Recognising and responding to mental health problems in the workplace

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Evidence suggests that levels of psychological distress are elevated in the veterinary profession compared to the general population. Work can play an important role in supporting the health and wellbeing of employees which in turn can enhance the effectiveness and profitability of the workplace. This article provides an overview of various mental health problems that may be experienced by vets and vet nurses, how to recognise possible signs, how to give assistance and when to involve other parties.

Mental illness is one of the greatest hidden problems in our society and tackling it would make a major contribution to improving national wellbeing. Mental health is crucial for our quality of life and also affects our ability to learn, work and be a good parent (Layard 2012). Psychological distress and mental ill health affect people who are in work as much as the rest of the general population. On the whole employers do not recognise or choose to ignore the signs of mental ill health and, according to recent surveys, grossly underestimate how many of their employees may need help (Shaw Trust 2010).

At any one time one worker in six will be experiencing depression, anxiety or problems relating to stress. The proportion rises to over one in five if alcohol and drug misuse are also included (McManus and others 2009). The prevalence appears to be higher among UK vets: in a recent survey over one in three vets reported symptoms indicative of probable clinical depression and/or anxiety; almost two in three vets were classified as 'at risk' drinkers (a pattern of alcohol consumption carrying risk of physical and psychological harm); and over one in four vets reported suicidal thoughts in the previous 12 months (a proportion that is five times higher than among the general population) (Bartram and others 2009). Moreover, vets are at elevated risk of suicide, with a proportional mortality ratio for suicide around three to four times that of the general population and approximately twice that of other healthcare professions (Bartram and others 2010, Platt and others 2010). Vets commonly attribute their psychological distress to problems at work. Work-related attributions of difficulties include work intensity (pace and volume), the duration of working hours and its associated effects on personal lives, and feeling undervalued by senior staff and/or management. Psychological distress and mental ill health have potential to reduce an individual's mental wellbeing, affect their physical health and impair social and occupational functioning.

The business costs of mental ill health include sickness absence, reduced productivity at work ('presenteeism') and replacing staff who leave their jobs because of mental ill health. The annual cost for UK employers is estimated at around £1,000 for every employee in the workforce. The cost estimates can be tailored to a specific organisation using a costing tool available online in which the inputs can be changed to reflect actual figures and individual circumstances (NICE 2009). Simple steps to improve the management of mental health in the workplace, including prevention, early identification of problems, and enhanced access to support can enable employers to save a substantial proportion of these costs and at the same time help employees whose health and careers are at risk of spiralling downwards into chronic ill health.

What about the distressed employee – are measures to keep them in (or return them to) work likely to be harmful to their health? Again there is good news – work is on the whole good for mental and physical health (Waddell and Burton 2006) and for many people being at work in a supportive workplace can be part of the solution rather than the problem.

Managing psychological distress

What then can employers do to create healthy productive workforces and to manage the psychological distress which will always be present and affecting their businesses? There are several key principles:

- Understanding of the potential positive and negative effects of work on mental health, and the reasons why better management of mental health at work makes good business sense.
- Prevention of mental health problems which are directly work-related. This may include for example, providing mentally healthy working conditions and practices in line with the Health and Safety Executive's management standards on work-related stress; adopting an organisation-wide approach to

promoting the mental wellbeing of all employees, including the development and implementation of a 'wellbeing policy'; adoption of a management style that encourages participation, delegation, constructive feedback, mentoring and coaching; and providing employees with opportunities for flexible working according to their needs and aspirations in both their personal and working lives.
- Training for line managers to help managers to identify and respond with sensitivity to employees' emotional concerns and symptoms of mental health problems.
- Intervention to improve access to care, particularly access to medical and evidence-based psychological support which wherever possible enables people to continue working.
- Effective rehabilitation to facilitate the reintegration of vets and vet nurses with respect and sensitivity back into the workplace following a mental health problem.

