

Sustaining Resilience at Work: How Organisations Can Encourage Good Mental Health Amongst Employees

Neil Greenberg

Professor of Defence Mental Health at King's College London
Managing Director of March on Stress
President of the UK Psychological Trauma Society

Who am I?

- » Professor of Mental Health based at King's College London
- » President of the UK Psychological Trauma Society
- » Military background in the Royal Navy for >23 years
- » Advised/supported
 - UK Government (e.g. FCO, DFID)
 - Media (e.g. BBC, NUK)
 - Emergency Services (e.g. Fire, Ambulance, Police)
 - Railway operators, accident investigators
 - Security Companies (e.g. Maritime, Land)
 - Military (e.g. UK AF, US, CAN)

The 'pessimistic view'!



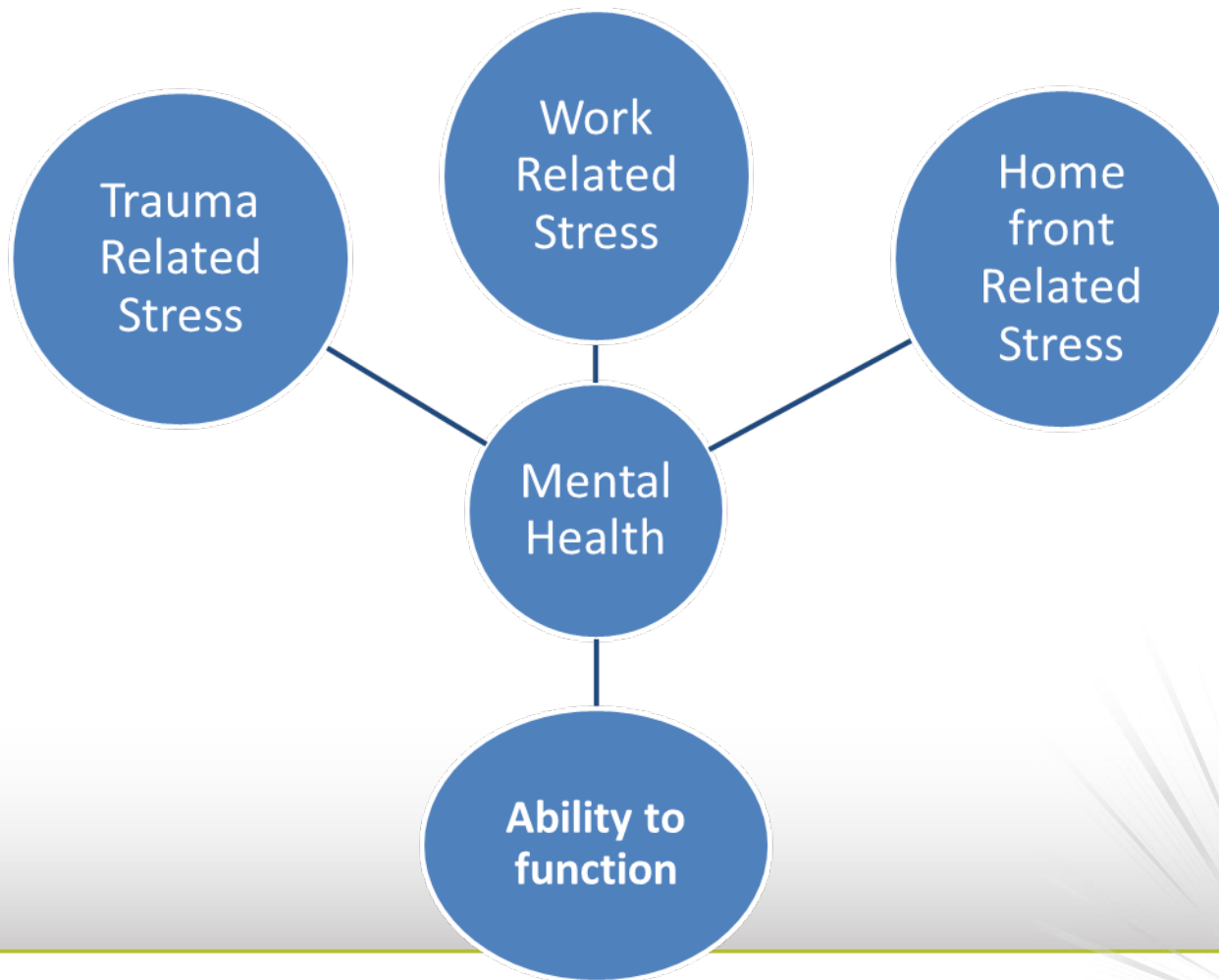
Economic costs of poor mental health

- Estimated 80M working days lost pa
- Direct costs of MI could be £23.1B pa
 - 11.8 lost employment
 - 4.1 NHS costs
 - 7.6 social security benefits
- Although RC Psychiatrists ~ £40B
 - Presenteeism – lost business/accidents/contagion effect

Mental health problems are common

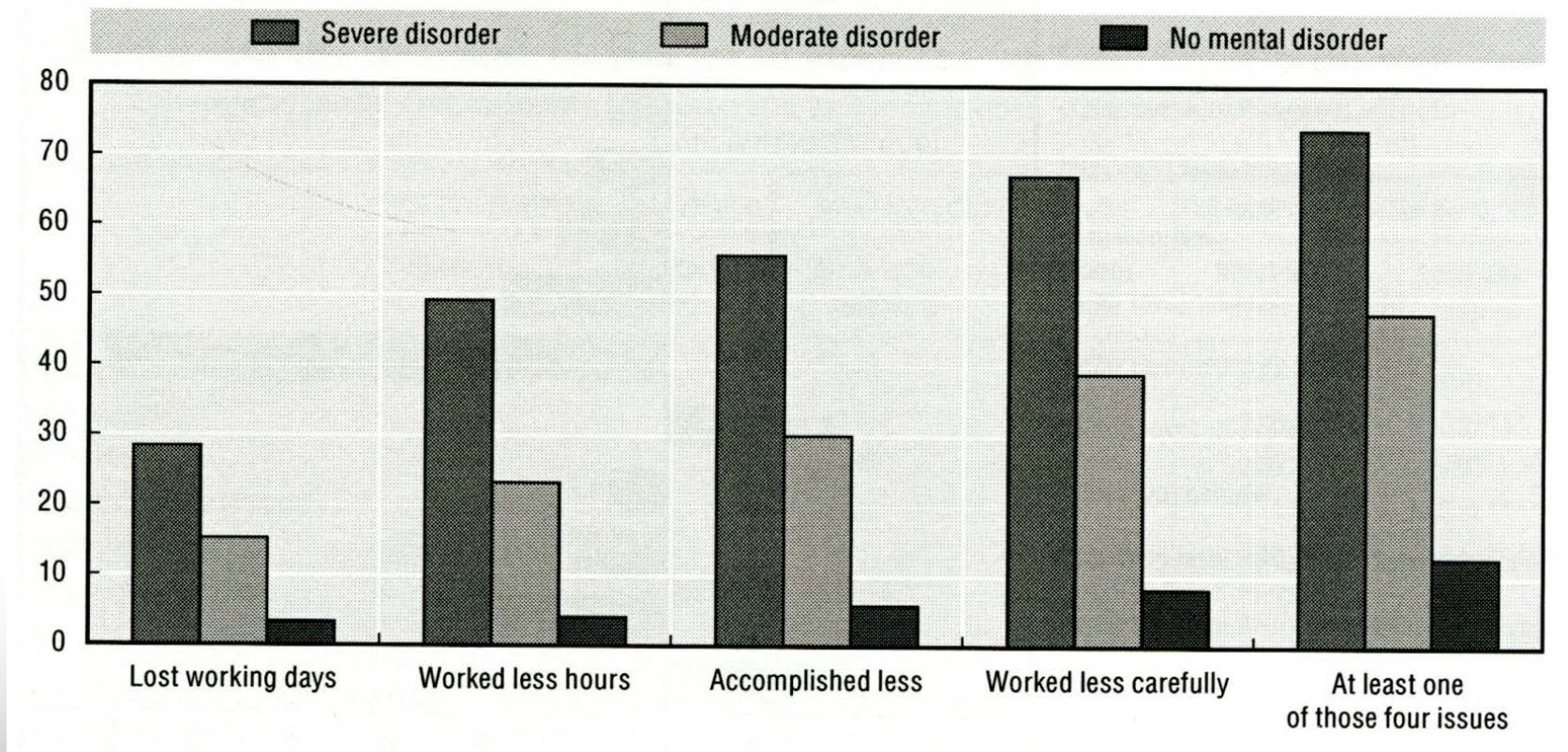
- 1 in 6 will have a significant mental health problem during their life
- Another 1 in 6 will have significant (non disorder) impairing symptoms (presenteeism)
- Serious (psychotic) disorders affect ~ 1% of population (static figures)

