Psychiatry and occupational medicine

Dr Max Henderson MSc PhD MRCP MRCPsych Hon FFOM

What is a psychiatric disorder?

Depression?

Recurrent depressive disorder?

Treatment-resistant depression?

Stress?

Anxiety?

Generalised anxiety disorder?

Burnout?

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Psychiatric disorders and work

Symptoms / direct

       low mood

       anxiety

       insomnia

       low energy

       poor concentration

       low self esteem

Psychiatric disorders and work

Indirect

        daytime structure

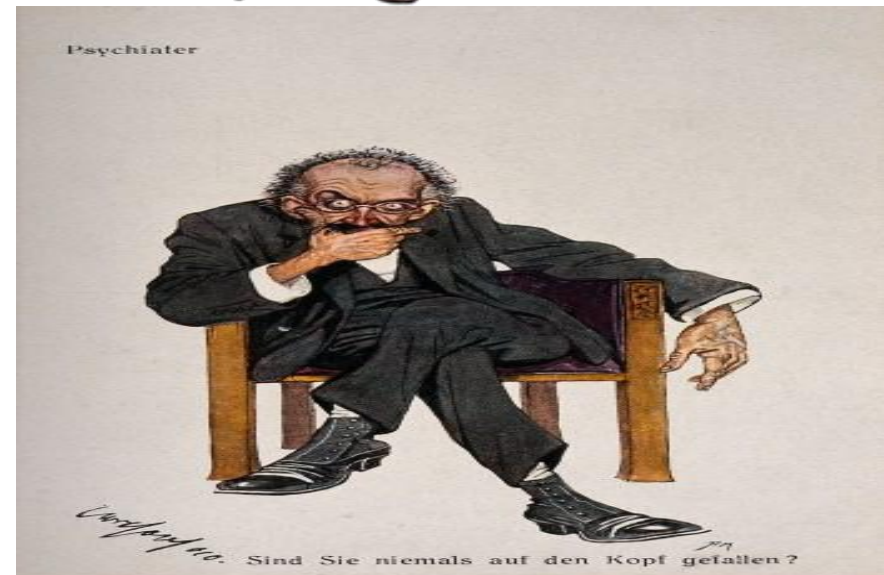   activities that create meaning
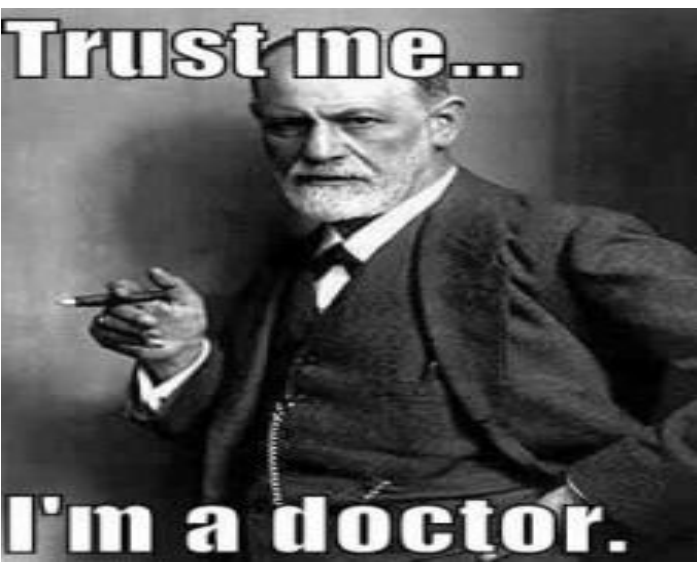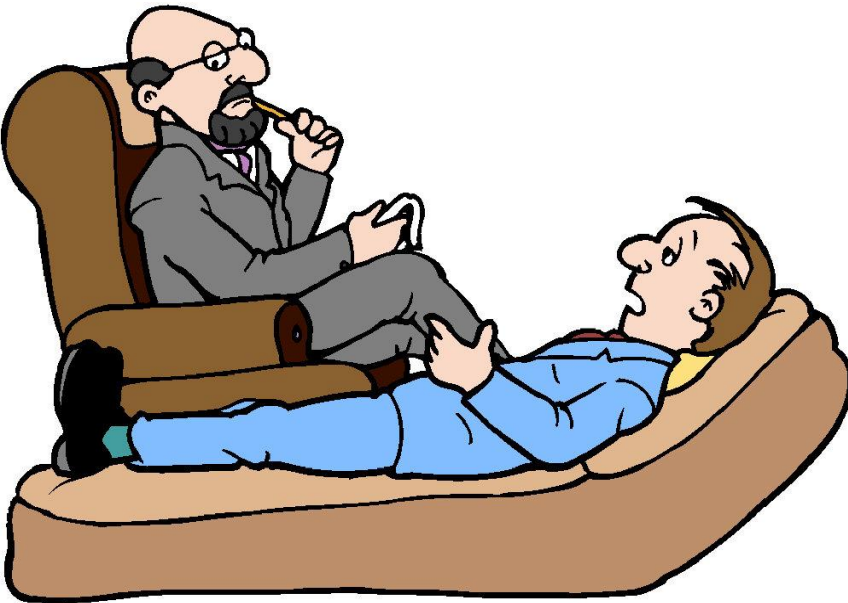
        wider cognitive function