This article aims to provide an overview of the different types of mental ill health most likely to be experienced by veterinary staff, how to recognise the signs, how to provide support and when to involve other agencies. It also briefly describes the most frequent mental health problems in individuals referred to the Veterinary Surgeons' Health Support Programme (VSHSP).

Related topics covered by previous articles in *In Practice* include strategies to enhance personal mental wellbeing (Bartram and Boniwell 2007), coping strategies (Bartram and Gardner 2008), understanding depression (Bartram and Baldwin 2007), managing the causes of work-related stress (Batram and Turley 2009) and creating sustainable performance in employees and organisations (Bartram and others 2012).

Box 1: Possible early warning signs of mental ill health in the workplace

- Working slowly
- Making mistakes more often
- Unable to concentrate
- Disorganisation and forgetfulness
- Poor time-keeping
- Increase in unexplained absences or sick leave
- Mood swings
- Unusual displays of emotion (eg, frequent irritability or tearfulness)
- Unable to delegate tasks
- Trying to work much too hard
- Over-reacting to problems
- Restlessness and agitation or tiredness, lethargy and lack of motivation
- Apparent loss of self-confidence and self-esteem
- Withdrawal from social contact
- Lack of interest in appearance or diminished personal hygiene
- Hand tremor
- Poor judgement or indecision
- Practising under the influence of alcohol or drugs
- Erratic or changed behaviour
- Being overtly aggressive or defensive
- Inappropriate dispensing and drug ordering
- Inability to communicate effectively
- Disappearing from the practice in a low mood but returning in a short time appearing much happier
- Increased client complaints
- Difficulty in coping with emergencies

Mental health problems

Work-related stress

Stress is a physiological reaction to feelings we experience in personally meaningful situations when pressure exceeds our perceived ability to cope. An event may be stressful to one person but not to another, largely because the level of coping resources and the meaningfulness of an event differs between individuals. Stress is not in itself an illness; it is a normal response that is essential to our wellbeing. A degree of work-related stress (positive stress or 'eustress') improves performance, motivation and level of fulfilment at work. However, persistent and excessive pressures that exceed our personal ability to cope lead to chronic stress, which can result in mental ill health (such as the disorders described below) and physical ill health.

Depression

Depression refers to a wide range of mental health problems characterised by the absence of a positive affect (a loss of interest and enjoyment in ordinary things and experiences), low mood and a range of associated emotional, cognitive, physical and behavioural symptoms. Distinguishing the mood changes between clinically significant degrees of depression (for example, major depression) and those occurring 'normally' remains problematic and it is best to consider the symptoms of depression as occurring on a continuum of severity. Commonly, mood and affect in a major depressive illness are unreactive to circumstance, remaining low throughout the course of each day, although for some people mood varies diurnally, with gradual improvement throughout the day only to return to a low mood on waking. In other cases a person's mood may be reactive to positive experiences and events, although these elevations in mood are not sustained with depressive feelings often quickly re-emerging. Accompanying symptoms typically include tearfulness, irritability, social withdrawal, an exacerbation of pre-existing pains, and pains secondary to increased muscle tension. A lack of libido, fatigue and diminished activity are also common, although agitation and marked anxiety can frequently occur. Typically there is reduced sleep and lowered appetite (sometimes leading to significant weight loss), but some people sleep more than usual and have an increase in appetite. A loss of interest and enjoyment in everyday life, and feelings of guilt, worthlessness and deserved punishment are common, as are lowered self-esteem, loss of confidence, feelings of helplessness, suicidal ideation and attempts at self-harm or suicide. Cognitive changes include poor concentration and reduced attention, pessimistic and recurrently negative thoughts about oneself, one's past and the future, mental slowing and rumination (repetitive thinking about the causes, symptoms and implications of one's sad mood).

