GREATER MANCHESTER POLICE

Our ref: 01/FOI/24/013580/Q
Please quote our reference number when responding

Monday, 25 November 2024

FREEDOM OF INFORMATION REQUEST REFERENCE NO: 01/FOI/24/013580/Q

I write in connection with your request for information dated 03/11/2024, I note you seek access to the following information:

1. Please provide a copy of your policy for dealing with officers who say they have suicidal thoughts.

The senior coroner for Greater Manchester North, Joanne Kearsley has recently commented on the treatment of a [redacted] student officer, [redacted], who killed himself:

'Kearsley also said the triaging of [redacted] case was "flawed" after he had disclosed the suicidal thoughts and that he should have been offered an urgent face-to-face appointment with the force's occupational health unit.'

2. For the year 2023/24, please provide (i) the number of officers offered urgent face-to-face appointments with your occupational health unit because of suicidal thoughts and (ii) the number of appointments officers had with your occupational health unit because of suicidal thoughts.

3. Please provide the number of staff in your occupational health unit (FTE).

Result of Searches

Following receipt of your request searches were conducted within Greater Manchester Police to locate information relevant to your request. I can confirm that some of the information you have requested is held by Greater Manchester Police.

Part 1 – please see the Stress and Mental Health Guidance for Managers V9 at the bottom of this email

Part 2 – No information held.

OHWS do not hold this type of data because when an officer or staff presents to supervision or is observed to be struggling with their mental health to the extent that they are experiencing suicidal thinking action is taken to immediately respond by giving advice and guidance to direct the individual to the NHS A & E, consider the use of the MHA, direct to individual to the GP or to facilitate a welfare check. OH is not an emergency service, within another scenario if an individual had an appointment with OH and within that assessment or review they expressed suicidal thinking which is an element within the assessment used we would explore this in context of intent and plans and then act accordingly to achieve a safe plan, we would also liaise directly with the GP if required.

Part 3 - FTE 26.4, Source – Force Posting Information as at 04/11/2024

GREATER MANCHESTER POLICE

Stress and Mental Health

Guidance for Managers

Version 9

17 July 2024

DATE THIS VERSION OF THE TOOLKIT IMPLEMENTED: July 2024

DATE NEXT REVIEW IS DUE: July 2026

TOOLKIT OWNER: Strategic Policy & People Relations Team

APPROVED BY: Chief Officers

GOVERNMENT SECURITY CLASSIFICATION: Official

IS THE TOOLKIT NEW OR REVISED: Revised

VERSION NO	DATE	SUMMARY OF CHANGES	AUTHOR(S)
1	April 2016	New Guidance to support the new approach to attendance management.	Policy and People Relations, HR
2	Mar 17	Updated to reflect change to include HR Transformation Changes re contact details for both GMSS and Boroughs	Policy & People Relations, HR
3	Aug 2017	Reviewed due to change in terminology from Psychological Ill Health to Mental Health and the inclusion of Suicide Prevention.	Policy & People Relations, HR
4	Sep 2019	Amended to change Wellness Action Plan to Wellness Plan.	Policy & People Relations, HR
5	Jan 2021	Information on Wellbeing Passport included. Amended due to Branch review.	Strategic Policy & People Relations
6	Oct 2021	Update change Employee Assistance Programme (EAP) from CiC to Health Assured	Strategic Policy & People Relations
7	07/07/2022	Update to reflect change in Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) (Amendment) (No. 2) Regulations 2022 increasing range of healthcare professionals authorised to issue fit notes.	Strategic Policy and People Relations Team
8		Updates to workplace adjustment information following ACAS updates.	Strategic Policy and People Relations Team
9	17/07/2024	Updated with new cipher and rebrand of OH&WS (previously OHWU)	Strategic Policy and People Relations Team

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Introduction

Your role is crucial in managing attendance, not only by dealing with attendance effectively and supportively; but also by seeking to prevent sickness absence.

Staff need to feel that they can raise work-related and non-work-related concerns or health problems with you; in the knowledge that they'll receive a sympathetic hearing and a tolerant and flexible response.

You're not expected to be clinicians, and this guidance won't replace medical or specialist advice where it's needed.

This guidance will help you support staff who are dealing with stress and mental health issues by explaining more about these conditions and suggesting ways in which you can assist them.

It should be read in conjunction with the following documents:-

1. Attendance Policy
2. Short Term Sickness Management Toolkit
3. Long Term Sickness Management Toolkit
4. Disability At Work Policy
5. Disability Management Toolkit

Additional guidance documents are also available on the following conditions:

1. Serious and Chronic Health Conditions.
2. Musculo-skeletal Disorders.
3. Disability Assessment Form and Guidance

With stress, and to some extent with mental ill health, there is a genuine possibility of ***preventing*** absence if you spot the signs early enough and talk to the individual; or if they approach you to discuss their problems.

This approach is more likely to be successful where there is mutual trust.

Remember, confidentiality is a key factor in establishing and maintaining trust. Staff may have particular concerns about discussing their personal circumstances which are putting undue pressure on them, or the fact they're suffering from a health condition which is of a psychological nature.

