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Introduction

Mental health services are **human** services – services are provided and received by people in relationship with one another, and those who provide care for people in emotional distress each have their own vulnerabilities and strengths. Receiving support and feeling supported makes the difference between thriving and surviving in work that is often intensely personally demanding. Failure to provide appropriate support for staff also has financial implications. Sickness rates of 5% currently cost the National Health Service (NHS) £700 million each year (Williams, Michie and Pattani, 1998), and more than 30,000 nurses left the profession in 1996 (Ward, 2000).

The Oxford English dictionary (1982) defines 'support' as:

to keep from falling, sinking, or failing, to strengthen, encourage or give corroboration to .

Supporting staff is therefore not necessarily "supervision", but supervision can be **part of** staff support. This chapter focuses on the provision of the strengthening and encouragement necessary for staff to be sustained in emotionally demanding work. Some of the potentially damaging effects of lack of staff support are outlined, the differences and overlap between support and supervision are identified, and some of the difficulties and obstacles in receiving and providing support, both at individual and organisational levels are discussed. Some guiding principles and specific suggestions as to how staff support can become an integral part of services at all levels are put forward.

Stress factors in mental health services

Working within mental health services is recognised as a demanding, stressful occupation both within community and residential settings. Changes in service structure, the development of integrated teams, and the increased demands for accountability, the meeting of targets, objectives and budgets have affected all front line practitioners. As mental health care has moved further and further away from an alliance with the traditional medically-based model of care, the psychological protection historically afforded by such a system has diminished, and all individual practitioners carry a greater degree of personal responsibility than in the past. The development of community rather than institutionally based services means that an ever increasing

number of practitioners are working alone and mental health workers in the community can feel lonely and unsupported. The demands of working alone can be also be exacerbated by the sole representative of a profession, for example the only social worker, occupational therapist or psychologist within a team and carrying a caseload for which one is responsible can leave insufficient time for camaraderie, friendship or appropriate professional support.

Practitioners stepping into community work for the first time can be particularly vulnerable, often fearful of their own professional autonomy and responsibility, and the autonomy of their patients. The higher expectations of service users compared with earlier times can also engender feelings of insecurity and frustration. Personal responsibility is often pushed to the "edges" in large organisations, and individual practitioners can be left with the full emotional impact of service users' problems, frustrated that "they", meaning managers, do not seem to care. Managers in all settings have to respond to the seemingly never ending demands made upon them by the organization – managing budgets, meeting targets, implementing policies and procedures - that they can be unaware when a practitioner's personal limits have been reached or when a practitioner has begun to carry an excessive and potentially damaging sense of personal responsibility.

In a study of Community Mental Health nurses in Wales, half the respondents were found to be over extended and highly emotionally exhausted, and therefore unable to give of themselves in their everyday work with their service users. One in seven experienced little or no satisfaction or sense of achievement in their work, whilst one in four admitted to negative attitudes towards those in their care (Hannigan et al, 2000). These feelings can be common for all front line practitioners in mental health, whether working in community or hospital settings, as working in this field is, by its very nature, inherently stressful (Moore & Cooper, 1996; Carson et al, 1995). If levels of stress and overload go beyond the capacity of personal coping mechanisms and staff are insufficiently supported, they will become emotionally exhausted and the symptoms of 'burn out' will appear.

Symptoms of 'burnout' - warning signs

Common early warning signs that staff are not receiving sufficient levels of support and maybe becoming overwhelmed are occasional episodes of "not coping", increasing cynicism towards the work in which they are engaged, and increased sickness rates. If this increasing emotional exhaustion is not recognized by the individual, colleagues or manager and the necessary supportive actions taken, staff will become increasingly less effective and eventually be unable to work.

Feelings, behaviour and thinking

The experience of 'burn out' or acute emotional exhaustion can be described in terms of feelings, behaviour and thinking.

Feelings can include:

- loss of a sense of humour
- persistent sense of failure
- anger/resentment/
- progressively more cynical
- afraid and lonely
- sensitive to criticism
- cannot be bothered
- depressed
- feelings of panic

Behaviour can include:

- resistance to service user contact and going to work
- working harder to achieve less
- increasing social isolation
- avoidance of contact with colleagues
- clumsiness
- aggressive driving
- inability to sit still or settle
- eating too much or too little
- nervous laughter

Negative thinking can include:

- thoughts about leaving the job
- loss of creative problem solving
- inability to concentrate or listen
- dehumanizing service users
- suspicion and mistrust of others
- inability to make decisions
- forgetful
- inability to make plans
- thinking about the past

The signs of burn out are usually much easier to recognize in others, rather than in oneself.