Generalised anxiety disorder

The essential feature of generalised anxiety disorder (GAD) is excessive anxiety and worry (apprehensive

expectation), occurring on more days than not for a period of at least 6 months, about a number of events or activities. The person with GAD finds it difficult to control the anxiety and worry, which is often accompanied by restlessness, being easily fatigued, having difficulty concentrating, irritability, muscle tension and disturbed sleep. The focus of the anxiety and worry in GAD is not confined to features of another disorder, for example having panic attacks (as in panic disorder) or being embarrassed in public (as in social anxiety disorder). Some people with GAD may become excessively apprehensive about the outcome of routine activities. Demoralisation is said to be a common consequence, with many individuals becoming discouraged, ashamed and unhappy about the difficulties of carrying out their normal routines. GAD is often comorbid with depression and this can make accurate diagnosis problematic.

Eating disorders

Eating disorders (EDs) are syndromes characterised by a persistent and severe disturbance in eating attitudes and behaviour, often associated with over-evaluation of body shape and weight, to an extent that significantly interferes with everyday functioning. They generally have an onset in childhood or adolescence but may also develop in later life. People with EDs often experience acute psychological distress and severe physical consequences such as cardiovascular and gastrointestinal problems and osteoporosis. In some instances the ED is short-lived and self-limiting, or only requires a brief intervention, but in others the ED becomes entrenched and necessitates more intensive treatment or proves intractable and unremitting. Mortality rates are elevated significantly. Different clinical presentations include anorexia nervosa, bulimia nervosa and a range of other EDs which do not meet the precise diagnostic criteria of the two prototypical disorders. About one in 250 females and one in 2000 males will experience anorexia nervosa. About five times that number will suffer from bulimia nervosa. During the course of one year, over one in 20 adults experience an ED of some form. This one-year prevalence decreases with age and the pattern is particularly pronounced for women: one woman in five aged 16-24, compared with one woman in 100 aged 75 and over (McManus and others 2009). Anecdotal reports from several UK veterinary schools suggest that EDs are common among women students.

Anorexia nervosa

Anorexia nervosa is a syndrome in which the individual maintains a low weight (BMI < 17.5) as a result of a preoccupation with body weight, construed either as a fear of fatness or pursuit of thinness. Weight loss in anorexia nervosa is induced by severe and selective restriction of food intake, with foods viewed as fattening being excluded, sometimes supported by excessive exercising or self-induced purging (vomiting or misuse of laxatives). As a consequence of poor nutrition, a widespread endocrine disorder involving the hypo-

Box 2: How do I raise my concerns with a colleague?

- Have a conversation in a neutral and private space
- Make sure there are no interruptions. Switch off your mobile phone.
- Ask open, non-judgmental questions. For example, 'I was wondering how you were doing?' Don't ask loaded questions such as 'What is wrong with you then?' or 'Are you stressed or something?'
- Describe specific reasons for your concern, avoiding accusation or blame.
- Listen empathetically. Allowing someone to talk about their feelings can bring them a better sense of clarity, perspective, resolution and control. Always allow the person time to answer. Be patient.
- Do not attempt to diagnose. You are not a doctor.
- Demonstrate your respect for the individual.
- Try and put yourself in the other person's shoes and see things from their perspective.
- Ask what kind of support they would most appreciate at this moment. It might feel appropriate at this stage to begin to discuss some immediate possible changes at work.
- Suggest other possible sources of support such as the Vet Helpline, the VSHSP, Samaritans or their family doctor (GP), but don't tell them what to do.
- If they talk about self-harm, suicidal thoughts or intent, take them seriously. Around two-thirds of people who die by suicide communicated their intent to others (Cavanagh and others 2003).
- Assure them that the conversation will remain confidential, unless they consent to you informing others.
- Afterwards, if the experience was particularly emotionally challenging for you, unburden by sharing your feelings with someone you can trust.

