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Mental health nurses' encounters with occupational health services

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Abstract

Background: Staff wellbeing is vital to the functioning of the UK National Health Service (NHS). Mental health nurses with personal experience of mental illness can offer a professionally and personally informed insight into the occupational health service offered by their employer.

Aims: To investigate mental health nurses' views of occupational health provision in the NHS, based on their personal experience.

Methods: A qualitative interview study using a purposive sample of mental health nurses with personal experience of mental illness.

Results: Twenty-seven mental health nurses met the inclusion criteria. Thematic analysis identified three themes: comparisons of 'relative expertise' between the mental health nurse and the occupational health clinician; concerns about 'being treated' by a service at their work; and 'returning to work'.

Conclusion: Occupational health provision in mental health settings must take account of the expertise of its staff. Further research, looking at NHS occupational health provision from the provider perspective is warranted.

Key words: mental ill health, NHS workforce, nursing, personal experience, occupational health

Introduction

All NHS organisations offer some form of occupational health (OH) provision for their staff, either commissioned externally or provided 'in house.' OH services for NHS employees vary depending on funding and commissioning arrangements, but the core service will include pre-placement checks and advice to staff and managers on health problems relating to work.¹ Whilst all NHS employees will have access to some form of OH service, not all will have access to a dedicated 'occupational mental health service.'² The aptitude of OH practitioners within the UK National Health Service (NHS) to screen for common mental disorders has been found to be variable, albeit in a profession with an appetite to improve its mental health literacy.³

The aim of this study was to explore mental health nurses' (MHNs) views of OH provision in NHS mental health services, based on their personal experience.

Methods

This paper presents qualitative findings from a sequential mixed methods PhD study⁴, approved by the Research Ethics Committee of the School of Health Sciences at City University of London. In phase one, 237 MHNs completed an online survey using validated measures of wellbeing^{4,5,6,7,8}. In phase two, 27 MHNs took part in semi structured interviews about their mental health and wellbeing. Participants were not known to the researcher beforehand. They had responded to the phase one national survey sent out by their professional body and had self-identified as having personal experience of mental health problems. Inclusion criteria for the interviews were: registered practising MHN; personal experience of mental health problems; completion of subjective wellbeing measures in the online survey. For this study there was no operational definition or 'cut off' point for mental health problems, rather participants were invited to self-determine whether they had such experience. The precedent for this definition comes from the terminology used in recent research on stigma in mental illness^{9,10}.

The number of interviews was determined by the number of survey participants meeting the inclusion criteria. All survey participants who met the criteria were invited to interview. The interviews took place between July 2013 and February 2014. They were conducted by a PhD student with a mental health nursing background under supervision from two experienced mixed methods researchers.

Interviews were conducted in person (n=12) or via Skype (n=15), lasting between 36 and 82 minutes. A topic guide was used. The interview schedule had been developed in collaboration with a mental health research group and a mental health service user reference group. The interviews were piloted with two volunteers prior to being approved for use in

the final study. Pseudonyms were used in interview coding and writing up. Audio recordings of the interviews were transcribed verbatim. Transcripts were coded using NVivo software. Reliability and validity of coding were assured through comparative coding of a sample of the transcripts. Interview transcripts were subject to thematic analysis, using Braun and Clarke's¹¹ method which derives both active and passive themes.

Results

Participant characteristics are summarised in Table 1. Twenty-two participants were female, five were male. Their experience of nursing ranged from a few months to 26 years, working in a variety of settings including forensic inpatients, outpatient memory assessment services, specialist psychotherapy and acute psychiatry. All had personal experience of mental health problems, either their own or a close family member's. The nurses lived throughout the UK, from the South West Peninsula to the Scottish Islands.

The sub-theme of 'experiences of OH services' emerged within the major theme of 'mental health nursing work and my experience of mental health problems'. In this paper we focus on the OH theme because of its particular interest to OH clinicians. Findings on the impact of participants' experiences of mental health problems on their clinical work have been presented in previous publications^{12,13}.