In the police service there have been understandable concerns about using terms such as "mental health" and "mental illness". For this reason, we have previously used the

terms “psychological ill-health” and “psychological sickness absence”. Through various publicity campaigns, we’re working to reduce concerns about the perceived stigma of mental health issues. There’s only physical health and mental health and we now need to use such terms appropriately. Please note that the expression “mental health problems” isn’t appropriate. On the other hand, “mental health”, “mental health issues” and “mental ill-health” **are** deemed to be appropriate.

Stress

Stress may lead to an absence from work; but can also be a factor where people are in work, but not working as effectively as they might. This is sometimes referred to as “presenteeism”.

Stress is not itself a health problem but it may lead to health problems. Stress is the feeling that people get when they become anxious that they can no longer cope with the pressures they’re under. This may be because of issues in their personal lives, or it may be work related. It could be a combination of the two.

However, use of the term “stress” isn’t always helpful. People may be working under pressure but might not be suffering from the adverse reactions of stress. It’s likely that people can deal with temporary high levels of pressure; but if these are prolonged the situation could cause the person to suffer from stress and at worse from stress-related ill health. Possible causes can include:

- Physical health problems (being stressed or depressed can add to such problems – see Appendix 1)
- Excessive tiredness, whether due to lifestyle, additional responsibilities outside of work or the demands of the role (one cause can be volunteering for lots of overtime - see Appendix 2)
- Personal or family problems e.g. when childcare or other caring responsibilities impact on an individual’s ability to work normally, moving house, financial worries, relationship breakdown etc.
- Demotivation and/or specific problems in the workplace including:
    - The role undertaken, the volume of work, deadlines, inability to control one’s own work etc.
    - Perceived lack of support
    - Difficult working relationships or conflict with colleagues
    - Anxiety caused by organisational change
    - Bullying or harassment

- Other factors causing dissatisfaction such as ineffective procedures or equipment, or a lack of clear direction or goals.

Appendix 3 summarises the HSE Stress Management Standards and lists some specific stressors found to be a factor in sickness absence in the police service, caused by stress.

Managing your own stress

Remember that you may become stressed too. Working under pressure is **not** stress but if you are anxious, or are becoming anxious, and if the description above has given you cause for concern, decide whether there is something you can do for yourself, or where you might get support if you want it.

Consider whether ***you*** feel able to confide in ***your*** manager. Consider whether you should consult your local Wellbeing Resilience Coach. Consider whether contacting Health Assured will help ***you***.

Mental Health

Mental health problems can:

- happen suddenly, because of a specific event in someone's life
- build up gradually over time
- be hard to spot because everyone has different signs and signals
- be hidden because many people find it difficult to talk about their mental health
- fluctuate over time which means that an employee's ability to cope with the demands of the job might change

Anxiety and Depression

At any one time about a sixth of the population will suffer from “minor” symptoms such as sleep problems, fatigue, irritability and worry. These don’t meet the diagnostic criteria for treatment but may still affect the person’s ability to function fully.

A further sixth of the population have symptoms which, because of their nature, severity and duration, would warrant treatment if brought to the attention of a healthcare professional. They’re usually treated by or via GP services in “primary” care settings. Many people, however, won’t seek treatment because of concerns about being stigmatised if they were to reveal such a problem to their managers and colleagues.

People with mental ill health are more likely to suffer from poor physical health and vice versa. Not only does serious or chronic illness cause anxiety and/or depression but being depressed can cause people to notice and report more physical symptoms.

An ongoing concern is the possibility of chronic, episodic ill-health. Appendix 1 identifies how people at work can suffer from depression because of concerns about physical health or because they've suffered from anxiety and depression previously. They may continue to suffer symptoms and may still be taking prescribed medications and/or undergoing therapy. This may affect their ability to undertake their full role. It's also possible that they don't manage their own health very well (see the Guidance on Serious and Chronic Ill-Health which includes the need for effective self-management and the role of the manager in helping individuals to achieve this).

On the other hand, we should understand that many people with a mental health diagnosis are healthy and are performing well at work. They may be managing their condition through medication, talking therapy and via the ongoing support of their colleagues and managers.

An organisation can help or hinder a person's efforts to remain in work. You can help them by ensuring that the demands of work are not beyond their current capacity; that they perceive that they've some say in the way they can control their work and that they perceive your approach as being supportive. Asking the individual what would assist them is the first step to providing that support.

Mental Ill-Health

The proportion of people in work who suffer from more severe mental ill-health is much smaller. (See also Guidance on Serious and Chronic Ill-Health).

Depression

Can be mild or moderate but it can include symptoms which are difficult for the person to deal with on their own. Severe depression (clinical depression) can cause a person to be suicidal.

Anxiety

May be associated with a variety of symptoms but its more severe forms can include panic attacks, phobias or obsessive-compulsive disorder (OCD).

Eating disorders

Can remain hidden for some time but can have a severe effect on the person's mental wellbeing and can lead to physical health conditions.

Bipolar disorder

Is characterised by extreme mood swings, varying from manic behaviour to deep depression. It can be managed through medication and therapeutic interventions which include an element of talking therapy; not least to ensure that the person complies with their medication regime.

Schizophrenia, personality disorder and suicidal feelings

Can all be very difficult for the individual to deal with but also can be very demanding on managers.

Suicidal Feelings

Please refer to additional guidance at Appendix 4 – Suicide Prevention. The Appendix includes a list of behaviours which might indicate that a person has such feelings. About two thirds of people who die by suicide have not been in contact with mental health services in the year before they die for treatment for conditions such as those listed above.