Sources of 'Stress'



Presenteeism and mental ill health

% of workers with productivity loss in past 4 weeks due to a mental health problem



Briton Danny Fitzsimons jailed in Iraq for contractors' murders

Danny Fitzsimons avoids death sentence but family say his PTSD meant he should never had been employed in a war zone

Caroline Davies

guardian.co.uk, Monday 28 February 2011 17.23 GMT

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Sgt. Robert Bales Returned to Military Base in Between Shooting Spree



MARCH
on stress.com

Presenteeism in spades!

Calls to review murder sentence of Sergeant Alexander Blackman

© 11 September 2015 · UK



Sergeant Alexander Blackman was convicted of murder at a court martial in 2013

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Germanwings plane crash: Andreas Lubitz 'rehearsed descent' on previous flight, says French report

France's BEA releases report into Germanwings crash, in which 27-year-old co-pilot Andreas Lubitz crashed plane into Alps, killing 150



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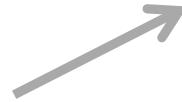
So....

- Common Mental Health conditions are...common
- They affect health and productivity
- They are pretty well understood
- So....surely we just need lots of MH care in the workplace eh?

Physical Health Treatment?



Treatment

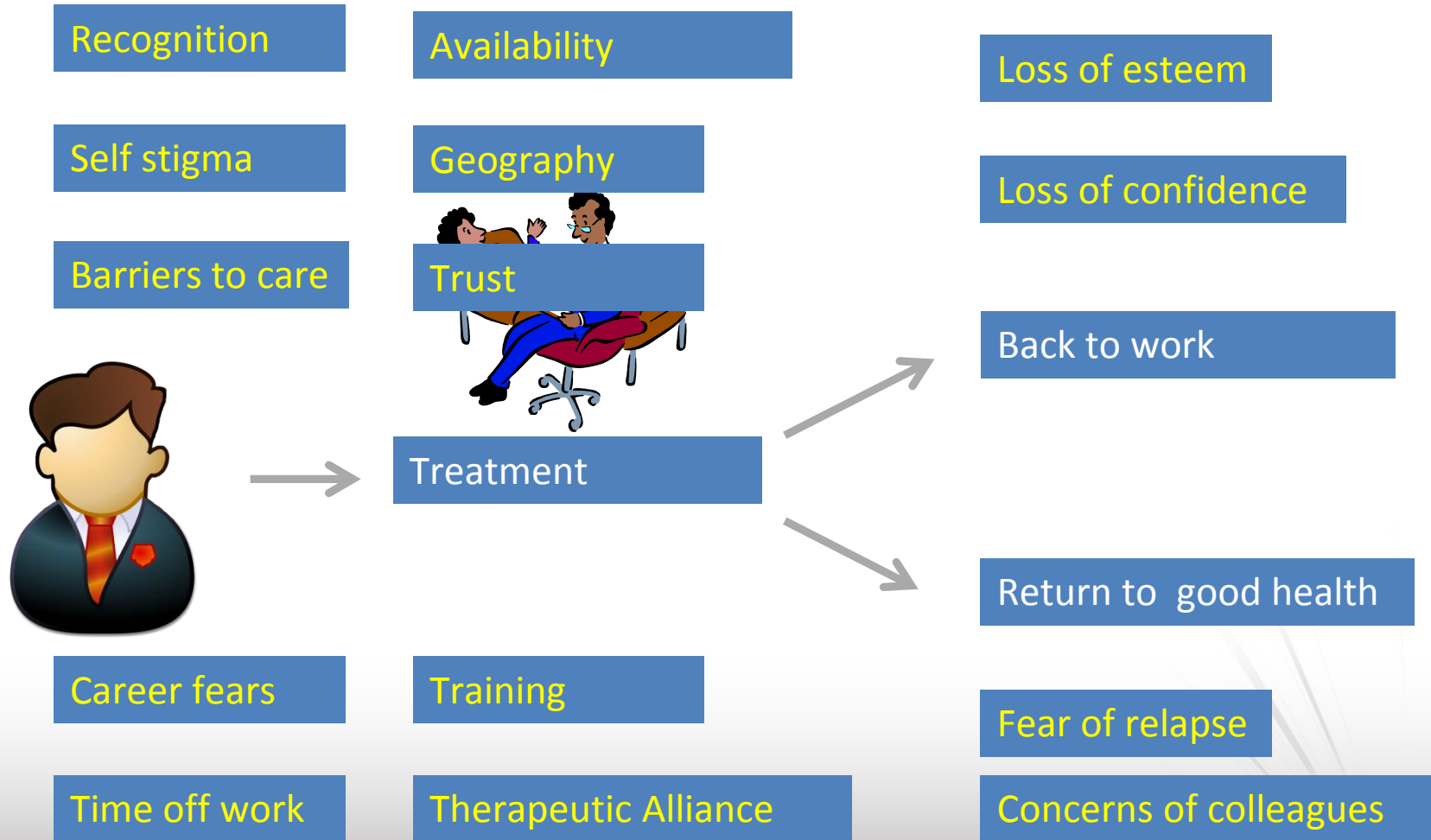


Back to work

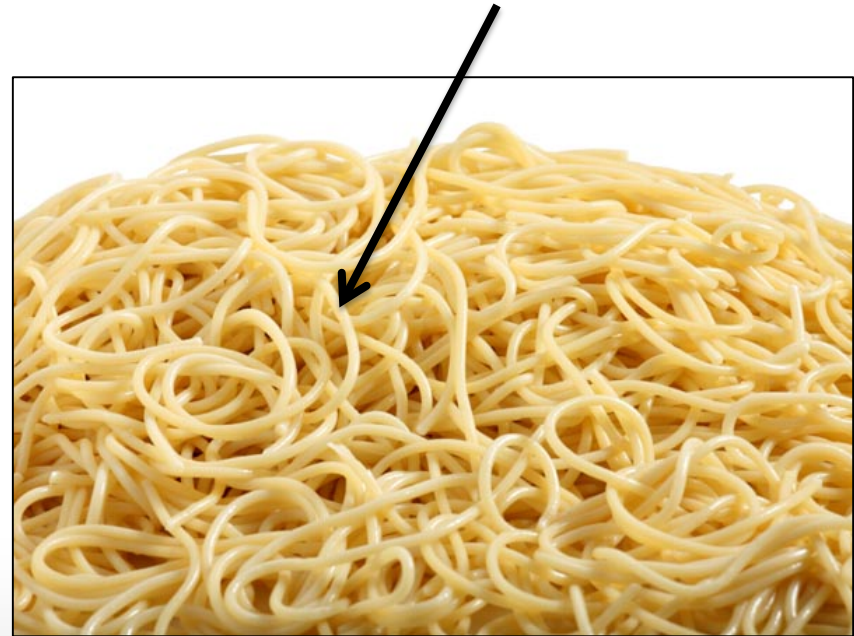
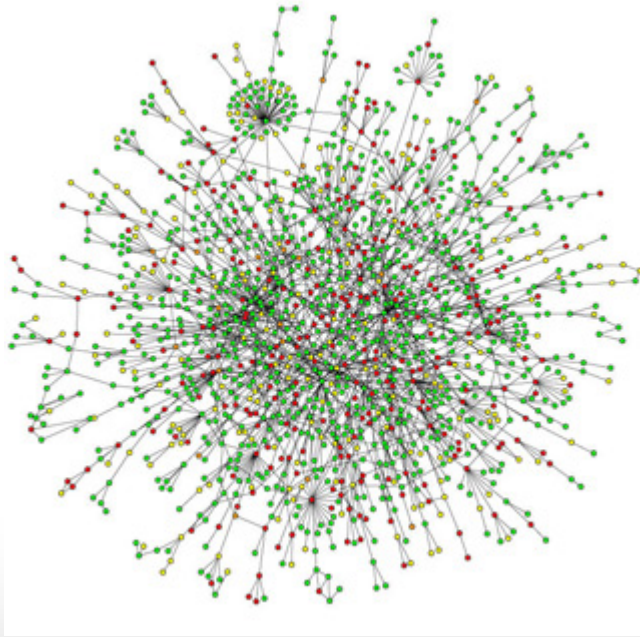


Return to good health

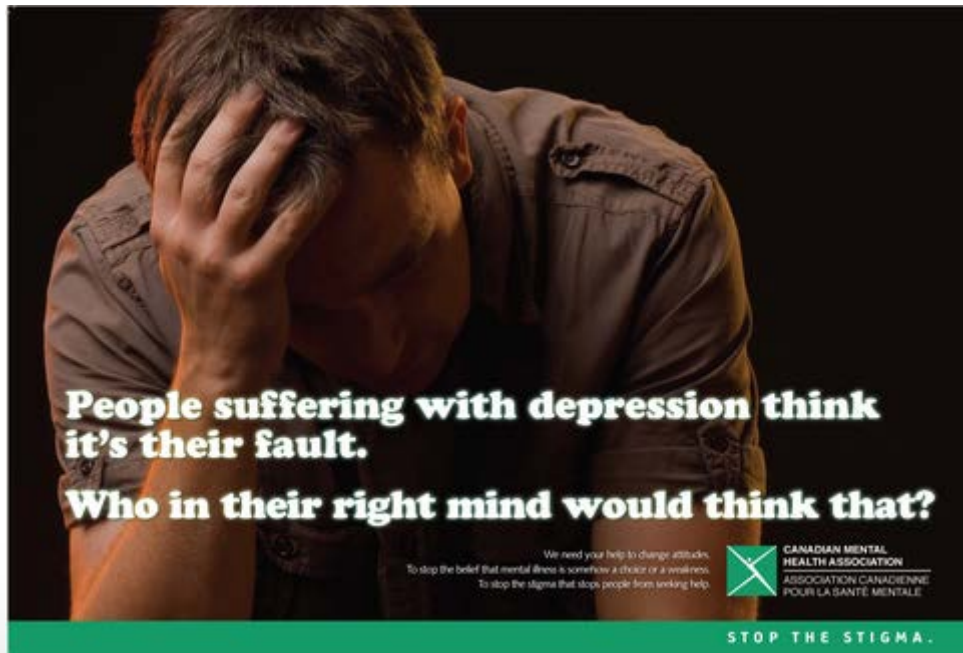
Mental Health Treatment?



The reality is that MH treatment processes are complex!




Stigma



**People suffering with depression think
it's their fault.**

Who in their right mind would think that?

We need your help to change attitudes.
To stop the belief that mental illness is somehow a choice or a weakness.
To stop the stigma that stops people from seeking help.

 **CANADIAN MENTAL
HEALTH ASSOCIATION**
ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE

STOP THE STIGMA.