        social contact

What is a psychiatrist?

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What sort of psychiatrists are there?

General adult
Drugs and alcohol
Forensic
Medical psychotherapy
Rehabilitation
Eating disorders
Neuropsychiatry
Intellectual disability
Liaison

What's a liaison psychiatrist?

Mainly working age patients

Interface between physical and mental health

    Self harm

    Psychiatric comorbidity

    Medically unexplained symptoms

Interface is with hospital teams

Much less focus on psychosis

Dialogue with a psychiatrist

- Should be welcomed by psychiatrist
- Remind them of your role
- Explain where their input fits in
- Benefits of proximity to labour market
- ASK THEM A QUESTION…
  - NOT just "please send me a report"
- Check they know about AMRA

Good news

- Focus is function
- Natural collaborators
- Work flexibly
- Very clever

Bad news

- Not very many of us..

- But its getting better

Work as a toxin

Stress at work

↓
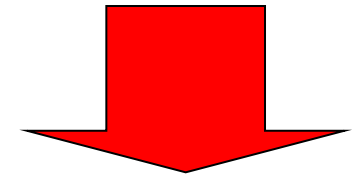
Ill Health

↓
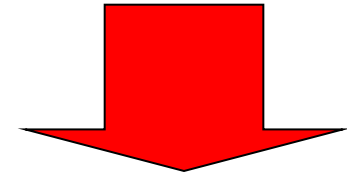
Sickness Absence

Work-related.....???