Box 3: Supporting an unwell employee in the workplace

- Schedule one-on-one time with an appropriate line manager on a regular basis. This time can be used to discuss work performance and to enquire about their wellbeing. People who are unwell will feel more supported if they are able to be open about their illness.
- Encourage appropriate use of sick leave entitlements.
- Reallocating workload: could you spread tasks throughout the team to allow the person to work flexible hours or take time off for any appointments? Could you relieve them from particularly stressful tasks such as out-of-hours work or busy evening surgeries?
- Providing a quiet, private and secure place for a person to take any medication or to be alone if they need to can be very helpful.
- With the employee's express permission, you may request medical reports or advice from their medical team.
- Consider restriction of unsupervised access to dangerous drugs at times of high risk to minimise opportunities to remove them from the workplace for self-administration.

thalamic-pituitary-gonadal axis develops, manifest in women by amenorrhoea. The subjective experience of anorexia nervosa is often at odds with the assessment of others. The conviction that weight control is desirable is usually strongly held, particularly when challenged, and others are seen as mistaken in believing the person should gain weight, particularly where there is a marked disturbance of body image. Weight loss is experienced as a positive achievement and, therefore, may be strongly reinforcing to someone with low confidence and poor self-esteem. As a result, they will often deny the seriousness of the condition. The condition generally starts with dieting behaviour that may evoke no concern. Indeed, some will experience reinforcing compliments. After a while, however, the commitment to weight loss increases, often with a number of secondary features such as social withdrawal, rigidity and obsessionality, particularly where these traits have previously been features of the person's personality.

Bulimia nervosa

Bulimia nervosa is characterised by recurrent episodes of binge eating and inappropriate compensatory behaviours (self-induced purging, fasting or excessive exercising or a combination of these) in order to prevent weight gain. Binge eating is accompanied by a subjective feeling of loss of control over eating. As in anorexia nervosa, self-evaluation is unduly influenced by body shape and weight, and there may have been an earlier episode of anorexia nervosa. The diagnosis of anorexia nervosa is generally given precedence over bulimia nervosa; hence adults with a BMI of less than 17.5 are accorded a diagnosis of anorexia nervosa regardless of binge eating and compensatory behaviours.

People with bulimia nervosa tend to not disclose their behaviour or seek treatment readily. Binge eating and purging are commonly associated with extreme feelings of guilt and shame. These emotions are sometimes reinforced by the pejorative language used by relatives and others, who may refer to 'confessing' or 'admitting' to purging behaviour. A person's ambivalence towards treatment often arises from the fear that, if they are stopped from purging, they will gain weight as a consequence of their binge eating. Depression and anxiety are frequently present in bulimia nervosa and self-harm by scratching or cutting is common.

Substance misuse

Substance misuse is an intermittent or persistent pattern of use of psychoactive substances, leading to social, psychological, physical, financial, occupational or legal problems.

In comparison with the corresponding gender in the general population, male and female vets drink more frequently, consume fewer units of alcohol on a typical drinking day and have a similar frequency of binge drinking (Bartram and others 2009). Around one in 20 of the general population is alcohol dependent (McManus and others 2009). The prevalence among vets is not known. There is evidence that the incidence of alcohol-related deaths among vets is not elevated compared to other healthcare professions and the wider general population. In the general population, the overall prevalence of drug use in the previous 12 months is around one in 10 and is most common in young men and women. Most of those who had taken drugs in the last year had used cannabis. The prevalence of drug dependence was around three in 100. Most dependence was on cannabis only, rather than other drugs. Alcohol, ketamine, benzodiazepines and opiates are the substances most frequently misused among individuals referred to the VSHSP.