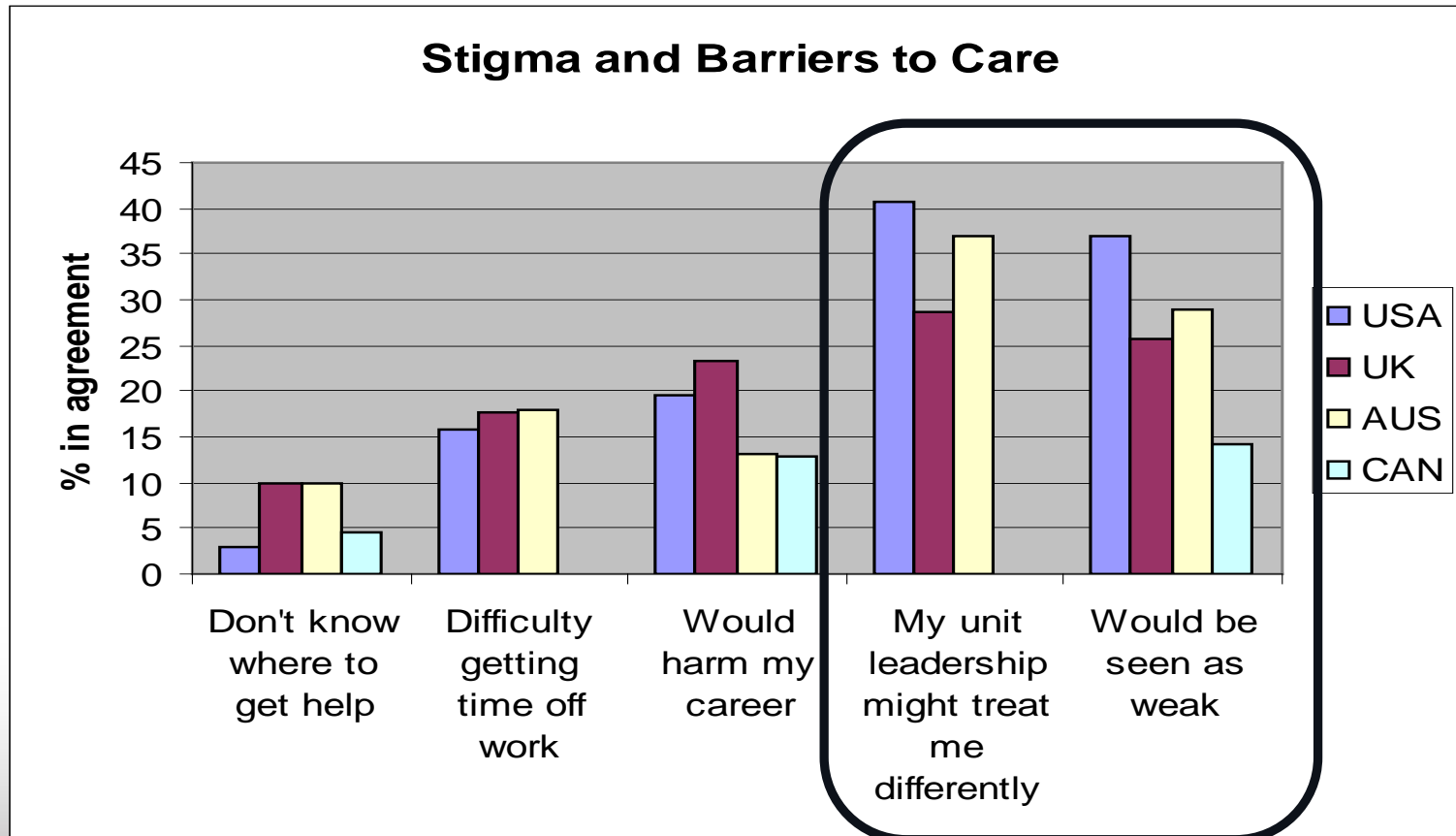
Types of stigma

- **Self-stigma** - occurs when a person with a mental illness starts to believe the negative and inaccurate stereotypes regarding people with mental illness
- **Public stigma** – is distinguished from self-stigma as the reaction that the general population has to people with mental illness and typically refers to the uninformed and negative attitudes and stereotypes held by many in the general community towards people with mental illness
- **Discrimination** – is the behavioural reaction to prejudice, where prejudice is understood as a general attitude toward a group, usually based on negative stereotypes. The stereotypes lead to negative attitudes which in turn affects the way an individual or group is treated (discrimination)

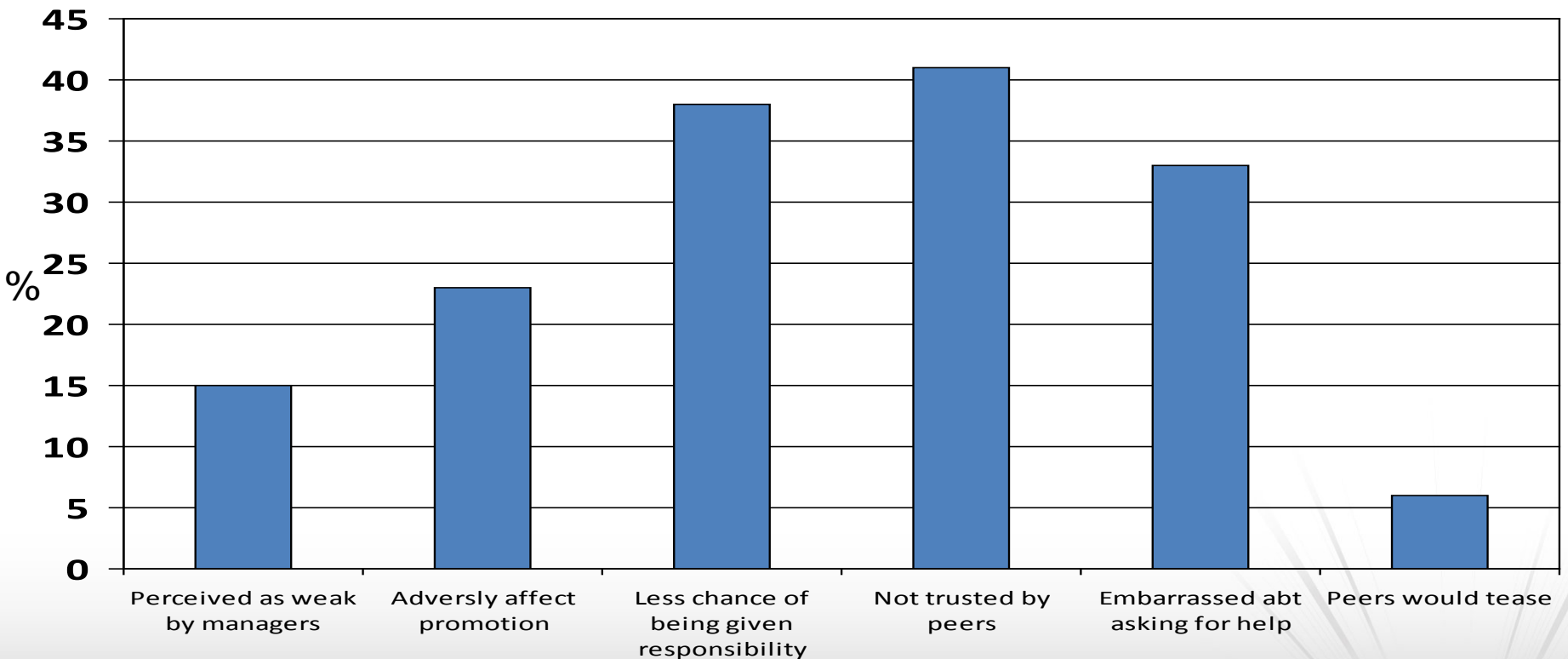
History of Stigma (and the military)

- WW1
 - Cowardice could lead to execution
- WW2
 - LMF and the RAF
 - General Patton
 - Churchill's view of military psychiatry
- Modern day
 - US purple heart
 - Security Clearance and MH