CASE EXAMPLE 1

Gina is a conscientious and highly experienced G Grade (senior clinical professional grade) community psychiatric nurse. She has worked in the same community mental health team (CMHT) for many years, gradually becoming the most highly regarded and most experienced member of the team, someone to whom others turn for help and advice, and who is seen as courageous in terms of dealing with a difficult psychiatrist. Gina herself came through a painful divorce a number of years ago and her children left home two years ago to attend university. She gradually became increasingly isolated both personally and professionally. She lost her enthusiasm for work, began to avoid service users, was increasingly bitter and cynical about the NHS and could not see the "the point of it all". After many years of never taking sickness absence, Gina became more frequently physically ill with minor somatic complaints, and her thoughts became increasingly negative, both about her own social isolation and the "pointlessness" of coming to work. Because other members of the team needed her for their own support and she had always been perceived as "strong", it took some time before other team members and Gina herself recognized the seriousness of the situation and that action needed to be taken.

Questions:

1. What could have been done to help Gina before her symptoms of "burnout" became acute?
2. How can a community team provide support for its members?
3. How do you know when you are reaching your own limits?

Sometimes practitioners may resist the concerns of their colleagues, and even be aware themselves that they are not functioning well, but insist that they cannot take any time off because of felt obligations to service users or colleagues. Lone community practitioners have the additional stress of knowing that if they themselves take time off, one of their colleagues who maybe already overworked will have to take on the additional work of the absent practitioner's caseload, and those working in hospital settings know that managing a ward with insufficient staff causes additional demands on all concerned.

Informal staff support

Processes of informal support are fundamentally similar regardless of the occupational group or status. They include individual friendships between those of equivalent status, informal networks which come together on an adhoc basis (for example cups of tea after meetings), particular staff groups who decide amongst themselves to meet up informally on a regular basis, such as "nights out" organized by ward staff or teams on a regular basis, or an informal "mentoring" relationship where an individual has an established relationship with a more senior member of staff who can be relied upon for support and encouragement when necessary. These informal support networks are sometimes considered to be optional extras, but for many working in mental health services, such networks can be personal "lifelines" during times of stress, and an extremely valued part of working life.

It could be assumed that these informal groupings might provide sufficient emotional support for staff. However, when a group of practitioners or managers come together for informal support, those present will not necessarily **feel** strengthened and encouraged unless the following factors have been present to some degree each person needs:

- to feel emotionally safe
- to be understood and accepted
- to be able to admit some of their own vulnerability
- to be able to express feelings without criticism from others
- to feel that those present share common difficulties and problems
- a sense of humour and perspective to be restored.

However, if a person is shy, feels unable to admit vulnerability, there are any interpersonal personal difficulties which inhibit the closeness of the group, or there are other organisational and interpersonal constraints, informal meetings will not necessarily provide the staff support required. It is thus not sufficient for organizations to simply facilitate informal social contact.

Clinical Supervision: support or scrutiny?

Formal support for practitioners and clinicians is most often provided through the medium of supervision, but as Cottrell and Smith (2000) comment, clinical supervision, while accepted conceptually, is not yet well established in practice. A detailed review of the many definitions of clinical supervision is outside the scope of this chapter, but it has to be recognized that despite the extensive literature now available, there is little consensus (Todd & Freshwater, 1999). The variety of broad based definitions contributes to confusion, but all definitions contain the following common elements:

- a process of support and learning
- discussion and reflection with a colleague in a safe environment with the purpose of developing competence
- ensuring quality patient services

Regular supervision is advocated for all mental health and social services staff, and it is increasingly recognised that such formal support for staff needs to be 'built in'. Why is it that efforts to implement and maintain clinical supervision often fail in practice?

Role conflict and role confusion

No matter how strong the organisation's commitment to ensuring clinical supervision, provision of supervision alone does not necessarily make the practitioner feel supported, and supervision may be given by the "wrong" person. If supervision is felt to have elements of scrutiny practitioners are likely to be concerned that in some way they might not "measure up" to the standards which they think are expected of them. They may be therefore

very reluctant to acknowledge their own difficulties or emotional vulnerability, and will be far more concerned that they are not “found out” in some way, either as not being sufficiently competent or not fulfilling the demands of the job.