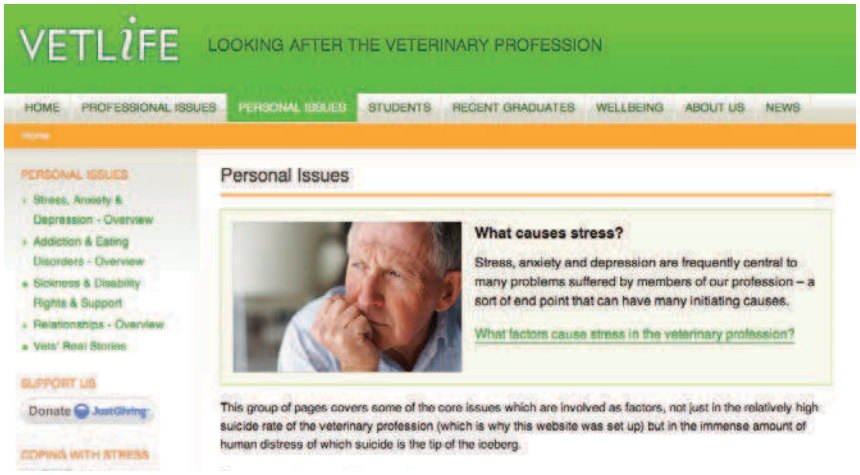

Fig 1: The Vetlife website offers useful information for coping with professional and personal difficulties

Early intervention

Managers and employees should be aware of common mental health conditions, how to identify early signs and symptoms and, most importantly, training to enable them to have the confidence to approach someone who is showing signs of distress and signpost them to appropriate help. Training workshops are available from organisations such as the Centre for Mental Health (Box 5). Individuals often require encouragement to seek help for mental health problems. They may perceive that support is of no value because it cannot change their circumstances, be concerned that seeking professional help may adversely affect their career, or believe they should be able to cope with their own problems. It is of concern that, among the general population, only around one quarter of people with a disorder is receiving any treatment (McManus and others 2009). Way of recognising, approaching, and supporting colleagues that may be experiencing difficulties are outlined in Boxes 1, 2 and 3.

Pathways to care, support and advice specific to the veterinary profession

Obviously, vets and vet nurses have access to the full range of healthcare professionals and support agencies available to others, such as Samaritans or the family doctor.

However, there are several alternative pathways to care and support available to members of the veterinary profession, including vet nurses and students. Vet Helpline, the VSHSP and Vetlife are funded by the Veterinary Benevolent Fund.

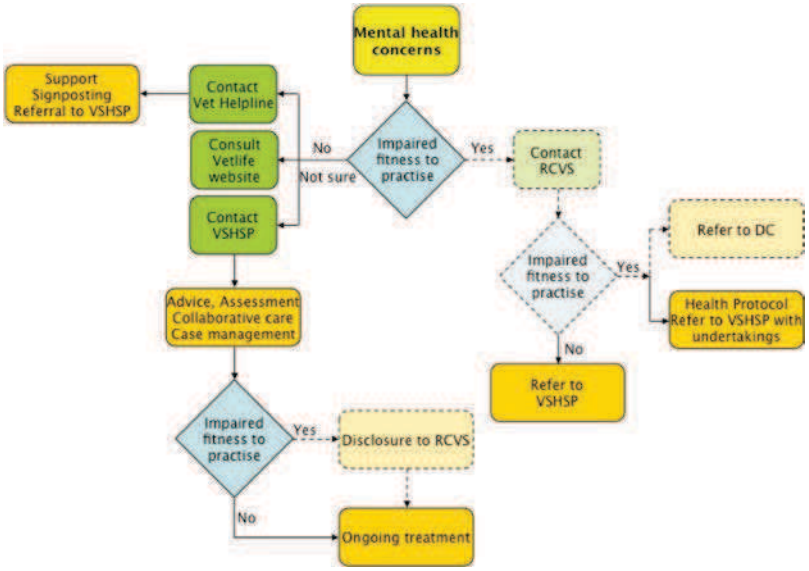

Fig 2: A summary of the pathways to care and support available to members of the veterinary profession

Vetlife website

The Vetlife website – www.vetlife.org.uk – provides information and support for veterinary professionals and has recently been updated extensively. Topics include professional issues such as managing conflict in the workplace and handling client complaints, and personal issues such as loneliness and finance (Fig 1).

