometimes home or school is not safe.

I would like to be clear that my manager has at all times been supportive and thoughtful during my absence and in my return to work. I felt that she was working within an Occupational Health

and HR framework that was not responsive enough to me in this instance. My concern is that the Occupational Health and HR process was not good enough in helping me to reach a positive ending in this role.

I appreciate the time taken to read this and hope that my experience might help inform better practice for others.

Regards,

Dr. Natalie Kemp