Men are more at risk than are women. The age group with the highest rate of suicide is 45 to 59 years for both men and women. Bereavement can be a factor especially if the person concerned died by suicide.

Alcoholism

Has a variety of stages. It's not uncommon amongst shift workers and workers in the emergency services. Even where a person has admitted their problem and is dealing with it; there may be relapses. This does not mean that the person won't succeed in defeating this problem or holding it at bay. It does mean that a Wellness Plan or similar agreement/ understanding has to be in place in order to deal with relapses. This is particularly important in the police service where a conviction for drunk driving or drinking on duty, for example, could result in dismissal.

Having a Wellness Plan in place can be helpful in many cases and might be crucial in others.

Further information can be found in the Wellness Plan guidance.

Supporting Staff to Remain in Work

Spotting the Signs

Where you know the individual well, you may notice changes in their behaviour. This should prompt you to speak to them privately so that you can enquire after their health and wellbeing as well as to offer your support. If the person tries to end the conversation using words such as “I’m fine” it could be appropriate for you to explain why you have concerns about them.

Other signs might include:

Appearance

- Lack of care or interest in appearance / self-care
- Looking miserable or exhausted
- Looking more nervous or anxious.

Habits

- Poor time-keeping, missed deadlines; or conversely arriving early and/or leaving work late
- More mistakes at work – or they could be more accident prone
- Increase in sickness absence or time off – sometimes brief but at short notice
- Changes in appetite for food but also for cigarettes (if a smoker) and for alcohol

Behaviour

- Loss of sense of humour
- More irritable or aggressive
- Becoming quiet or withdrawn, becoming more isolated from colleagues
- Tearfulness
- Becoming more talkative, sometimes raising the same issue(s) frequently
- Drop in performance
- Poor concentration
- Poor decision-making
- Mood swings, including becoming tearful

Fatigue

Stress may be caused in part by fatigue, but fatigue can also be caused by stress. People can underestimate the effects of fatigue on them. They may think that they “ought” to be able to manage their home life and their duties at work without expressing concern about fatigue. Fatigue should be considered as a potential cause of some of the signs you

might see when a member of staff appears 'below par', such as irritability, moodiness, impulsiveness or lacking in concentration.

Appendix 2 provides further information about how to recognise and deal with Fatigue.
An individual may have been dealing with personal circumstances at home and/or at work for some time and may not have realised that their behaviour and mood has changed so much. Alternatively, it's possible that the person has had bad news recently concerning themselves or a family member, or that some other sudden circumstance has occurred. They may be shocked by what is happening to them or to someone else, or by something they've seen or heard.

At times people will blame something that happened at work for their behaviour. This may be due to perceptions about the way they've been treated by the organisation, which may include you as their manager.

Although one single issue can prove very stressful; it's often the case that an incident or issue which is complained of is the "final straw"; on top of a mixture of other stressors.

Offering Support

In an ideal situation, an individual would remain in work but would provide you with a "Fit Note" from their GP or other authorised healthcare professional; explaining that they were suffering from stress/anxiety/depression and that temporary adjustments would benefit the individual and keep them in work.

However there will be many occasions when an individual hasn't supplied a Fit Note and may not have spoken to you at all about their current concerns and state of health; where you could be called upon to:

- Spot the signs
- Provide immediate, appropriate and relevant initial support if the individual is temporarily incapacitated by their distress. In the most severe cases you might have to decide, as you would with a physical injury to seek urgent medical assistance e.g. by taking the person to Accident and Emergency.
- More likely you would need to begin to discuss what support and temporary adjustments the individual needs, in order to be able to continue coming to work.
- Consider whether you should merely remind or inform the individual about the support available from GMP's external Employee Assistance Programme (EAP – current provider Health Assured) or whether you need to make the initial contact on their behalf.

- The individual might also benefit from being signposted to your local Wellbeing Resilience Coach and/or the GMP Mental Health Support Network.
- You'll need to monitor the situation and to ensure that the person knows how to seek additional support at any time, whether from yourself or a colleague.
- You should also check in with them again and ask them how they are – this is how ongoing support is provided and perceived.

Once you've been made aware that the individual is struggling, support should be offered.

This could include doing the following:

- Check in with them – for example, ask how they are and if they need help.
- Recognise changes in their behaviour.
- Try to understand how their mental health impacts them.
- Understand that adjustments might not work the first time, and might need to change over time (see information about workplace adjustments below)
- Be flexible in your approach and respond to changing needs.
- Show ongoing support – mental health fluctuates over time and adjustments might need to be in place for days, weeks, months or sometimes years.
- Consider the needs of the individual and the team in case anything needs to change.
- If you're unsure of what to do, you should seek help from GMSS.

Dealing with people who are visibly distressed or emotional

Stress and having to deal with mental health issues can lead to staff experiencing distress whilst at work.

As a manager, you ***should*** hold people to account over issues of conduct or performance, including frequent absences; but only after you have considered whether these might be signs of stress or related health problems so that you can take a suitable approach.