Born with a certain genetic risk

Early life events

Genetic and personality influence how we deal with life events

Life events as an adult

All of this operates within a societal context

Combination of these results in mental illness
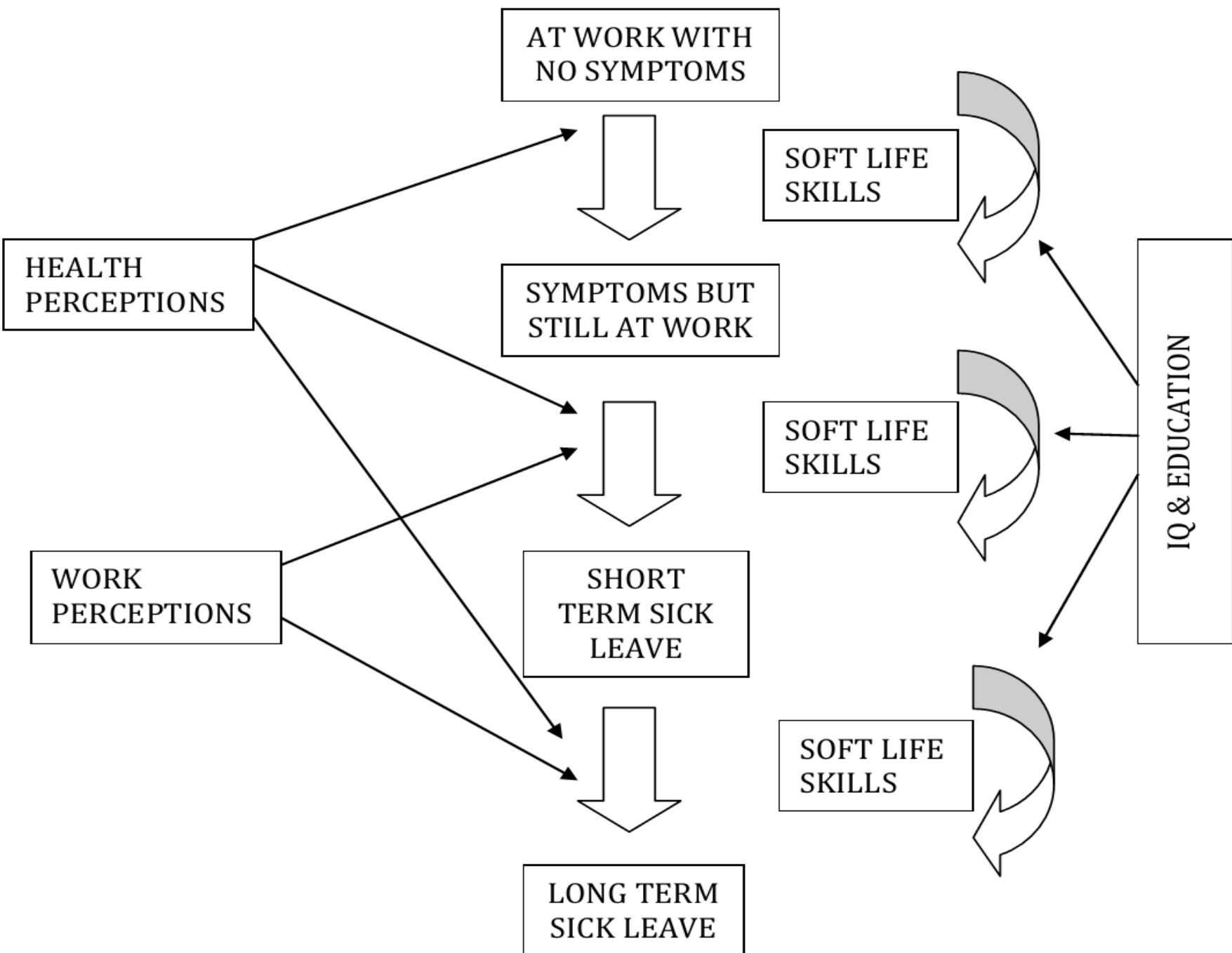
Occupational Health

- This is the key relationship (IMHO)
- Source of support at work
- Way of getting a view about work issues into the employer
- Assistance with RTW plans and adjustments
- Corroborative history re aspects of work: discipline / complaints / appraisals

Establish a dialogue....!

Is this real life?

