

Responding to Distress at Work

A guide for HR and senior managers: clear roles, proportionate responses and better use of occupational health

When an employee's distress has become difficult to manage, it is rarely one problem. There are usually three, and they are connected.

The first is the employee's own difficulties, often with managing distress, boundaries and relationships at work, sometimes in someone who is technically capable and performing well. The second is the manager's approach, which may be compassionate and invested, but may also mean taking on too much responsibility for the employee's emotional wellbeing. The third is the organisation's approach to mental health, which may provide occupational health support without any clear framework for what is reasonable support, what is individual responsibility, what management should expect and what belongs to clinical care.

This guide is about the third, because it is the one that shapes the other two. It is written for HR and senior managers, and is best read alongside its companion for line managers, Supporting Without Rescuing.

What is the actual problem we are trying to solve: the employee's wellbeing, the manager's confidence, the impact on the team, or all three? They require different interventions.

01

Establish the facts before deciding on an intervention

Situations like this tend to reach HR as a story about one person, often told by people who are worried, tired or frustrated. Before anything is decided, build a factual picture.

What you need to know:

- Specific incidents: what happened, when, and who was involved.
- Frequency: how often, and whether it is increasing, decreasing or stable.
- Work impact: what is happening to the work itself, as distinct from relationships.
- Team impact: who else is affected, and how.
- What has already been tried, by whom, and what happened.
- What support, adjustments and occupational health advice are already in place.

Hear from the line manager directly, and listen before presenting solutions. Early conversations are often about the employee without the manager's own account, and that account can change the picture considerably. It is also where you find out what the manager fears, what they have been carrying and what they need.

02

Separate clinical needs, management responsibilities and behavioural expectations

It is possible for somebody to have significant mental health difficulties, perform exceptionally well in their role and still behave in ways that adversely affect colleagues. Those things are not mutually exclusive.

Much of the confusion in these situations comes from treating three different kinds of need as one. It helps to name them separately, and to be clear about who owns each.

CLINICAL NEEDS	MANAGEMENT RESPONSIBILITIES	BEHAVIOURAL EXPECTATIONS
Diagnosis and treatment	Workload, adjustments and supervision	Respectful communication
Crisis support and care plans	Feedback and performance conversations	Appropriate professional boundaries
Emotional regulation interventions	Fairness and team wellbeing	Accountability for workplace conduct
Owned by: the person and their clinicians	Owned by: the line manager, with HR	Owned by: everyone, applied consistently

The organisation needs to support the employee without assuming that every difficult interaction is an unavoidable consequence of their mental health. Equally, it must not assume a behaviour is manipulative simply because it is emotionally intense.

THE KEY QUESTION

If we temporarily removed the diagnostic labels, what specific workplace behaviours would we be concerned about, and how would we ordinarily manage them?

Then consider what reasonable adjustments are needed before deciding on any intervention. Where a mental health condition has a substantial and long-term effect on someone's day-to-day activities, it may count as a disability under the Equality Act 2010, and the duty to make reasonable adjustments applies. Acas guidance emphasises support, evidence, reasonable adjustments and fair process.

Describe behaviour, not diagnosis

In meetings about a struggling employee, conversation can drift towards what is “really” wrong with them. People with no clinical training start weighing up conditions, and partial or inaccurate information gets repeated until it sounds like fact.

Avoid this. A pattern of emotional instability, intense relationships, reassurance-seeking or difficulty with boundaries may be relevant to a clinical formulation, but it is not enough for anyone at work to conclude that someone has a particular condition. Diagnosis needs specialist assessment, and there is no need to settle it in order to improve management practice.

Instead, describe what you can observe, and stay open to more than one explanation:

- How the person responds to criticism, disagreement or uncertainty.
- How and when they seek reassurance, and from whom.
- How they cope when things feel overwhelming.
- Where the work is going well, which is easy to lose sight of.

Keep what is written down factual and proportionate. Health information is special category data, and speculation about someone’s mental health has no place in meeting notes.

Agree a framework for responding to distress

Without an agreed approach, every difficult moment becomes a fresh judgement call for the line manager, usually made under pressure. A simple shared framework means the manager is not deciding alone, and the employee gets a consistent response.

LEVEL 1

Everyday distress: routine support

When: Anxiety, frustration, relationship concerns or disagreements, without any immediate safety concern.

Response: Empathy, a brief discussion, the person’s own coping strategies, then back to workplace priorities. Follow up in the next scheduled check-in if needed.

LEVEL 2

Functioning affected: structured support

When: Persistent distress, being unable to complete work, repeated interpersonal conflict or a noticeable deterioration.

Response: A planned management conversation, HR and occupational health input, a review of adjustments and an agreed support plan.

LEVEL 3

Safety concern: urgent action

When: Current suicidal intent, credible threats of serious self-harm, severe disorientation or immediate danger.

Response: Follow your organisation's crisis procedure. Make sure the person gets urgent clinical help, and contact emergency services where necessary. The line manager should not manage this alone.

IF SOMEONE NEEDS HELP NOW

If there is an immediate risk to life, call **999**. Samaritans are available free, 24 hours a day, on **116 123**. In England, NHS 111 (option 2) connects to an urgent mental health service.

This is an internal management framework, not a clinical risk assessment tool. Any current concern about suicide or self-harm needs an appropriate individual assessment, not assumptions based on what someone has disclosed in the past.