When given the opportunity to talk about personal issues affecting them, it can lead to them appearing distressed when they have been working hard to 'put on a brave face' in the workplace. But giving them the time and opportunity to talk about the cause of their distress can be a relief for them too and though it may feel uncomfortable for you, it demonstrates a level of trust they have in you. They don't expect you to solve their problems or have all the answers, but they will appreciate you genuinely asking what you can do to support them. Offer them a break from the conversation if they'd prefer it but ensure they are not left alone if you have real concerns for their immediate welfare. Don't be afraid to ask them if they've considered harming themselves. This won't put the idea in their head but will give them 'permission' to share suicidal thoughts they may be

experiencing. Be prepared for how you will respond if they do share these concerns. Keep calm and reassure them that there is support available to them. Seek support ensuring they're not left alone till immediate concerns pass.

Discussing Issues with Staff

You're not expected to be a counsellor; however you ***are*** expected to deal with the individual in a sensitive manner, privately, keeping their issues confidential, not putting pressure on them to reveal external problems and trying not to be judgemental about any issues raised, or defensive when the issues relate to the workplace. You need to understand their perceptions before you can deal with the reasons for them being stressed or off work sick. You should lead the discussion - although it's often the case that once you have made a start the individual will then explain their situation at some length.

Tips on how to hold such a discussion:

- When explaining your concerns to an individual say "I" not "we" to avoid giving that person the impression that people are talking about them. Later on, when discussing potential solutions, you can use the term "we" to show that the person and yourself are working on the solutions together.
- Don't avoid the issue; if someone has come to ask for help it may have been very difficult for them to reach this point. If you delay the conversation this may stop them from sharing their concerns with you.
- Be aware of your body-language; do you look like you are relaxed but paying attention? Or do you look uncomfortable or watching the clock?
- If you know someone has been unwell, don't be afraid to ask how they are.
- Ask open questions. How are they, what impact is their problem causing (not necessarily work-specific), what solutions have they thought of – while appreciating that a distressed person may not be able or ready to discuss potential solutions?
- Avoid clichés: comments such as "Cheer up", "I'm sure it will pass" or "Pull yourself together" won't help.
- Try to be open-minded and non-judgemental, not just about the health problem but also about the individual's lifestyle etc., the details of which might be new to you.
- Is this an on-going issue or something that immediate action could put right?
- Has work contributed to their distress?
- Are there any problems outside work they might like to talk about and which it would be helpful for you to know about?

- Ask how you can help: people will need support at different times and in different ways; so be prepared for additional responses to this question in subsequent discussions. You may need to give the person time to mull things over and get back to you.
- Is the person aware of external sources of support (if they've an on-going problem they may already have accessed such services e.g. bereavement counselling, alcohol services)?
- Is the person aware of sources of support which can be accessed as a GMP employee (which includes Specials) e.g. the Employee Assistance Programme (EAP), currently provided by Health Assured?
- Is there any aspect of the person's medical care you should know about? They do **not** have to divulge medical diagnoses or prescribed medicines etc., but if in work they have a duty to divulge what they know about the possible side effects.
- Does the person have any ideas about any adjustments that might be helpful, either short term or long term? (This is why an Individual Stress Risk Assessment is useful i.e. in teasing out issues and potential adjustments).
- If the individual has been dealing with an on-going mental health problem that you didn't previously know about; they can choose to explain what coping strategies they've been using- which might assist any discussion about adjustments.
- It's useful to discuss communications; for example whether there is information they'd be willing for you to share with their colleagues. Otherwise you should treat all of the information shared with you as being confidential. You also need to discuss how they prefer future contact to be made and whether they'd be happy for one or more colleagues to contact them.

Where practicable (which may require more than one discussion) you need to reach an agreement with the person as to what will happen next, who will take action and record the agreement (another reason for using the Individual Stress Risk Assessment).

Suicide Prevention

The causes of suicide are complex; but there are steps we can take to reduce the risk.

"***The best foundation for suicide prevention is a holistic approach to health and wellbeing in the workplace, which encourages employees to understand its importance and to be open about their concerns and anxieties***." Nigel Jones, Chair, Mental Health Alliance

Dealing with Myths about Suicide

1. Not all people who die by suicide have mental health issues; 2 in 3 are not known to mental health services.
2. People who threaten suicide should not be assumed to be seeking attention; all such statements should be treated seriously and should be seen as an opportunity to discuss what help they can access.
3. People who attempt suicide are at an increased risk of trying again without appropriate support. It has also been shown that a high number of people who have died by suicide had practiced self-harm.
4. Talking about suicide isn't a bad thing. It can help to open the door to a meaningful conversation and encourage people to seek help.
5. Suicide is not inevitable – it is preventable

The advice provided in this document applies equally to the risk of suicide:

- spotting the signs
- offering support
- signposting people to internal and external support mechanisms
- making temporary adjustments to workplace pressures and;
- following appropriate procedures for staff who are off sick or who have recently returned to work.

Appendix 4 – Suicide Prevention – what to do in a crisis, provides more information.

Stress Risk Assessments

Whether or not the pressures on your member of staff are allegedly work-related you may decide that it's appropriate to carry out an Individual Stress Risk Assessment.

This is based on the HSE Management Standards and the HSE "Return to Work" questionnaire. It may help you to make joint decisions about any temporary adjustments. The risk assessment should be discussed and revised on a regular basis including at monthly one to one meetings or more frequently if appropriate.

If you or your staff perceive that work-related issues are impacting on them ***as a team*** you can refer to the Guide to Work Related Stress, which includes a template Risk Assessment.