Vet Helpline

Vet Helpline is a 24-hour telephone helpline service – when the caller dials 07659 811 118 they are put through to an answering machine where they can leave contact details. The call will normally be returned shortly after leaving a message, certainly within one hour. There are currently around 25 anonymous volunteers operating on a rota system to provide the service every day of the year. They are either veterinary professionals or their spouses and all have undergone comprehensive training with Samaritans. They offer confidential, empathetic, listening support and 'signposting' and, with the caller's consent, can refer callers for specialist advice, such as from the VSHSP, where appropriate.

Veterinary Surgeons' Health Support Programme

The Veterinary Surgeons' Health Support Programme (VSHSP) provides professional advice, assessment, collaborative care, and case management services for vets, vet nurses and students with substance misuse, eating disorders and other mental health problems and, where necessary, provides onward referral to specialist services. The service is similar to the health support programmes available in other clinical professions. It is run by a national coordinator who is a mental health professional and deals with referrals in confidence. The VSHSP accepts informal inquiries, self-referrals or referrals via third parties including colleagues and family. VSHSP treatment programmes vary but are designed to suit an individual's specific medical needs. For some, advice from the programme's national coordinator is sufficient; the more severely affected may require outpatient or inpatient treatment and proactive long-term follow-up and support. With intervention and an individually tailored therapy programme a high proportion will return quickly to work and normal family and social relationships. The cost of a course of treatment at a well-established clinic may be given as a gift from the Veterinary Benevolent Fund to those individuals requiring in-patient treat-

Box 4: Supporting return to work after a period of absence

- Remain in touch during the period of absence. This provides you with the opportunity to be updated on their recovery, reassure the individual that they are a valued member of staff and, without hassling them, give an expectation of their return to work.
- Return to work should be planned carefully in advance, with guidance from the employee and their healthcare professionals.
- Invite the employee to call in to the workplace for an informal coffee to meet colleagues again before starting back, as it's often difficult for people to come 'over the threshold' again.
- Remember that, even if they have been very unwell, generally return to work is perfectly possible and may make an important contribution to further recovery.
- Update the employee on any relevant changes at work that may have occurred during their period of absence.
- Discuss what reasonable adjustments might be made to their role, responsibilities or work practices.
- Follow the guidance supplied by the individual's GP in the Statement of Fitness for Work ('fit note')
- Ensure that the returning employee feels in control of what colleagues and others know about the reasons for their absence.
- Encourage colleagues to help in the individual's rehabilitation process.
- Organise a phased return to work.
- Reduce working hours either temporarily or on a permanent basis.
- Allow more flexibility in working hours.
- Be proactive in arranging regular meetings to discuss the individual's wellbeing and the possible impact on their work.
- Ensure that additional supervision is available in case it is required. The returning individual may have lost some confidence in their abilities.
- Allow time off for healthcare appointments.
- Discuss with the employee how the early warning signs and symptoms of any possible relapse could be identified in future and how they feel it might best be dealt with if it was to occur.
- Remain positive with the individual throughout their rehabilitation.
- Recognise that despite being fit to return to work the individual have residual symptoms and it may be some time before they reach previous levels of productivity.
- Providing a private space for employees to rest, cry, or talk with supportive colleagues.
- Be aware of an employer's legal obligations under the Equality Act 2010 if mental ill health has a substantial and long-term adverse effect on the ability to carry out day-to-day activities.
- Seek legal advice and possible mediation if considering termination of employment or dismissal. Handle these matters with great sensitivity to mitigate further psychological distress to the individual.