Other (24%)

Diseases of the circulatory system (5%)

Injury, poisoning (6%)

Diseases of the nervous system (6%)

Mental disorders (42%)

Diseases of the musculoskeletal system (17%)

Long term conditions

Long term conditions: 30% of population of England (approximately 15.4 million people)

Mental health problems: 20% of population of England (approximately 10.2 million people)

30% of people with a long-term condition have a mental health problem (approximately 4.6 million people)

46% of people with a mental health problem have a long-term condition (approximately 4.6 million people)

Return to Work After Depression-Related Absence by Employees With and Without Other Health Conditions: A Cohort Study

Jenni Ervasti, PhD, Jussi Vahtera, MD, PhD, Jaana Pentti, BSc, Tuula Oksanen, MD, PhD, Kirsi Ahola, PhD, Teija Kivekäs, MD, PhD, Mika Kivimäki, PhD, and Marianna Virtanen, PhD

ABSTRACT

Objective: Among employees with depression, diagnoses of other psychiatric and somatic conditions are common. However, few studies have examined whether the combined presence of depression and other psychiatric or somatic disorders adversely affects return to work after depression-related absence from work.

Methods: We examined the association of present and recent psychiatric and somatic conditions and return to work after depression-related absence in a cohort of 9908 Finnish public sector employees with at least one such episode. The data included a total of 14,101 episodes during the period January 2005 to December 2011.

Results: A total of 89% (n = 12,486) of depression-related absence episodes ended in return to work during the follow-up. For those episodes, the median length of absence was 34 days (interquartile range, 20–69 days). After adjustment for sex, age, socioeconomic status, and type of employment contract, present or recent psychiatric disorders other than depression (hazard ratio [HR] = 0.78, 95% confidence interval [CI] = 0.74–0.83), cancer (HR = 0.66, 95% CI = 0.47–0.92), diabetes (HR = 0.73, 95% CI = 0.62–0.86), cardiovascular disease (HR = 0.78, 95% CI = 0.62–0.99), hypertension (HR = 0.76, 95% CI = 0.67–0.85), musculoskeletal disorders (HR = 0.82, 95% CI = 0.77–0.87), and asthma (HR = 0.84, 95% CI = 0.75–0.94) were all associated with a lower likelihood of returning to work compared with depression episodes without other conditions.