Supporting Staff who are Sick

Please refer to the Attendance Policy and Toolkits on Short Term Sickness and Long Term Sickness. The principles remain the same as with physical ill-health i.e., you should:

- Make and maintain contact;
- Advise / suggest that they seek support from a Wellbeing Resilience Coach or from the Mental Health Peer Support Network;
- Ensure that the individual is getting the appropriate help from the NHS, GMP's external Employee Assistance Programme and/or the Occupational Health and Wellbeing Service;
- Conduct a Return to Work Discussion for short term absence or as part of the welcome back to work for long term absence;
- Decide whether a Plan to Support Improved Attendance is appropriate (short term sickness) or whether you need to agree a Return to Work Plan (long term sickness) which includes not just the return to work, but any period of recuperative duties, and the support which may be necessary to prevent relapse.

Things to Consider

When supporting your member of staff please consider the factors below:

- In cases where the individual perceives that you as their line manager has been (or has been part of) the cause of their sickness absence; it's important that another manager is nominated to act in your place.
- If you weren't able to prevent your member of staff going sick, it's often the case that they could, in the right circumstances, return to work before they're 100% fit as work can help their recovery. They don't need to go back to their GP or other authorised healthcare professional if they perceive that they can return to work earlier than the date on their current fit note. However, you need to ensure that staff are fit enough to work. It may be appropriate to agree relatively short term adjustments (typically lasting just a few days) without the need for a written Plan; unless they're long term sick when a Plan **is** required.
- Supporting return to work is about good people management. You don't have to be knowledgeable about health conditions. The skills you should utilise include effective communication, sensitivity, and an understanding of the individual and awareness of context.

- Ideally officers and staff should be able to trust you and perceive you and management generally as being supportive; even if "firm but fair" actions must be taken.
- Trust can be fostered when the member of staff sees that support for their wellbeing and attendance extends well beyond their return to work, rather than perceiving that once they're back at work their manager has lost interest in their health, which can damage trust in the manager and in the organisation. This is why you should continue to ask how the person is on a regular basis, in one to one meetings.

Making Contact

There is already separate guidance on establishing and maintaining contact with staff who are sick; but in the case of mental ill-health there may be additional issues and concerns you'll have to deal with. Early, regular and sensitive contact enables the provision of appropriate support (e.g. referral to OH&WS) at the right time but is also a factor in reducing the length of absence.

In the early days; the fact that you're offering support and that you're genuinely concerned for the person's wellbeing, could be more important than the content of the discussion. You may need to refrain from discussing interventions until the individual is ready.
Potential barriers to establishing and maintaining contact include:

- Agreeing who should be dealing with the absence. If the individual has raised issues about you as their manager, perhaps in the form of a grievance, or if they perceive that by your actions (or inactions) you have contributed to them being sick; then an alternative manager will need to assume the responsibility, at least initially, and sometimes throughout.
- Individuals may not know that they've a mutual duty to get in touch; and that their manager will be supportive. It's better if this is established in the workplace ***before*** sickness occurs.
- You may worry that trying to establish contact will be difficult or that it will be seen as inappropriate and even harassment. There is good evidence that most people would ***prefer*** to be contacted rather than to become isolated. However, they'll probably prefer ***contact by arrangement*** e.g. when talking to the person set a clear date and time for your next contact; and please try to honour the commitment.

- At initial meetings, make it clear that you're not there to talk about work but to ask how they're feeling and what support they need. This should help to reduce the pressure they may be feeling to return too soon when they're not yet well enough.
- Family members, seeing the distress etc. of their loved one and possibly not understanding GMP's supportive approach; may want to speak on behalf of the individual. Tact and diplomacy rather than an insistence on compliance will assist you to outweigh their concerns.
- The individual may have indicated (usually via a family member or friend) that they don't want any contact; without giving an explanation of the reasons. What needs to be established is whether an intermediary can make the initial contact – this could be another manager, one of the individual's colleagues,a local Wellbeing Coach or a Mental Health Peer Supporter. The aim is to arrive at a point where normal means of contact between the individual and yourself can be re-established.
- A lack of innovation in relation to the means of contact; does the individual prefer contact on their home phone as opposed to their personal mobile phone, would they agree to using Skype or similar if scheduled? If they don't want to meet you at home; could a neutral venue be used, perhaps with them being accompanied by a person of their choice?

Returning to Work and Rehabilitation

It's **essential** that you refer the individual to the OH&WS if an absence is caused by mental ill-health and is due to last 2 weeks or longer. You shouldn't wait for the absence to become long term (29+ days).

However you shouldn't assume that medical intervention is sufficient if the individual perceives that their problem is work-related. In the referral you'll need to explain what efforts you have made to support the individual and what you know of any circumstances leading up to the absence.

In cases of severe depression or other mental ill-health, the individual may well need a course of treatment before their manager can discuss rehabilitation with them. Even so, it's important that the person does not feel neglected. Managers should keep in touch to give reassurance and support.

Most people who experience an episode of mental ill-health recover, return to work and make a positive contribution to the work of the organisation. The aim is to facilitate as

early a return to work as is practicable and to implement a rehabilitation plan (which may or may not include recuperative duties), based on an understanding of the reasons for the absence and using tools such as the Individual Stress Risk Assessment so that you can offer reasonable adjustments. Your aim is to avoid the situation where the individual feels well enough to return to work but fears to do so; because of exposure to managers, or colleagues, or other aspects of work.