Participants described a range of experiences of their employer's OH service, from 'absolutely wonderful' to 'they weren't very helpful at all'. Principal findings were that three common sub-themes emerged relating to OH services, Firstly, several participants were concerned by their perception of a relative lack of expertise in mental health of the OH clinicians to whom they had been referred. A second theme was rejection of OH input, linked to anxiety about being 'treated' in the same services and by the same professionals where

they worked. A third theme was 'negotiating the return to work,' with participants having mixed experiences of how the return was broached and managed. The genesis of these themes within the overall study is presented in Table 2.

Within the first theme of 'perceived lack of expertise', MHNs expressed concerns about a mismatch between their knowledge of mental health assessment and that of the OH clinician. For some MHNs the OH clinician they saw had raised a differential in expertise themselves:

'Well, the woman whom I saw had no experience in mental health at all. She was a general nurse. And so she just had no idea, really, you know. I mean, to be fair, she did say 'I have no idea.'

For one nurse a mismatch of expertise between herself and the OH clinicians was anticipated rather than experienced. She discussed how she avoided accessing OH services due to a fear of what the other MHNs had described about their experiences:

'I'd want to know they were more experienced than me in mental health to deal with my mental health. I don't want to go to someone who has done a module on mental health in their occ health (sic) training to know about my mental health.'

The MHNs' perceptions of mental health expertise or lack of it among OH clinicians demonstrated the critical gaze which they as mental health professionals cast on their own experiences as service users or patients. One newly qualified nurse, described undertaking an OH assessment as part of the application process for nurse training. She submitted to a request from the OH clinician, describing the experience as 'mortifying': Because of a

self-declared past history of self-harm, she was asked to remove her tights and show her legs in the assessment, in order to prove she had no recent self-harm wounds. She said:

'I was only 17 when he was doing it [an OH assessment]. I didn't want my chances to be affected by me as a stupid wee girl at the time.' Since qualifying as a MHN she had reflected on this encounter and deemed it inappropriate and misjudged.

Within the second theme, participants described rejecting OH input on managing their condition at work. One nurse, who worked in a specialist forensic setting, had not gone to her OH service because she did not consider the practitioners had sufficient understanding of her work. OH for her organisation had been contracted out to a non-NHS OH service. Based on prior experience of the service following a workplace injury she said:

'Because they don't tend to understand forensic nursing. I mean, for example, ****(the OH service provider) give return-to-work interviews and don't even know what control and restraint is, or, you know, if somebody has an injury, and they go for an interview, they say, well, you know, do you think I'm fit to respond, and they don't even know what control and restraint is.'

Here the mixed economy of NHS OH provision was highlighted. Whilst one nurse associated her OH service being outsourced with lack of grasp of mental health work, other MHNs had not declared their mental health problems at work because they were concerned about the service being provided in-house. There was a fear of exposure and broken confidentiality. For one nurse this was due to her overhearing a colleague talk about a friend who worked in the OH service. In contrast another nurse described a positive experience of his OH service because he had seen a counsellor who was employed by and known within his trust. For him this was a strength of the OH provision.

The third theme was 'negotiating the return to work.' For some participants, OH contact was limited to negotiations about returning to work. This was not a therapeutic encounter. For some MHNs who had rejected OH input, the relationship with OH was functional and procedural with a focus on sickness absence monitoring and phased returns. In one case, limited interest and input from the OH service was welcome, and reflected for the MHN an acknowledgement that her sickness absence was being resolved. Another MHN's account of a positive OH experience conveyed that the OH clinician had some authority and took charge whilst she was in a difficult situation.

In summary, across the three themes MHNs critically appraised OH provision from their standpoint as mental health experts. Whilst a range of experience were described, with some MHNs describing excellent organisational responses to their mental health needs, the common thread was the way that MHNs critically appraised their experience of OH services based on their expertise in mental health work. This was similar to their critical appraisal of their experiences as patients and carers, as previously reported^{12,13}.