This is most likely to occur if the supervisor is also a manager, is of significantly higher status, or the role of the supervisor is unclear. If the roles of manager and supervisor are insufficiently clarified or overlap, there will be resistance to supervision and any potential benefits are likely to be nullified (Grant, 2000). Lack of clarity between managerial and clinical supervision will create anxiety and mistrust in the supervisee and a conflict of interests and role confusion in the supervisor/manager.

CASE EXAMPLE 2

When supervision had to be introduced into the CMHT it was decided by management that supervision be given by the person who is next above in grade. Therefore a G Grade CPN had to be supervised by an H Grade who is also the team manager. The G grade’s comments were, “you should be honest about what you are struggling with but if it’s your manager you can’t admit anything because there is not enough trust. She says it’s ok, but if you admit you’re struggling it will be seen as not being up to scratch. I had to be supervised by the grade above and it had to be H grade, I could not choose who it was. I don’t particularly like her and do not trust her not to use things against me.”

“I myself have to supervise an E grade who is also my friend. Because she is my friend we have respect and trust, but it is mixed. If things are running well it’s good, but it is hard when there are any disciplinary issues.”

Questions

1. From whom do you receive supervision?
2. Are there elements of role confusion? (If so, why do you think this is?)
3. Is it possible for supervision to include both the monitoring of casework and accountability **and** personal support?

Usually when there has been a decision made to implement supervision and supervision is seen as desirable, there is considerable discussion as to how much time may be appropriate. Any time taken for supervision can be seen as time taken away from that given to service users and other work responsibilities. The frequency of time allocated usually varies depending on level of experience, less experienced staff being considered to need more time, for example once per week/fortnight, more experienced staff less frequently. However, even if agreement is reached regarding the allocation of time, role conflict and role confusion can create difficulties for both parties and this allocated time is less likely to provide the support for staff that is needed.

Psychological proximity

Degrees of perceived "psychological proximity" between participants may also impact on the implementation and operation of clinical supervision.

Proximity describes the perceived or real collusive interpersonal relationship between two or more participants, who without awareness foster closeness through the exclusion of another. Collusion only has to be perceived to have an impact on supervision. Some examples of these potential difficulties are outlined briefly below. For a more detailed discussion see Cottrell and Smith (2000).

If supervisors are perceived as agents of the organisation, and if those receiving supervision have not been sufficiently involved in its implementation, suspicion is immediately engendered. Without clear prior discussion relating to what subjects may be discussed and what will happen to the information, participants will be guarded and hostile and will not participate in the process of supervision with openness and commitment.

Supervisees and supervisors may also sometimes be perceived as being "in league" with one another and may meet and form a sub-group within an established system. Typically they may wish to provide peer supervision for one another, or start a process of supervision for others. Unfortunately, this can result in envy and hostility from other practitioners, and sometimes the needs of the organisation for information and the needs of the manager for control and authority can be neglected. The supervisee/supervisor dyad practise as though they were in an organisational vacuum, and, without awareness, may fail to make sufficiently close contact with other team members, and not sufficiently recognise and appreciate their needs and abilities.

CASE EXAMPLE 3

A group of six practitioners, committed to utilizing Psycho Social Intervention approaches in their own caseloads, continued to meet as a group for mutual support and peer supervision, even when their training was not sufficiently recognized or valued by the Trust for which they worked. Meetings took place monthly, sometimes covertly without the support of management. These meetings did enable those present to share their frustrations, maintain their commitment, sense of humour and perspective, and further develop their knowledge base, but other colleagues felt excluded and perceived the group as separate and elitist.

Questions

1. How could these difficulties have been avoided?
2. In what circumstances would group supervision be beneficial?

Qualities of good supervision

Supervision will not be perceived or experienced as a form of professional clinical support without the following qualities:

- The roles, responsibilities and expectations of all parties - supervisors, supervisees, managers, the organisation as a whole – must be clearly elucidated before attempting to introduce supervision. It is essential to ensure that none of the stakeholders is unwittingly excluded whether supervision is to be implemented within hospital or community settings.
- The time and energy spent addressing core issues of roles, responsibilities and expectations is more likely to lead to the successful adoption of clinical supervision, and allows anticipated problematic factors in the process of implementation to be identified and addressed in advance.
- Those providing supervision must be trustworthy and professional, able to provide the emotional “safe space” where difficulties and vulnerabilities can be addressed openly.
- The supervisor needs to be accessible, emotionally responsiveness and attuned to the needs of the supervisee.
- Supervision needs to balance caseload with professional development and personal support. If supervision is focused only on the management of casework it is likely to be experienced as scrutiny.
- Supervision should develop confidence to deal with difficult cases, provide reassurances that feelings are normal, and help set limits for individual responsibility.