Whatever the causes of sickness absence, the longer the person is away from work the more likely it is that they'll need a period of recuperative duties to ease them back into the workplace. People who have been sick with physical ill-health may also be anxious about attending work, whether they'll regain their full capacity for work etc. They may have heightened concerns – hopefully unwarranted – about the way they'll be viewed by their colleagues. Individuals will benefit from you showing your understanding of such issues and agreeing mutual plans as to how to overcome them. Ongoing discussion of the Return to Work Plan is vital in order to build and maintain trust rather than for trust to be lost, impacting negatively on the person's wellbeing.

The main reason for offering recuperative duties is to help rehabilitate the person, and thereby to bring about an earlier return to work. Examples of adjustments can be found below. Whether these are "reasonable" depends on issues such as the amount of disruption of work, cost, whether the hours and duties worked are reasonably substantial and whether the adjustments are practical. Please bear in mind that a large organisation such as GMP will be viewed as having more opportunities to provide adjustments, especially if short term, than say a small commercial enterprise.

It's important that you welcome the individual back to work; and that you hold an informal Return to Work Discussion. You may need to nominate a colleague to do this if you're not in work on that day. The person should not be faced with a situation where they perceive that a backlog of work, e-mails etc. will cause them stress or that they don't have a place to work (less easy for some staff in an agile-working environment). The person should not be given the impression that their arrival back at work is unplanned and that there isn't meaningful work for them to undertake, as guided by the Risk Assessment.

Supporting Staff with Longer-Term Conditions

Please refer to the **Guidance on Managing Serious and Chronic Ill-Health.**

It's vital that the right approach is taken to supporting staff with longer term conditions. You shouldn't assume that an individual who has gone through a period of dealing with

stress or sickness absence is incapable of returning to their full duties and to maintaining good attendance; but there needs to be an understanding of:

- Circumstances at work which might have triggered a problem in the past, and how these can be avoided;
- Staff who have on-going problems at home e.g. to do with care responsibilities, the ill-health of family members, the on-going effects of relationship breakdown etc.;
- Staff who are undergoing long-term treatment via the NHS and whose health problems can be described as “chronic” rather than “acute”.

Even where a health problem has had an impact on their daily living and is of long duration, which may indicate they should be considered to be disabled, there may be no or few adjustments necessary. A **Disability Needs Assessment** may be required and will assist you both in considering what adjustments might be needed.

Most adjustments are relatively simple, inexpensive and temporary; however in the longer term some may need to be permanent, which could have contractual implications. For information about how to implement workplace adjustments, see the Disability Management Toolkit.

Adjustments might include (but aren’t confined to):

Communication and Working Styles

- Making sure the individual is working with trusted people to limit the impact of different working and communication styles.
- Agreeing a preferred communication method to help reduce anxiety.
- Considering the current workload and making some temporary changes.
- Rearranging some of the individual’s responsibilities, possibly by allocating some of them to a colleague and/or adjusting the content of the job.
- Allowing the individual greater control over how they plan and manage their time and their workload
- A phased return in relation to the hours worked and the way that these will increase over time. Consider if this would help the person to readjust to commuting by initially not travelling at the busiest times.
- Allowing time off for treatment or in some cases convalescence. The Police Treatment Centres now offer a Psychological Wellbeing Programme for contributing members. Although the members are usually regular officers, Specials, PCSOs and CDOs can also contribute and can have access to the same facilities.
- Temporary changes to shift patterns (although you shouldn’t assume that the individual can’t work their usual shifts).

- Exploring longer-term changes to hours and duties including part-time or flexible working and even possibly redeployment.
  The Individual Stress Risk Assessment will have helped you to consider other issues such as training needs, physical demands and the work environment.

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Changing the physical working environment

Some examples of changes to the physical working environment could be:

- When appropriate, agreeing to some work being undertaken at home for some of the time. For advice/support on how to arrange this contact GMSS.
- Discussing whether a quieter place to work would be helpful, if possible.
- Providing rest areas away from the main staff area to allow someone to rest away from social demands, where possible.
- Providing reserved parking to reduce the stress of commuting, if necessary.

Additional Support

- Regular check-ins, support them with prioritising their work and creating structure in the working day
- Training or coaching to build confidence in skills relevant to the job
- Providing a buddy or mentor to be a dedicated person who can support with work tasks

Where an individual is suffering from a longer term condition, it's possible that the person has been encouraged by a clinician, therapist or counsellor to develop coping strategies. These may include being able to predict a possible relapse and to take action to prevent it. They may need additional support from you at such times, possibly informed by a Wellness Plan.

Individuals may also chose to agree a Wellbeing Passport, this will be in addition to other more formal documentation. The wellbeing passport provides a way for individuals to explain to new managers about their situation and any agreed adjustments, without having to go into the detail of any medical condition, disability or family circumstances. The background information will have been considered at the disability needs assessment meeting (or other appropriate meeting), when it was needed to agree the reasonable adjustments required.

The Wellbeing Passport is not intended to replace the need for an adjusted duties plan, disability needs assessment, risk assessment, wellness plan, COVID-19 individual risk assessment or sickness management processes. It's intended to ease an individuals move from one manager to another.

Staff that have had such issues in the past and have developed ways of coping may actually be better at dealing with the pressures of work than people who have never experienced such an issue.