Stigma and barriers to care



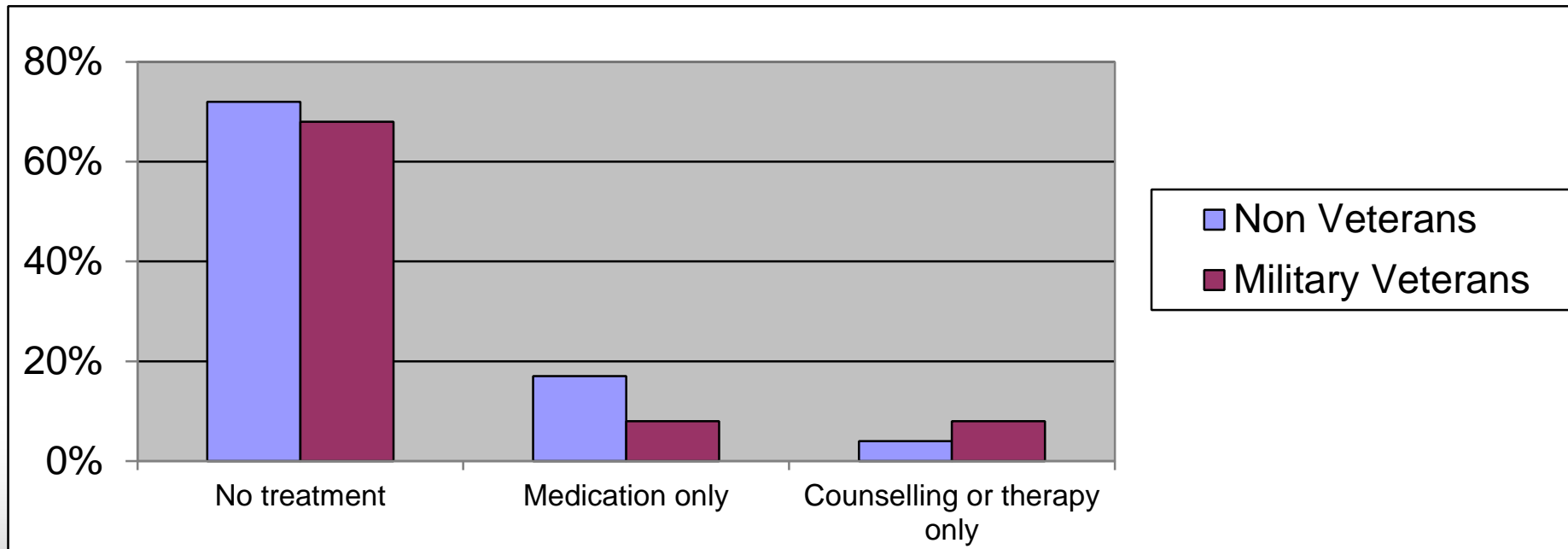
Why don't journalists seek help for MH issues?



Greenberg et al, JMH, 2009

And it's not just an issue for “stiff upper lip” professions

Help seeking for PTSD



So if stigma prevents help
seeking....when do people seek
mental health care?

What leads people to seek help?



EUROPEAN JOURNAL OF
**PSYCHO-
TRAUMATOLOGY**

THE OFFICIAL JOURNAL OF THE EUROPEAN SOCIETY FOR TRAUMATIC STRESS STUDIES

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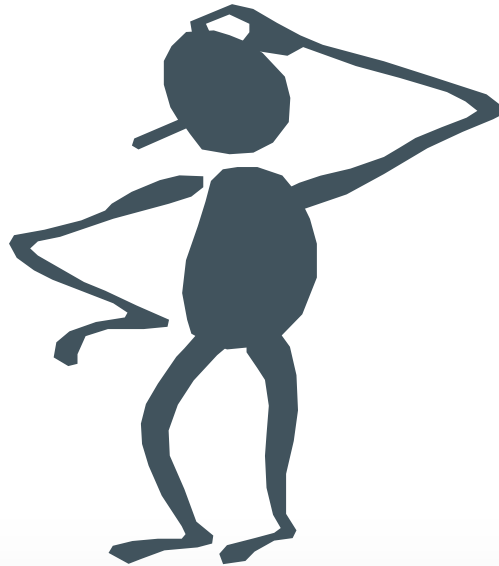
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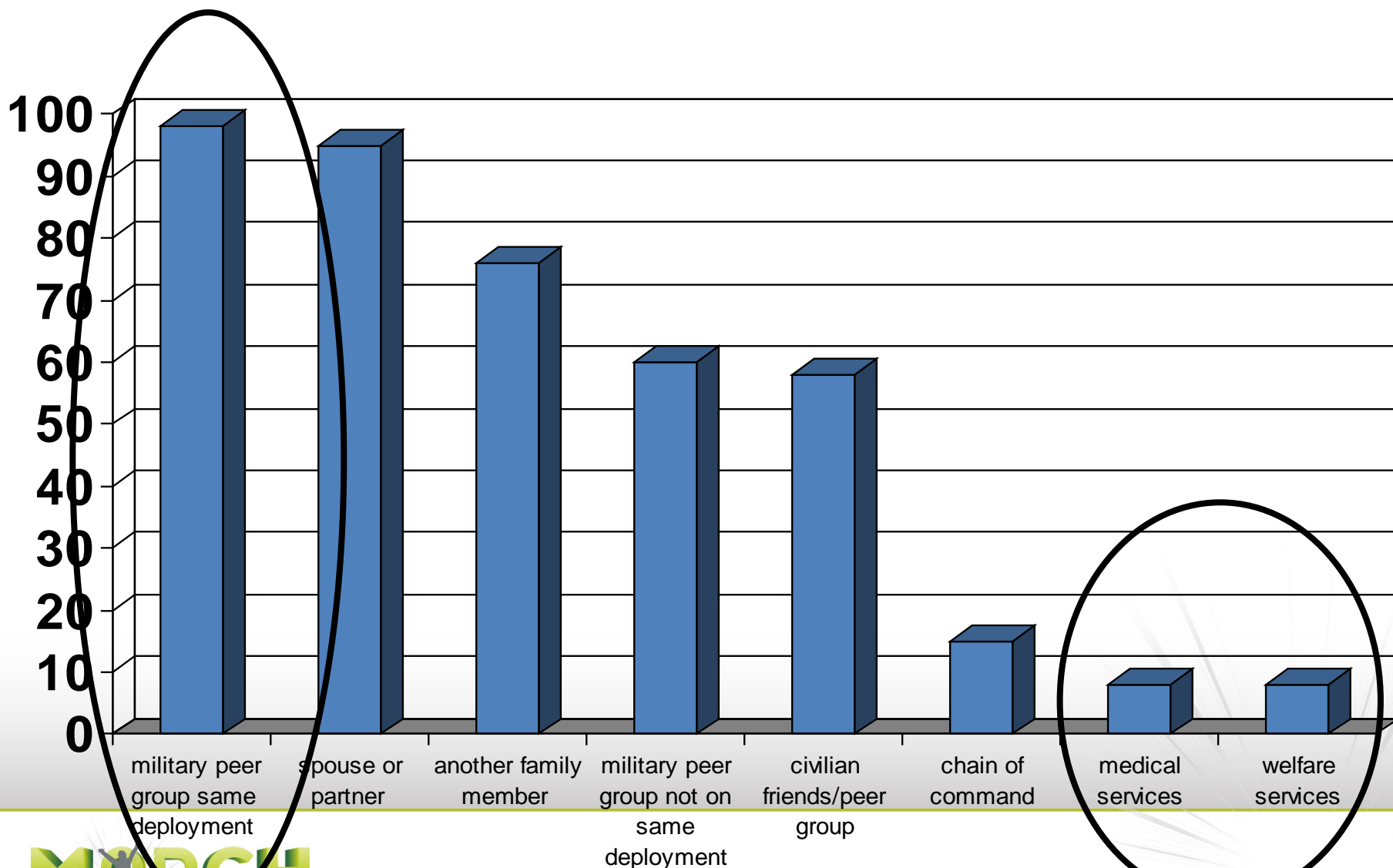
Exploring positive pathways to care for members of the UK Armed Forces receiving treatment for PTSD: a qualitative study