Supervision allows organizationally sanctioned time for participants to communicate, and fosters alliances which provide a form of social support, develop clinical skills, and mitigates against isolation and detachment.

There are many difficulties in the provision of supervision, and the evaluation of clinical supervision in terms of service user or staff outcomes in the longer term is methodologically complex (Burrow, 1995; Fowler, 1996) but there is significant evidence regarding the beneficial effects on staff well being (Butterworth et al, 1997). The provision of time to reflect upon practice demonstrates an organisations’ commitment to an endorsed process whereby staff may address practice and personal issues as an integral part of their working day. Genuine commitment, rather than the appearance of commitment (Grant, 2000) by organisations to the provision of personal time for staff is essential, and it is the responsibility of all parties to ensure that personal support for staff is an integral part of the supervision process.

Stress factors for managers

While it is now well recognised that support and supervision is essential for practitioners providing clinical services, appropriate and relevant support

specifically for managers in Mental Health and Social Services is often neglected. The role of manager has undergone, and is still undergoing, immense change, and many are now more isolated and carrying more individual responsibility for targets and budgets.

Ongoing changes in mental health services have resulted in greater potential confusion regarding a manager's role. Is s/he a leader or a manager? Who is actually responsible for the team's performance and the meeting of targets and deadlines - the manager or the senior clinician? Who is the team leader? Role confusion can be exacerbated when managers are expected to manage practitioners from a different professional background, for example a manager with a social work background having to manage nurses, psychologist, occupational therapists, and lack of clear lines of accountability and responsibility can also be significant contributory stress factors.

Managers are also regularly expected to implement and be accountable for changes demanded by the organisation, but often without any training or support in understanding the complex **processes** involved in initiating, implementing and sustaining change. Because managers are judged and held accountable, it can be a source of great anxiety that staff are not changing in the ways that are required, or within the expected timescales. These stresses can be exacerbated by managers having to spend so much of their time reacting to demands/crises, which allows insufficient opportunity for proactive contributions or creativity.

Many managers have been appointed as a promotion from direct face to face service user work. For many it is a shock to discover that those people whom they have previously worked alongside as friends and colleagues view them very differently once they become a "manager". They may no longer be considered trustworthy, and may also be "blamed" by front line practitioners for difficulties within the organisation. Managers' experience of "divided loyalties" can be very stressful. Their prior experience as a practitioner means that they have sympathy and understanding for their colleagues but they are now representing the organisation and have to implement organisational demands from their own higher level managers. Thus, if specific support is not provided, managers can feel far more alone.

CASE EXAMPLE 4

In a Personal Development day facilitated by the author, middle managers from different services listed the following factors as major difficulties: 1) differences in priorities between managers and different team members; 2) the expectation by team members that all requests can be met; 3) the "gap" between statutory requirements and what individual practitioners think they should do; 4) tensions between clinical and managerial responsibility, particularly in relation to Consultant Psychiatrists; 5) little feedback about "good" things; 6) being perceived as "an inanimate problem solver"; 7) no acknowledgment of work done; 8) lack of clarity of outcomes; 9) "never able to finish"; 11) too much irrelevant information; 12) lack of involvement in budget setting but being responsible for managing and monitoring; 13) lack of role clarity at senior and middle management level; 14) inadequate recognition of skills and experience; 15) the impact of significant organisational changes on managerial roles and inter-professional relationships.

As can be seen from the following comments, the Personal Development Day was the first time the managers had met together for mutual support without the scrutiny of higher management:

- "it provided a chance to look at myself in terms of my position in relation to my role within the team I manage and my role within the Trust as a whole."
- "it was an opportunity to reflect and to share other managers' ideas and thoughts."
- "the day gave me the opportunity to get to know my colleagues personally, and gave me time to share experience and to realise that many have the same problems."

Questions

1. What are the implications for recognising the unique role of middle managers within your organisation?
2. What kind of support do they need?

Support for managers

Providing opportunities for informal support for managers can be difficult. A group of staff based within the same building or ward will be able to provide much informal support for its members. However, although the manager may provide considerable formal and informal support to team members, and is the person that staff turn to when problems arise, s/he is much more restricted in being able to use colleagues for his/her own personal support because of differences in status

Thus support for managers must be addressed at an organisational level, and seen as an integral part of the job in the same way as clinical supervision (Gilbert, 2003).