You may need to act with discretion when deciding how much time off to allow for medical appointments and treatment (the usual maximum is four hours).

GMP Policies

Alcohol and Drug Misuse Policy

Pregnancy & New Parent Management Toolkit

External Support

AnxietyUK

Mind – How to support staff who are experiencing a mental health problem

Mind – Helping someone else

Mind – Blue Light Programme

Mental Health Foundation

NHS

Rethink Mental Health

Royal College of Psychiatry

Time to Change

Samaritans

Self Help

Tools

Guidelines on having a sensitive conversation

Appendix 1 - How depression at work can lead to relapse if not properly managed

Appendix 2 - Fatigue

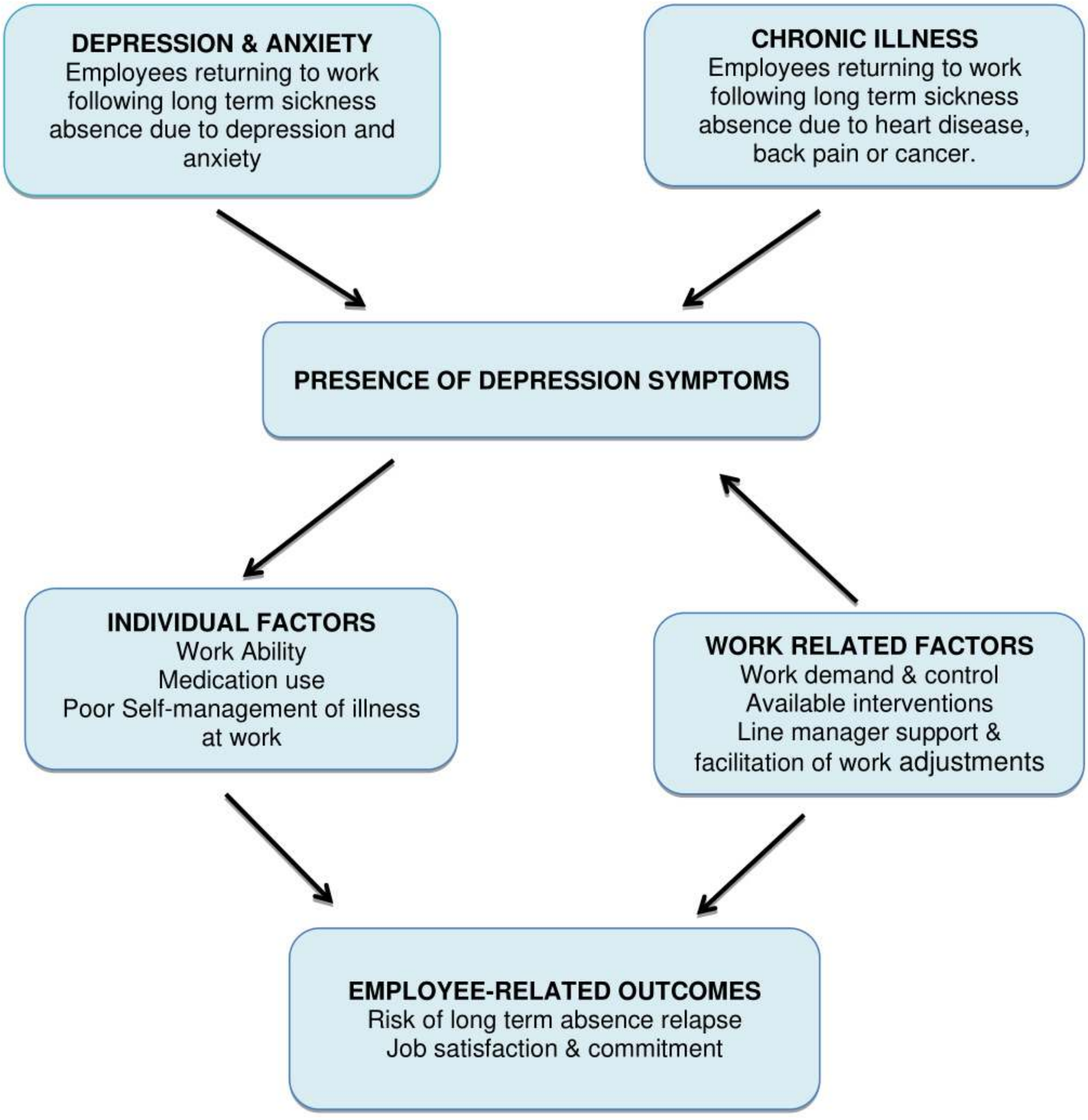
Appendix 3 - HSE Stress Management Standards

Appendix 4 – Suicide Prevention – What to do in a crisis

Appendix 1

How depression at work can lead to relapse if not properly managed

The objective is to consider how best to support the person to manage their "Individual Factors" and to control the "Work Related Factors" in order to ensure the best outcome in terms of keeping the individual in work, but also working effectively and engaged.



Appendix 2

Fatigue

"***The management of an organisation have a duty to manage risks from fatigue, irrespective of an individual's willingness to work extra hours or preference for certain shift patterns for social reason***."[1]

While the above explains the reasons for e.g. the Working Time Directive; it relates specifically to the world of employment. However many people who suffer from fatigue, whether on a long-term or on a temporary basis, do so because of circumstances outside of work.