To make it work in practice, agree in advance:

- Who the line manager contacts at Level 2 and Level 3, including out of hours.
- Where your crisis procedure is written down, and that managers know where to find it.
- How a Level 2 or Level 3 situation is recorded, and who sees the record.
- How the employee is told about the framework, so it is a shared arrangement rather than something done to them.

05

Get more from occupational health by asking different questions

Organisations sometimes find that occupational health has little more to add. That is often because the referrals have focused on the employee's conditions, rather than on the workplace difficulties management actually needs help with.

A fresh referral, where appropriate, can ask specific functional questions:

1. What adjustments would help the employee manage distress and interpersonal difficulties at work?
2. Would structured supervision and predictable communication be beneficial?
3. Is there a need for an individual workplace wellbeing or crisis plan?
4. Could changes to workload, communication or working patterns improve functioning?
5. What should management reasonably do when difficulties arise, and what should be directed to clinical services?

Any contact with the employee's GP or psychiatrist should follow the proper consent and confidentiality process, and occupational health can advise on whether clinical liaison would help. Employers should generally receive functional recommendations, not unrestricted medical information. Explain to the employee what is being asked and why, and share the referral questions with them.

06

Build a workplace support plan with the employee

A plan written about someone is far less effective than one written with them. Include the employee's own views, their strengths and the reasonable adjustments agreed.

A good plan usually covers:

- What tends to trigger difficulties at work, and the early signs that things are getting harder.
- What helps, in the person's own words, and what does not.
- Regular check-ins: when, how long and what they cover.
- How and when to raise something urgent, and with whom.
- Agreed adjustments to workload, communication or working patterns.
- What the manager will do, and what they will not, at each level of the framework above.
- Where clinical and personal support sits, outside work.
- When the plan will be reviewed.

Mind's Wellness Action Plan is a widely used free template for this kind of conversation, and many organisations adapt it.

07

Help the employee develop skills, without asking managers to be therapists

An employee who struggles with distress may benefit from developing different responses to difficult emotions, particularly when they feel criticised, rejected, misunderstood or overwhelmed. Approaches drawn from dialectical behaviour therapy and cognitive behavioural therapy offer a useful vocabulary, without anyone at work attempting to provide therapy.

Distress tolerance

Learning to experience strong emotions without immediately acting on them or seeking external reassurance.

At work: agreeing a pause before replying to a difficult email or raising a concern.

Emotional regulation

Recognising triggers and early warning signs, and developing appropriate ways of responding.

At work: naming early signs in the support plan, and what helps when they appear.

Interpersonal effectiveness

Communicating needs, accepting disagreement and managing conflict without escalation.

At work: preparing for difficult conversations, and agreeing how disagreements will be raised.

Self-efficacy

Building confidence that they can navigate difficulties independently, while still accessing support when needed.

At work: noticing and naming the occasions they managed something on their own.

There is an important distinction between helping someone develop their own coping strategies and telling them to be more resilient. It also matters that the employee is not made solely responsible for problems that may be partly shaped by management or team culture.

A QUESTION FOR THE ORGANISATION

How can we create an environment that supports their existing strengths, while also helping them develop the skills they find more difficult?

08

Support the manager, not just the employee

Managing an employee with complex difficulties can produce considerable anxiety, particularly where there has been a history of suicidal thinking or self-harm. Managers in this position often say yes to everything because they fear what will happen if they say no.

Make sure the manager has:

- Someone to speak to about the situation, other than the employee and their own team.
- Clear agreement on their boundaries, including scheduled check-ins and escalation routes.

- Permission to step back from Level 3 situations, and to hand them on.
- Time to manage the rest of their team, which is easily squeezed out.
- Support with the difficult conversations: feedback, boundaries and responding to distress.

Confidential advisory sessions for the manager, separate from any support for the employee, give them somewhere to explore their own responses: why saying no feels so hard, whether they fear a crisis, and how to keep their support sustainable.

09

Agree the outcomes, then review them

A meeting about a situation like this should leave with agreement on five things:

1. The factual picture: specific incidents, frequency, work impact and what has already been tried.
2. The manager's boundaries, including scheduled check-ins and escalation routes.
3. Whether existing occupational health advice is enough, or a new, more targeted referral is needed.
4. A workplace support plan, developed with the employee and including their views, strengths and reasonable adjustments.
5. A review date, around four weeks later.

At the review, look at three things separately: the employee's experience of the support, the manager's confidence and the impact on the wider team. Progress on one does not guarantee progress on the others.

A REFLECTION FOR HR AND SENIOR MANAGERS

Think about a situation in your organisation where an employee's distress has become difficult to manage.

Is it clear what is clinical, what is management and what is conduct?

Does the line manager know what to do at each level of distress, and who to call?

Has occupational health been asked about function, not only about diagnosis?

Does the employee have a support plan they helped to write?

Does the manager have somewhere to take this themselves?

Good management is neither rescuing nor withdrawing support. It is creating the conditions in which employees can function effectively, access appropriate help and develop greater independence.

FURTHER GUIDANCE

- What reasonable adjustments are, Acas (<https://www.acas.org.uk/reasonable-adjustments>)
- Mental health and the law, Acas (<https://www.acas.org.uk/supporting-mental-health-workplace>)
- Reasonable adjustments for disabled workers, GOV.UK (<https://www.gov.uk/reasonable-adjustments-for-disabled-workers>)
- Employment practices and data protection: information about workers' health, Information Commissioner's Office (<https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/employment/information-about-workers-health/>)
- Stress and mental health at work, Health and Safety Executive (<https://www.hse.gov.uk/stress/>)