Box 5: Useful resources

- Vet Helpline 07659 811118
  A 24-hour peer-support and 'sign-posting' service staffed by trained volunteers.
- Veterinary Surgeons' Health Support Programme 07946 634220 or VSHSP@vetlife.org.uk
  The VSHSP provides professional advice, assessment, collaborative care and case management services for vets, vet nurses and students with substance misuse, eating disorders and other mental health problems and, where necessary, provides onward referral to specialist services.
- Samaritans 08457 909090
  Emotional support for those experiencing distress, despair, or suicidal feelings.
- Vetlife www.vetlife.org.uk
  Website funded by the Veterinary Benevolent Fund, providing information and support for veterinary professionals.
- Centre for Mental Health Workplace Training www.centreformentalhealth.org.uk/training/
  Training programmes that aim to help organisations to identify psychological distress in the workplace and appropriately support and manage people at work.
- Mindful Employer www.mindfulemployer.net
  A UK-wide initiative run by Workways, a service of Devon Partnership NHS Trust, aimed at increasing awareness of mental health in the workplace.
- British Veterinary Association legal services www.bva.co.uk/legal.
  A legal advice line for personal and professional issues and mediation or legal representation services to resolve employment disputes are available free of charge to all BVA members.

ment who are not able to obtain funding from other sources or fund themselves. The national coordinator can call on the support of 'special carers', members of the profession who are recovering from mental health problems themselves, and 'regional carers', members of the profession who are able to provide local support to the person, their family and their practice or other workplace. The national coordinator can be contacted on 07946 634 220 or VSHSP@vetlife.org.uk. The VSHSP is the appropriate first point of contact for health-related concerns that are not thought to be directly relevant to current fitness to practise. Pathways to care, support and advice are summarised in Fig 2.

Fitness to practise

The RCVS Codes of Professional Conduct 2012 require that vets and vet nurses 'must take reasonable steps to address adverse physical or mental health or performance that could impair fitness to practise; or, that results in harm, or a risk of harm, to animal health or welfare, public health or the public interest'. In addition, when there is concern that a veterinary professional's physical or mental health compromises their perception, cognition or insight in a manner which might impair their fitness to practise, steps must be taken to 'ensure that animals are not put at risk and that the interests of the public are protected'. This may involve reporting those concerns to the RCVS.

The RCVS Health Protocol, which forms part of the supporting guidance to the RCVS Codes, provides a framework for effective rehabilitation of vets and vet nurses whose fitness to practise may be impaired because of health-related concerns. The protocol provides that individuals whose cases are not referred to the Disciplinary Committee (DC), because there is no public interest to be gained from doing so, can be invited to give undertakings which may, for example, require that they undergo medical treatment or temporarily limit the extent to which they practise. Cases may be monitored by through workplace and medical supervisors and the RCVS frequently refers cases to the VSHSP. It is the experience of the VSHSP national coordinator that Health Protocol cases are handled with sensitivity, compassion and understanding by the RCVS.

When an individual is referred or self-refers to the VSHSP for advice or treatment they are assured that, where the safety of animals in their care or the public is not compromised, the referral will be handled on a confidential basis with no reporting to the RCVS or other third parties. Disclosure by the VSHSP to the RCVS is only made where the health-related concerns raise the possibility of impaired fitness to practise. Such exceptions to the duty of confidentiality are rare and should not undermine the trust that anyone can place in the VSHSP. Disclosure will normally be limited to those rare situations where the individual is not complying with assessment, treatment or monitoring, or heeding advice to remain on sick leave, and will be done in the full knowledge of the individual concerned.

Returning to work

Almost 50 per cent of long-term absences from work among the general population are due to mental health problems, mainly depression and anxiety. Many people with mental health problems fear that, no matter how good a recovery they have made, their symptoms will be made worse by going back to work, especially if they perceive that work contributed to their ill health. This is especially so for those who believe that work has either caused their health problem or made it worse. However, returning to a supported work environment after a period of ill health is often a positive experience, leading to further improvements in health and wellbeing. Work provides a structure to the day, a greater sense of identity and purpose, opportunities to build and maintain social relationships and support, and brings a sense of achievement and improved finances. Box 4 provides guidance on supporting return to work after a period of absence.

Conclusions

Mental health-related problems require medical care and empathetic emotional support to facilitate rehabilitation and a return to effective working. Recognising and responding to such problems in the workplace is a reflection of our responsibility to look after the well-being of ourselves and our colleagues, but it also makes good business sense. Treatment and support can lead to a full recovery, and a phased return to work is often an important part of that process.

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