Conclusions: Among employees with depression-related absence, return to work is delayed in the presence of other psychiatric and somatic conditions. These findings suggest that other diseases should be taken into account when evaluating the outcome of depression-related absence. Randomized controlled trials are needed to examine whether integrated treatment of mental and physical disorders improves successful return to work after depression.
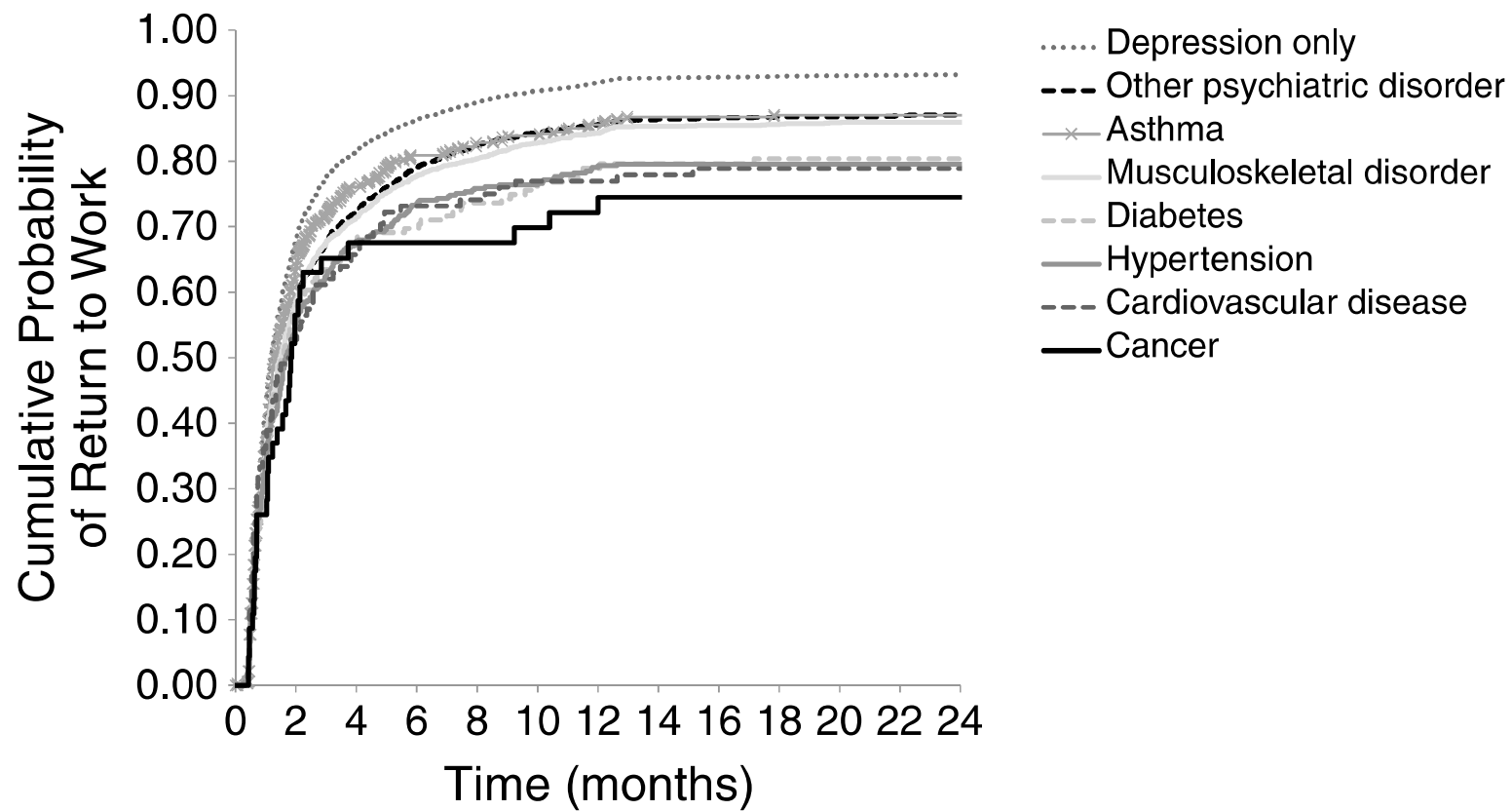
FOM / Royal College of Physicians

- First ever national audit of NHS OH practice
- Audit of 6286 case notes
- Covered 267 different NHS Trusts (69% of all Trusts in England)
- Focused on the first consultation after a staff member went on long term sickness absence (> 4 weeks)

National case note audit results

2.1: Is there any evidence that the OH Professional has attempted to assess whether or not the patient might be depressed?	National (6,286 cases)	
	Number	%
Yes	2,650	42
Yes, but no evidence of distress	1,019	16
No	2,617	42

	Referred with psychological diagnosis	Referred with musculo-skeletal diagnosis	All other categories of referral diagnosis
Percentage of patients assessed for depression	83% (1,727/2,091)	12% (147/1,277)	17% (340/1,943)

Key findings and recommendations

Case note audit: first consultation with NHS staff off work for at least four weeks for any health-related reason

Participation

- 82% (152/186) of OH services providing to NHS trusts in England participated in the audit.

- The number of cases entered nationally was 7,636; an increase of 21% from 2008.

Sickness absence

- The average length of sickness absence at the audited appointment was eight weeks, however 30% of cases had been off sick for least 12 weeks and 5% had been absent for over six months.

  NHS trusts need effective systems for early referral to OH for staff on long-term sick.

Depression assessment

- The proportion of cases assessed for signs and symptoms of depression rose from 58% in 2008 to 67% in 2010. This increase was particularly marked for cases where the presenting diagnosis was a physical one (15% to 52%).

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[1] National Institute for Health and Clinical Excellence. *Depression in adults with a chronic physical health problem: Treatment and management* (CG91). London: NICE, 2009.