Considerations:

- Individuals are not necessarily good at assessing how fatigued they are.
- Where it may seem that neither work nor domestic duties could be a cause of fatigue, the reasons could be due to choice of lifestyle – not just in relation to e.g. socialising but also in relation to use of social media, or other uses of devices such as telephones, tablets, computers and televisions.
- Individuals who appear to cope reasonably well with fatigue could still be adding to their stress levels and possibly to physical health problems.
- Asking a member of your team about whether they're fatigued requires the same sort of tact, diplomacy, sensitivity and understanding as you utilise when discussing stress. Indeed fatigue could be a source of stress; or stress and fatigue are both being caused by similar factors.
- When a team member raises an issue with you regarding fatigue; you need to help them to explain to you whether it's temporary or long-term, whether it started at a specific point in time or has emerged over a period of time; so that you can consider what support to provide.
- Excessive overtime should be questioned. As well as being a potential cause of fatigue it could indicate that there are issues that the person is dealing with (such as financial and/or relationship problems).
- Because the exigencies of the service mean that proper breaks can't always be taken; it can become a habit not to take them and you might assume that people don't need them.
- Flexible working patterns might include allowing the individual to declare a preference for certain shifts; which however should (in the context of dealing with the effects of fatigue) include a rationale around being less fatigued rather than seeking adjustments for other reasons. Clearly in a shift-working organisation there are operational limits (especially in specific roles) about how much flexibility can be agreed.

Advice is available on the People Pages about the health implications of shift working and how these can be mitigated or reduced.

[1] HSE Human Factors Briefing Note No. 10: Fatigue

Appendix 3

HSE Stress Management Standards

The HSE Standards break down work pressures into defined areas, which then facilitate risk assessment etc.

These are:

a) **Demands** – this includes issues such as workload, work patterns and the work environment.

b) **Control** – how much say the person has in the way they do their work.

c) **Support** – this includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.

d) **Relationships** – this includes promoting positive working to avoid conflict and dealing with unacceptable behaviour.

e) **Role** – whether people understand their role within the organisation and whether the organisation ensures that they don't have conflicting roles.

f) **Change** – how organisational change (large or small) is managed and communicated in the organisation.

Research has shown the importance of some very specific factors in relation to stressed police officers who went sick. The list of "possible actions" in the Individual Stress Risk Assessment should help to reduce the impact of these.

Demands: Staff were adversely affected by having to deal with and prioritise demands from different groups which they found out undue pressure on them.

Control: officers who answered "seldom" or "never" in response to questions about them being able to control their work by having a say in the planning and speed of how work was carried out were more likely to go sick.

Support: Officers who went sick were more likely to respond to say that they perceived that they were not supported when undertaking emotionally demanding work by their managers and were less supported by their colleagues. There was also considerable variation in whether the officer perceived that they had been supported in returning to work. GMP's approach to attendance management is aimed at ensuring that staff always feel supported in this way.

Role: Officers who went sick were more likely to have a number of issues about their roles, especially role ambiguity. They were not clear what was expected of them and what their roles and responsibilities were. In theory this is a factor which we can work to ensure is not prevalent at GMP but, for example, there will be officers who have been displaced due to changes or who have been redeployed for a variety of reasons who could feel "lost" in their new role.

Change: Officers in the survey expressed concerns about having opportunities to question managers about change.

Appendix 4

Suicide Prevention - What to Do in a Crisis

In the context of suicide; high risk behaviours include:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself (e.g. on line)
- Talking about feeling hopeless or having no reason to live
- The person suggesting that they wouldn't be missed by family, friends or colleagues if they were to end their life.
- Giving away personal, meaningful items
- Suddenly becoming positive after a long period of low mood. This can occur when a person has made the decision to end their life. It's very important not to delay talking with them about your concerns.

Other behaviours which might constitute a risk include:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increased use of alcohol or drugs
- Acting anxiously or agitated; behaving recklessly
- Sleeping too little, or too much
- Withdrawing or feeling isolated
- Showing rage or talking about revenge
- Displaying extreme mood swings

Don't avoid asking a person if they have thought of harming themselves or ending their lives due to embarrassment or concern you may be wrong. If the person isn't feeling suicidal they'll tell you. At the risk of embarrassment, you may save a life.

If the individual is showing high risk behaviours, then advice about seeking counselling or seeing a GP and/or a referral to the OH&WS might not be sufficient. Using their experience and judgement managers or colleagues may have to decide to take the person to a hospital Accident & Emergency Department for an immediate assessment.

Postvention

"Postvention" is the term used to describe the support give to those bereaved by suicide. There is no single or "right" way to respond to situation; rather there should be an awareness that support should be provided in such circumstances. Support is available within GMP from the Mental Health Peer Support Network and Wellbeing Resilience Coaches.

A few of the guidelines include:

- Support and promote healthy grieving
- Avoid assumptions about how people will or should respond
- Encourage mutual support
- Provide group support
- Some people may benefit from counselling but this could be weeks and months rather than days after the death of a colleague
- Don't assume that people will need time off work but give them some time if you judge it to be appropriate in the circumstances; while encouraging the resumption of daily routines
- Look out for people experiencing longer term issues
- People who've experienced a close suicide bereavement are at increased risk of suicide themselves. This should be kept in mind when immediate support is offered and at significant times such as anniversaries.