Discussion

This study discusses the perceptions and experiences of MHNs of their employer's OH services. OH provision within mental health care provider organisations has not been extensively researched. While literature that has looked at nurses' experiences of mental health problems at work has addressed 'return to work' plans and attitudes of colleagues,^{14,15,16} the role of OH services for MHNs has not previously been explored in depth, save for one study¹⁷ which surveyed MHNs' views on a Scottish OH service. They found that while MHNs were aware of the OH service, they preferred to self-care or to get

informal support from colleagues. Similarly, in the present study self-care was often a preferred option, due to a lack of confidence in the OH provider.

There is insufficient evidence to determine whether participant's concerns about relative expertise and potential risks of declaring mental illness at work are commonly held or warranted. However, these findings accord with previous studies of doctors' views of OH services. In their review of the literature on the mental health of doctors, making the case for a dedicated Practitioner Health Programme, Brooks, Gerada and Chalder¹⁸ describe similar fears and experiences as described by the interview participants in this study. Doctors may not seek help for mental health problems because of concerns regarding confidentiality and the implications of their ill-health for their professional standing. MHNs in this study either feared or experienced a lack of skill from their OH service, or were not comfortable receiving treatment from the same organisation for which they worked. Burman-Roy et al² found that workers presenting at their specialist occupational psychiatry clinic were often still in work yet 'between' primary and secondary services. They argued that OH services should bridge this gap for employees. This suggests that OH clinicians should be open to providing a therapeutic as well as a practical service.

This study shows that MHNs can be disappointed with the mental health aspect of their employer's OH service. This finding reflects a previously found mismatch between health worker expectation and what is on offer from NHS OH services¹⁹, which may be addressed through the OH clinician offering a clear explanation of their role at every consultation. This recommendation is reiterated in a recent systematic review of characteristics of effective collaboration between employers and OH services²⁰. The allegiances that OH clinicians have to both the employer and the employee²¹ should be stated. Given the limitations to what may have been commissioned from an OH service, it may be unrealistic or

unreasonable for a MHN to expect their OH consultation to be a purely therapeutic encounter, although, of course, all medical or nursing consultations would be informed by the relevant codes of professional conduct, which place care for the patient at the centre of all practice^{22,23}.

In our study we found that whilst stigma was a factor, nurses did not seek help from the services available at work due to a fear or experience of not being understood, and for their professional expertise not being taken into account. Again, these findings accord with similar research on doctors with mental health problems. Henderson et al²⁴ found that 'self-stigmatisation' as well as fear of reproach from others was a feature of doctors' accounts of taking time off due to ill health. Garelick²⁵ argues that doctors don't seek help for psychiatric problems due to stigma, but also due to symptoms and traits associated with mental ill health: the pessimism associated with a depressed state of mind and common personality traits associated with being a doctor. Lack of disclosure and lack of engagement with services perpetuates stigma by masking the extent of mental health need within the workforce and therefore limiting the allocation of resources.^{24,26,27}

The findings of this study are based on a single cohort of interviews. This limits generalisability to the MHN profession as a whole. However the sample of nurses interviewed was from different parts of the UK, working in a number of different NHS organisations. The specific context of the NHS should also be taken into account, meaning that these nurses' experiences of OH may be unique to the geographical and political context of UK healthcare. This paper presents selected findings from a mixed methods study with a broad research question and accordingly, only tells part of the story of MHNs' wellbeing. The wider study found that MHNs overall have a low subjective wellbeing^{4,5}. The study also found that there were some clinical advantages to nurses having personal experience

of mental health problems, namely as a motivator to work in the field and a source of enhanced understanding of, and empathy for, their patients¹². The findings are important nonetheless because they offer a critical perspective on occupational mental health, and provide an insight into why some nurses may not disclose their mental health problems at work.

Nurses in this study were critical of the care and treatment they had received in various settings, but of particular interest to employers is their view that OH services may not provide MHNs with mental health advice or treatment that reflects the MHNs' own expertise in the field. Where employers may be commissioning OH services or where employee health and wellbeing strategies in mental health service providers are being developed, employers should take account of the knowledge and skills of their employees. Their expertise should be used in both the design of services, and the development and implementation of OH policies. Occupational mental health services within organisations employing MHNs must be reflective of the specialised nature of mental health nursing work.