Depression detection and management of staff on long-term sickness absence

Occupational health practice in the NHS in England

A national clinical audit: round 2

Executive summary

Royal College of Physicians

fom
Faculty of Occupational Medicine

NHS Plus

A diagnosis of depression should be considered in staff on long-term sickness absence, including where they present with a physical illness.

- The proportion of cases with detected depression who were asked about thoughts of suicide rose from 31% in 2008 to 49% in 2010.

- The proportion of cases with detected depression who were asked about alcohol use rose from 33% in 2008 to 46% in 2010.

- In both audit rounds 70% of cases were asked if they thought workplace factors had contributed to any depression (in 2010, 57% of these cases thought that workplace factors had contributed compared with 64% in 2008).

In 2010 there was an increase in the frequency and quality of assessments for depression. Scope remains for OH professionals to ask more often about core symptoms of depression, suicidal thoughts, alcohol use and work factors.

Poor occupational outcomes

- Poor mental health ☑
- Poor physical health ☑
- IQ? ☑
- Educational attainment ☑
- Adverse early life ☑

What sort of job?

- Low status ☑

- Low pay

  ☑

- Poor management (strain..) ☑

- Greater job insecurity ☑

And if they lose that job?

- Low self esteem
- Poverty
- Relationship breakdown

- What about the next generation?
  - Poor parental mental health
  - Poor parental physical health
  - poverty

Strategic Review of Health Inequalities in England post-2010

Marmot Review: First Phase Report

June 2009

Fair Society, Healthy Lives

Click to LOOK INSIDE!

STATUS SYNDROME

HOW YOUR SOCIAL STANDING DIRECTLY AFFECTS YOUR HEALTH AND LIFE EXPECTANCY

MICHAEL MARMOT

The
Noonday
Demon

An Atlas
of
Depression

❖

Andrew Solomon

"Checking for depression among the indigent is like checking for emphysema among coal miners….If this is how all your friends are, it has a certain terrible normality to it. You attribute your pain to external things and, believing these externals can't change, you assume that nothing internal can."

Andrew Solomon

The Noonday Demon

Employment and health inequalities

1. Risk factors for poor occupational outcomes are clustered
2. Poor mental health aggravates them all
3. People with mental ill health accumulate workplace risks for poor occupational outcomes…..
4. Which can then impact on the next generation
5. No work and poor work are major contributors to social gradients in health

Equality Act / DDA

Qualifying person

- Impairment of normal daily function - substantial
- Has lasted or is expected to last 12 month
- Judged off medication
- Relapsing and remitting conditions
- NOT about the diagnosis ("recognised")