Dominic Murphy^{1}, Elizabeth Hunt¹, Olga Luzon² and Neil Greenberg¹*

Where do people get 'help' from?



Who do people get support from after work?



Learning points....

- Most people do not seek help for MH problems
- They tend to wait until the last moment before asking for assistance (? too late)
- When they do seek help they prefer informal sources over professionals

So....

- Organisational MH improvement is a complex intervention
- It requires a balance of approaches:
 - Primary
 - Secondary
 - Tertiary

Primary Prevention

- Policy
 - Sets culture (“this organisation believes that.....”)
 - Clarifies responsibilities (organisation and individual)
 - Details support options (EAP, BUPA, OH, staff counsellor etc.)
- Leadership training (esp junior leadership)
- Training should specifically aim to forge supportive teams

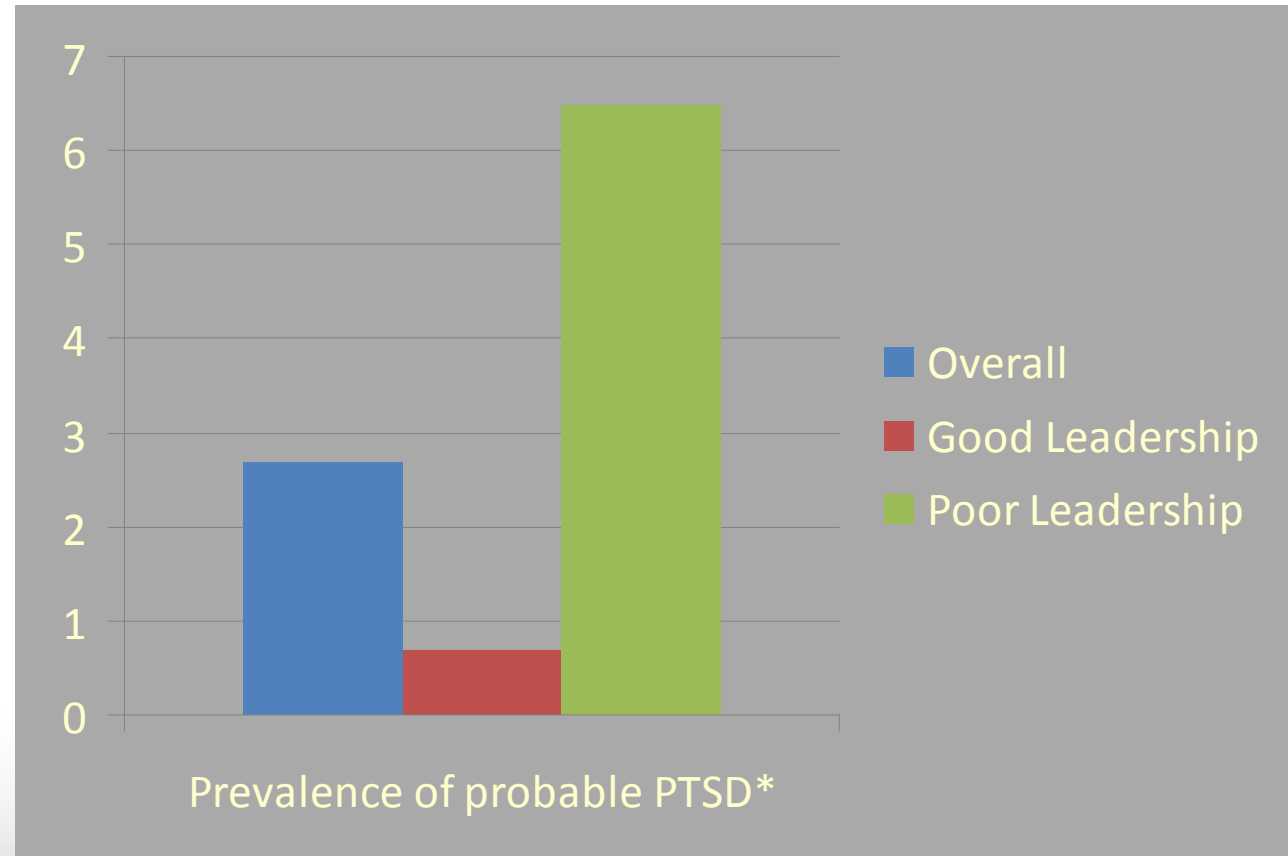
Leadership and PTSD – Afghanistan 2010

My immediate leaders do not:

Embarrass juniors in front of other unit members
Accept extra duties/tasks to impress their superiors

And do:

Treat all members of the unit fairly
Show concern about the safety of unit members



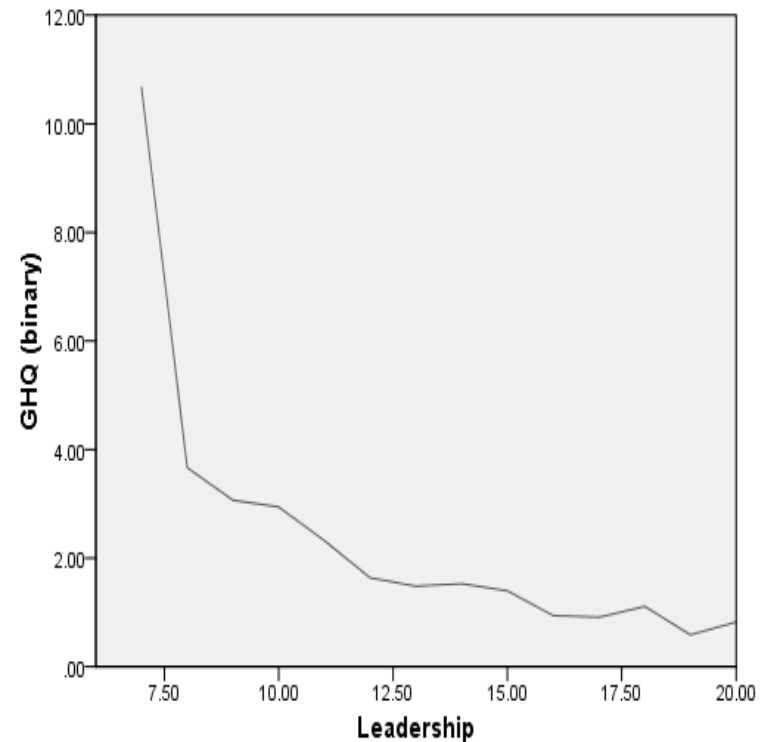
GHQ and Leadership (non-deployed personnel)