Formal support for managers needs to include:

- The provision of a safe space, either in groups or individual mentoring, where difficulties and vulnerabilities can be acknowledged openly. Due to concerns about being seen as “failing”, support for managers could usefully be provided by an outside facilitator.
- Open discussion of and support for the reality and difficulties involved in managing a diverse group of people.
- Greater clarification of role, responsibilities and the setting of boundaries.
- Acknowledgment that managers do not necessarily have the skills to manage change. Specific training in understanding the factors that enhance or inhibit the change process, the effects of organisational change upon individuals and how to facilitate change by the use of positive strategies may need to be provided.
- Acknowledgment and support for the inevitable “in between” position of middle management and the resulting struggles when having to respond to both the concerns of practitioners and the demands of the organisation.

Managing change: a special case of staff support

There is now a myriad of books and articles about the management of change. This section focuses on what is often forgotten - change cannot occur without loss. In the push to implement the change agenda in mental health - policies, services, working practices - the psychological effects of loss are often given insufficient attention, and this often lies at the root of many of the difficulties associated with implementing change.

Everyone experiences sadness at the loss of familiar places, ways of living/working that “used to be”, and to which they were emotionally attached. According to Marris (1996) loss fundamentally disrupts the ability to find meaning, and therefore feelings of loss can be evoked by any situation where the ability to make sense of life is disrupted. This process will occur no matter how “rational” or “beneficial” changes may seem to be to another person who does not have the same intensity of attachment. Thus, for example, even if it “makes sense” to close a hospital and even if staff who have worked there also agree that it is the best option, those who have worked in that environment for many years will experience feelings of sadness and loss at the change. The severity of this reaction will be directly dependent upon the **intensity** of that member of staff’s earlier emotional attachment, and will vary from person to person. Acute feelings of loss will also not necessarily be shared by younger members of staff whose attachment to the old hospital is less, and whose professional identity has not been established in that working environment. Adapting to any loss requires

psychological reintegration - i.e. a recognition that previous meanings by which one made sense of life are no longer valid, and that new meanings to make sense of a new situation, have to be reconstituted.

Reactions to loss/change

The process of loss of meaning through change means that events have become unpredictable. To readjust, some continuity of meaning has to be restored before life will feel manageable again. A person will automatically actively search out for "threads of continuity" in their experience to join the past to the new present, and find ways to restore a sense that what has been lost can still give meaning to the present. For example, staff who have spent many years working in a particular place in particular ways who are then required to work in a different place and in different ways have to find ways of integrating knowledge and skills acquired within one setting to the very different demands of another setting. Somehow, the past has to be reformulated so as to make sense in the present and the future. This process will be more difficult when change is enforced rather than freely chosen, and when past contributions of staff are not specifically validated and valued. Many difficulties in implementing and sustaining change in organisations arise from an inadequate understanding of these natural human processes in reaction to change.

In supporting staff through change an essential question to be addressed is: Can staff make sense of what is happening? All too often there is insufficient consultation and lack of information as to how new services, policies and procedures connect with each other and/or will operate in practice, and also even more importantly, how proposed changes will connect with the experience and skills staff gained in different settings and circumstances. Imposed changes often result in feelings of powerlessness, disorientation, anger and resentment. These feelings need to be understood and accepted such that appropriate ways of supporting staff through change can be provided. If staff cannot make sense of changes in terms of their own experience and professional background and are not able or helped to react in articulate ways to the threats posed by change, their sense of loss is more likely to result in apathy, depression, aimlessness or cynicism, even when changes may be intelligent and necessary. Many managers and organisations become frustrated and anxious when staff do not embrace changes enthusiastically, but, if these issues could be addressed openly, many of the difficulties in implementing and sustaining change could be minimised.

Support for staff during periods of significant change needs to incorporate the following good practice points:

- Each person has a profound need to maintain consistency and to sustain familiar attachments and understandings which make life

meaningful. This includes the environment in which staff spend their working lives.