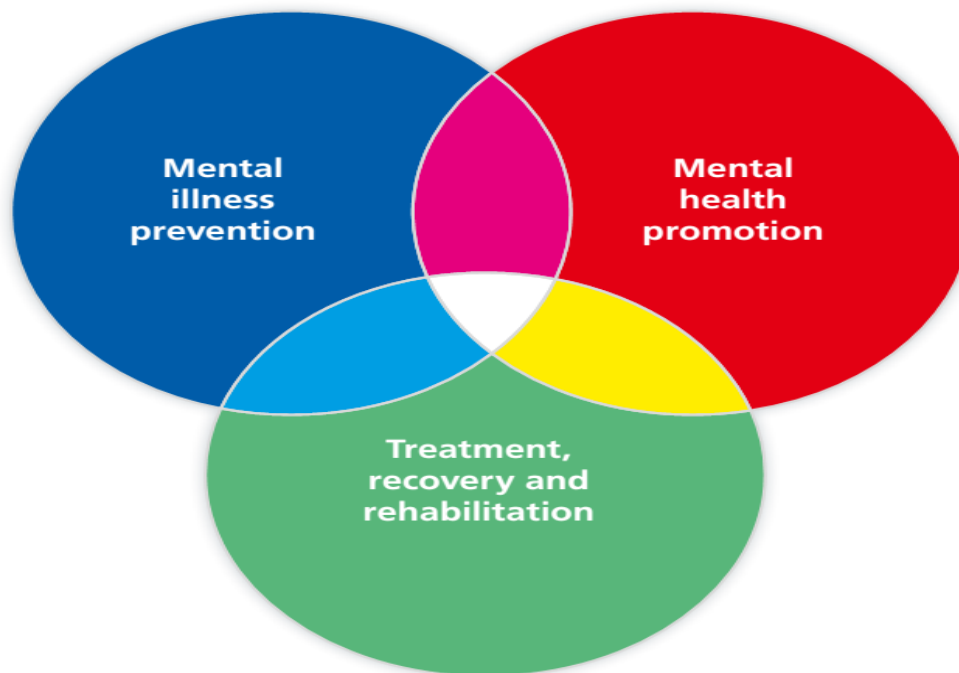# Equality Act / DDA

- Bipolar affective disorder?

- 1st episode of depression?

- Generalised anxiety disorder?

- Alcohol dependence?

- Recurrent depressive disorder?

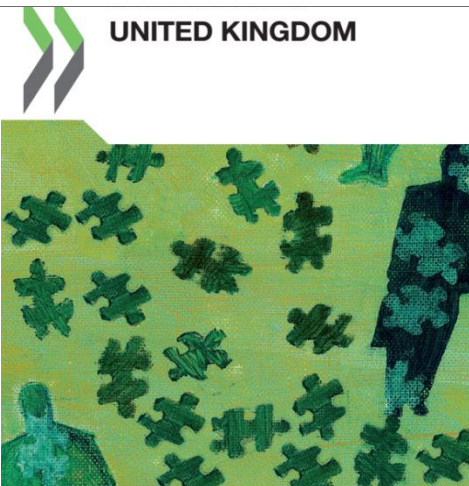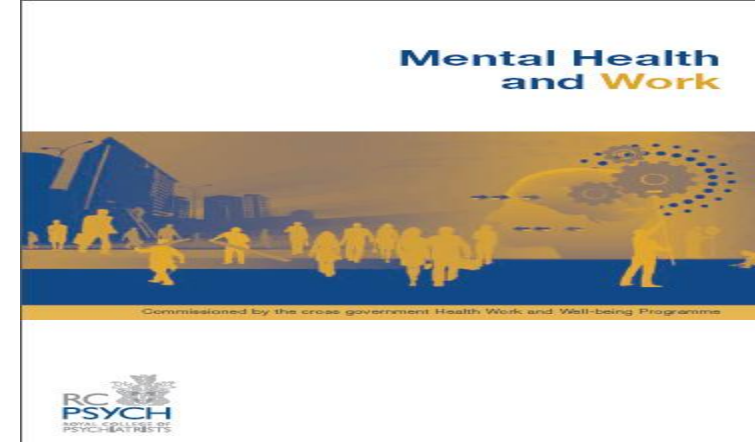- Badly treated depressive disorder?

Natural history of untreated depression

- Whiteford et al (2013)

- Systematic review and meta-analysis

- 53% untreated depression *in primary care setting* will resolve in 12 months

Sick on the Job?
Myths and Realities about
Mental Health and Work

OECD

Dame Carol Black's Review of the
health of Britain's working age population

Working for a
healthier tomorrow

Mental Health
and Work

Commissioned by the cross government Health Work and Well-being Programme

RC
PSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS

UNITED KINGDOM

Developing a mentally healthy
workplace:
A review of the literature

A report for the National Mental Health Commission and the Mentally Healthy
Workplace Alliance

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June 2013

UNSW | Psychiatry
Medicine

UNSW | Australian
School of
Business

BLACK DOG INSTITUTE

Australian Government
National Mental Health Commission

Department
for Work &
Pensions

Department
of Health

GSR
GOVERNMENT SOCIAL RESEARCH
Social Science in Government

Psychological Wellbeing
and Work

Improving Service Provision and Outcomes

Christian van Stolk, Joanna Hofman, Marco Hafner,
Barbara Janta

January 2014

RAND EUROPE   This report has been written by RAND Europe.