My immediate leaders do not:

- Embarrass juniors in front of other unit members
- Accept extra duties/tasks to impress their superiors

And do:

- Treat all members of the unit fairly
- Show concern about the safety of unit members



GHQ and camaraderie

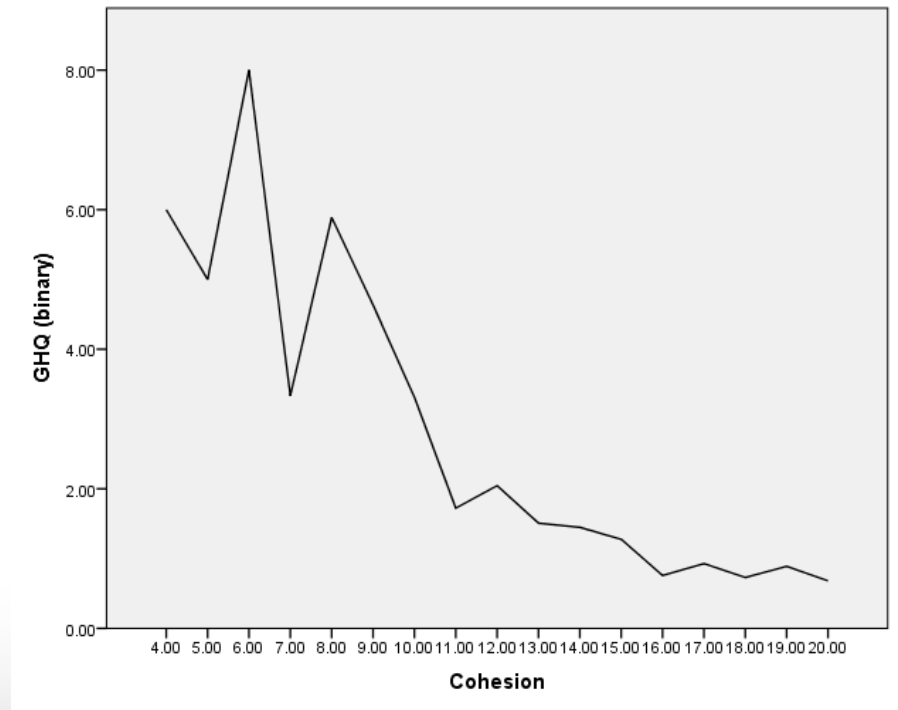
In my unit

I feel a sense of comradeship (or closeness) with others

I can go to most people when I have a personal problem

My seniors are interested in what I do/think

I feel well informed about what is going on



Secondary Prevention

- Early detection of emergent difficulties
- Proactively asking the right questions
- Overcoming FINE
- Monitoring and intervention by peers who know what to ask:
 - TRiM (trauma risk management)
 - StRaW (sustaining resilience at work)

Promoting organizational well-being: a comprehensive review of Trauma Risk Management

D. Whybrow¹, N. Jones¹ and N. Greenberg²

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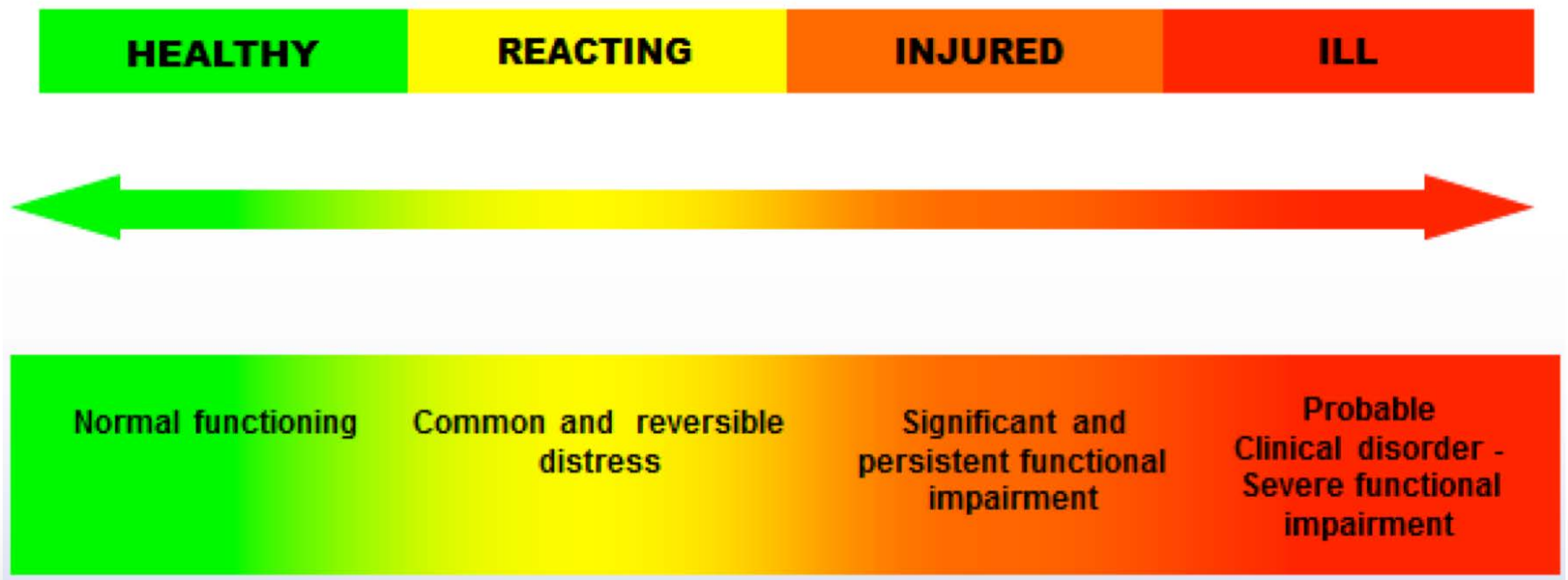
- www.kcl.ac.uk/kcmhr under publications

StRaW



- A peer support package designed to improve organisational **resilience**
- Based on good science and best practice
- A 'novel' approach for non-traumatic stress
- Empowers self-reliance whilst encouraging appropriate help-seeking

What to make of the information gathered during the StRaW interview?