Key points:

- NHS employers commission occupational health services for their staff, however the extent and quality of occupational mental health provision is variable.
- Mental health nurses with personal experience of mental health problems criticise their employer's OH service from their 'expert' perspective as mental health patients and mental health professionals.
- Stigma affects engagement with employer's OH services, as does a lack of awareness of the role and remit of the OH clinician.

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Table 1: Participant Characteristics

| Pseudonym | Gender | Age | Ethnicity | Job role |
|----------------------|---------------|------------|------------------|--|
| 1. Ellen | f | 30-39 | WB | Community Mental Health Nurse |
| 2. Rob | m | 40-49 | WB | Staff Nurse |
| 3. Patty | f | 60 plus | WB | Cognitive Behavioural Therapist Nurse |
| 4. Ryan | m | 21-29 | WB | Staff Nurse |
| 5. Melissa | f | 50-59 | WB | Community Mental Health Nurse |
| 6. Joanna | f | 30-39 | WB | Cognitive Behavioural Therapist Nurse |
| 7. Carrie | f | 30-39 | WB | Senior Psychological Wellbeing Practitioner |
| 8. Eleanor | f | 21-29 | WB | Staff Nurse |
| 9. Rose | f | 40-49 | WB | Community Mental Health Nurse |
| 10. Yvonne | f | 40-49 | WB | Clinical Nurse Specialist |
| 11. Neil | m | 50-59 | WB | Clinical Nurse Specialist |
| 12. Diana | f | 30-39 | WB | Community Mental Health Nurse |
| 13. Heather | f | 21-29 | WB | Specialised Dementia Unit Staff Nurse |
| 14. Fiona | f | 50-59 | WB | Staff Nurse |
| 15. Sylvia | f | 40-49 | WB | Staff Nurse |
| 16. Monica | f | 40-49 | WB | Staff Nurse |
| 17. Christine | f | 40-49 | WB | Community Mental Health Nurse |
| 18. Norman | m | 30-39 | WB | Community Mental Health Nurse |
| 19. Ruth | f | 40-49 | WB | Community Psychiatric Nurse |
| 20. Jackie | f | 40-49 | WB | Crisis Resolution Home Treatment Team Senior Nurse |
| 21. Trevor | m | 60 plus | WB | Community Mental Health Nurse |
| 22. Tracy | f | 21-29 | WB | Outpatient Clinic Nurse |
| 23. Zoe | f | 21-29 | WB | Staff Nurse |
| 24. Alison | f | 40-49 | WB | Crisis Resolution Home Treatment Team Senior Nurse |
| 25. Chloe | f | 30-39 | WB | Dementia Care Staff Nurse |
| 26. Lucy | f | 40-49 | WB | Bank Staff Nurse |

Table 2: Thematic Thread of MHNs' Experience of Occupational Health Services

| Research question | Broad Qualitative themes* | Sub themes* | Occupational health sub themes |
|--|---|--|---|
| How do UK mental health nurses negotiate, use and manage their own mental health and wellbeing? | Mental health nursing work and my experience of mental health problems | <ul style="list-style-type: none"> • Experience of occupational health services • Colleagues and managers • Use of self - nursing identity • Use of self - disclosure and boundaries • Motivation and career choice | <ul style="list-style-type: none"> • Percieved lack of expertise |
| | Subjective experience of mental health problems | <ul style="list-style-type: none"> • Family history • My life at the time • My experience of health care work • Experience informing personal experience | <ul style="list-style-type: none"> • Rejecting OH input on managing their condition at work. |
| | Looking after my subjective wellbeing | <ul style="list-style-type: none"> • Activities • Attitudes • Other people relationship w work • Using work skills on myself | <ul style="list-style-type: none"> • Negotiating the return to work |

*findings from other themes and subthemes have been presented in other journal publications^{12,13}