- Some changes, at both personal and professional levels, involve the loss of important attachments, and thus the process of grief will occur.
- Too many changes break down emotional resilience. It is essential to recognise the human need for continuity between past and present. If changes are disruptive and frequent staff will lose confidence that their professional lives have a meaningful continuity of purpose.
- It is essential to make explicit what will be lost and threatened by change. If this is not done the process of systematically exploring what can be retrieved and reformulated from the past into different contexts for the future cannot take place.
- During the process of change conflict must be expected and even encouraged. Staff need to be explicitly given the opportunity to react, to have past contributions, experience and skills validated, to contribute their own suggestions in terms of implementing any planned changes, and to articulate their own ambivalent feelings.
- It must be accepted that individuals and groups will react to change differently. Every individual and each staff group has to find its own sense of continuity.
- It must be acknowledged that all individuals love particular environments, people, ways of working, and these cannot be readily substituted simply because there are rational/financial reasons for change.
- Change requires time and patience.

The pace of change in mental health services shows no sign of abating, and often organizations find themselves reacting to rapidly changing political and social agendas, rather than being able to reflect upon, plan for, implement and review change in ways that are effective and meaningful to staff. Ongoing change adds to the stress already experienced by both practitioners and managers in mental health services and is a major contributor to increasing cynicism and difficulties in retaining trained staff. It is essential that organizations acknowledge the human costs of change and provide the necessary support for staff through the process.

Good Practice points for staff support

Stress is a very imprecise term for what is in essence a complex, multivariate and multi-level phenomenon, but it is usual when considering support for staff to focus on individuals – their workloads, coping strategies – and the

provision of supervision. However, focusing solely on supporting staff as individuals can mean that stresses resulting directly from the organization's ethos and practices can be ignored. Even within individual supervision there can be a tacit agreement that organizational practices are not acknowledged or their implications for individuals discussed (Duncan-Grant, 2001). Most organisations now provide individual staff support by the provision of supervision time and staff counselling services, but this does not necessarily mean that the ethos of the organization is humane. Providing staff support on a purely individual level will not succeed over time if there are working practices within the organization which are actively harmful for staff. Some organizations implicitly maintain a "macho" image such that a manager or practitioner who takes time off, utilizes staff counselling services or requires support is somehow seen as a "failure" and not up to the job. In such organizations individual vulnerability cannot be acknowledged.

The following Good Practice points are relevant to all staff in mental health services – front line practitioners, the managers who manage and support practitioners on a daily basis, and higher level management who set the culture, ambience and ethos of an organization.

- Optimal levels of stress are essential for growth and development, but perception of stressors is mediated by individual personality. What is stressful for one person may not be for another and vice versa, therefore staff support and supervision need to be tailored to individual needs.
- The most protective factors in terms of maintaining good mental health and resilience have been shown to be - use of social support, maintaining a balance between home and work, the degree to which someone is motivated and extended in their work.
- The most effective ways of supporting staff include: the mobilization of interpersonal support, the provision of greater control and autonomy, assistance with problem solving, facilitating interpersonal awareness and provision of feedback and advice.
- Managers needed to be given sufficient support and training in managing change and the psychological effects of the processes of change and loss. This would allow the expectations of what can be achieved, from both from individuals and organisational systems, to be more realistic and is more likely to reduce the levels of cynicism and burn out amongst staff.
- There may be occasions when decisions may have to be imposed on staff, but, no matter how seemingly time consuming, **facilitating** decision making such that staff feel more in control and that their expert knowledge and experience is valued will always be of greater benefit in the longer term. The involvement of

suggestions/solutions/ideas from practitioners can have a radical effect on how change can be implemented and maintained and is likely to **enhance** morale.

- Managers at all levels within an organisation need to be actively supported and taught how to maintain their own personal resources. This will enable them to provide a supportive ethos within the organisation, set a good examples of proactive self care, to be more understanding and supportive of the staff whom they manage, more sensitive to potential burn out in others, and thus able to take restorative action sooner.
- Support for staff needs to be embedded within an organisational culture, ethos and strategy which is genuinely committed to humane and caring organizational practices.

Concluding Comments

The pace of change in the mental health agenda continues unabated and the resulting ongoing demands and responsibilities of all frontline practitioners show no sign of reducing. Those working in mental health services carry increasing independent clinical responsibility. Roles are often becoming broader and all-encompassing, while, at the same time, the expectations from government and the public of what services can provide for those in emotional distress continues to rise. Thus, the provision of appropriate support for staff is even more fundamental and essential than before. No matter how comprehensive policies and strategies, implementation is totally dependent on the practitioners who care for others and the managers of services. It is essential that all front line practitioners acknowledge their own humanity and vulnerability and seek out the support required for them to provide for the needs of others; that managers not only ensure support for staff is provided but also that they themselves receive the support that they need, and; organisations recognise that a commitment to humane working practices and investing in the well being of their staff is their best investment for the future.

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