Employee Under Stress Decision Pathway

Green Zone (Ready):

- Good to go
- Advise, reassure
- Check-in when possible
- Advise to make contact again if required

Yellow Zone (Reacting):

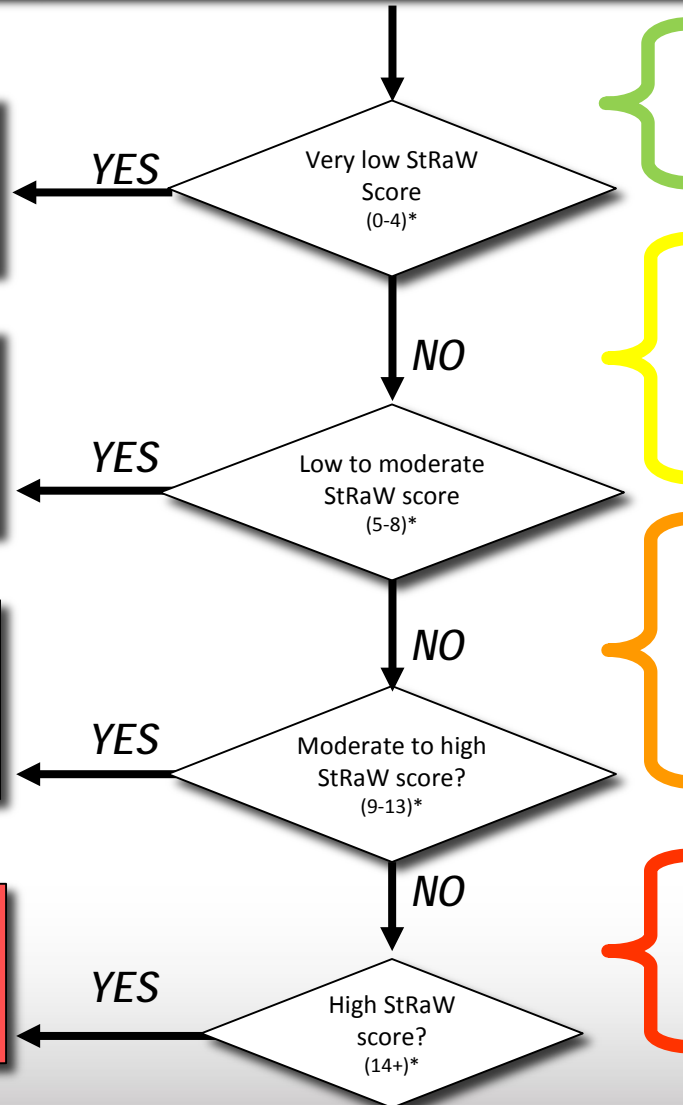
- Advise on self-care (including sleep/exercise//leave)
- Actively manage work, home & social stressors
- Consider mentoring/EAP etc
- Plan a review

Orange Zone (Injured):

- Improve self care (as above)
- Talk to manager/HR - consider temporary workplace adjustments
- Consider EAP/GP/BUPA
- Mentor and support
- Plan a review

Red Zone (Ill):

- Advise/support them to see GP
- Consider EAP/BUPA/Occ Health
- Ensure 'treatment compliance'
- Mentor back to work if possible
- Liaise with HR/boss



No Distress or Loss of Function:

- No major problems
- Possibly concerned about 'normal' symptoms

Distress or Loss of Function:

- Some difficulty relaxing and sleeping
- Decreased social/recreational activity
- Unusual and excessive fear, worry, or anger
- Some negative thoughts about self or future
- Difficulty performing normal role
- Mild change from normal personality

Significant Distress or Loss of Function:

- Great difficulty in falling asleep or staying asleep
- Withdrawal from social or recreational activities
- Uncharacteristic outbursts of rage/despair/panic
- Great difficulty controlling emotions
- Significant negative thoughts about self or future
- Loss of usual concern for moral values
- Unhelpful coping behaviour (e.g. alcohol)

Highly Distressed or Loss of Function:

- Difficulties lasting for more than several weeks
- Failure to cope
- Unable to continue as is
- Problems that get worse over time

*all scores are for guidance only

Peers as psychological mentors?

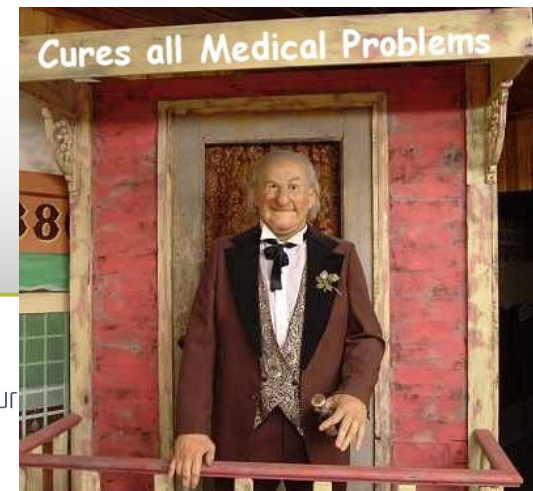
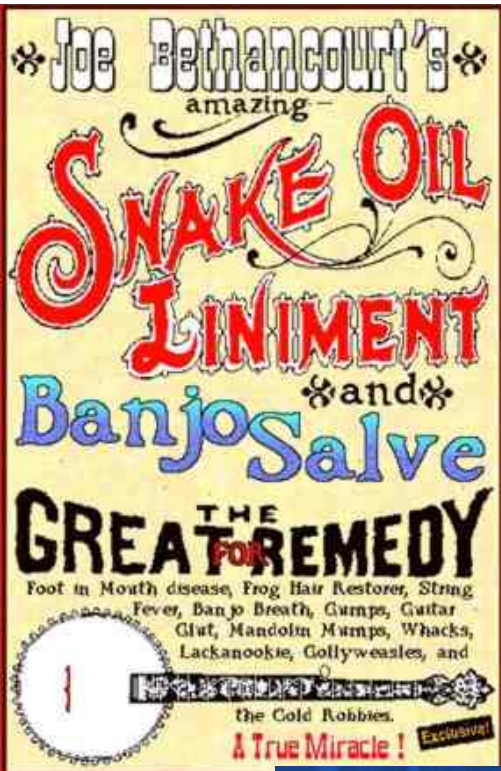
- Basic Cognitive Behavioural Therapy
- Motivational Enhancement Therapy
- Problem Solving Therapy
- Basic relaxation techniques (e.g. grounding)

And Tertiary intervention (treatment)

- Medication may well have a role
- Standard psychotherapies and many variants: e.g.
 - 1 day CBT 'resilience' workshops
 - Remote delivered therapy (inc Telephone, Skype, IM)
 - Compressed therapy (e.g. 1 week CBT for PTSD)
 - Guided self-help (has to be guided!)
 - Groups (e.g. BA)
- But you cannot ignore the psychosocial context
 - Poor training, uncertainty, harassment, leadership, home pressures etc



Beware - sellers of *Bad Science* often will say they have 'the answer'



Summary

- Lots of good reasons to proactively support staff at work
- Classic treatment only [?small] part of complex spaghetti bowl
- Paying attention to intra-organisational primary and secondary prevention good for resilience and effective RTW
 - Clear policy
 - MH informed leadership and workforce
 - Trained peers (TRiM and StRaW)
 - Stigma reduction
 - (Occupationally focused treatment services)

Any Questions?



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