OECD

Health at work –
an independent review
of sickness absence

Dame Carol Black and David Frost CBE

November 2011

1

John Gordon, a professor of epidemiology at Harvard . . . in the late fifties sat me down and said: "No mass disorder afflicting humankind has ever been brought under control or eliminated by attempts at treating the afflicted individual nor by training large numbers of therapists." I never forgot his words, and I make my classes memorize them because this is the essence, the whole spirit of public health. One does not get rid of mass plagues afflicting humankind, including the plague of mental and emotional disorders, by attempts at treating the individual. (P. 213)

Workplace Counselling Works! Update

Last January the British Association for Counselling & Psychotherapy published a major new study by Professor John McLeod of the University of Abertay, Dundee, showing that COUNSELLING can reduce levels of stress in the workplace by more than 50 per cent.

It also revealed that:

Counselling in the workplace could also reduce levels of sickness and absence by between 25-50%.

Workplace counselling is effective in relieving the symptoms of both anxiety AND depression.

"People who need workplace counselling show signs of psychological distress equivalent to that found in out-patient psychiatric hospitals" (Professor McLeod).

Successful results can be achieved after as little as 3-8 sessions of counselling.

Workplace counselling at least covers its financial costs.

Among other results, this latest study shows that workplace counselling has the potential to:

- improve mental health for 78% of clients
- reduce rates of sickness/absence
- raise workplace performance

Counselling

Workplace counselling

M Henderson, M Hotopf, S Wessely

An appeal for evidence

Mental health problems at work are big news;[1–7] hardly a week passes without a new report highlighting stress at work or the proportion of absences from psychiatric causes. The numbers involved are enormous,[8] to the point where one might be concerned that this was yet another public health issue.[9] Both unions and employers perceive a problem, though it

way, and that there are no specific occupations which are intrinsically dangerous to mental health. Any alleged harm must be a demonstrable injury to health, not simply "occupational stress", and must be attributable directly to work. This is especially important as stress at work is common and only infrequently damages health. They stated that employers are entitled

described and commented on using the language of evidence based medicine. The conclusions are clear and unequivocal. It claims that after counselling, work related symptoms return to normal in more than half of all clients, and sickness absence is reduced by over 25%; that workplace counselling is an effective treatment for anxiety, depression and substance misuse as well as "stress". It is claimed that such results can be produced by as little as three sessions of any style of counselling as they all turn out to be effective. Was this the expert evidence that the judges referred to?

A more detailed reading of the report raises questions as to whether its conclusions can be justified. No studies were found that reported a negative outcome. This is surprising given the record of psychotherapy research.[19–21]

Mentally positive workplaces

Review by Sam Harvey (UNSW, Sydney)

6 domains

1. Job design
2. Protective factors at team level
3. Enhancing personal resilience
4. Promoting early help-seeking
5. Organisational approach to treatment for mental illness
6. Organisational culture e.g. stigma

Mental health positive

What does it **NOT** mean?

- Mental health patients get special treatment
- Mental health patients get care at the expense of workers with other disorders
- Crossness, disagreements or anger are not allowed
- Resilience is not valued

MENTAL HEALTH 'JOURNEY'

HEALTHY WORKER ⟷ SYMPTOMATIC OR AT RISK WORKER ⟷ MENTAL ILLNESS ⟷ SICKNESS ABSENCE

Primary prevention

Secondary prevention

Tertiary prevention

WORKPLACE PREVENTION STRATEGIES

Designing and managing work to minimise harm

JOB DESIGN

Enhancing personal resilience, generally and for those at risk

INDIVIDUAL

Supporting workers' recovery from mental illness

ORGANISATIONAL

Promoting protective factors at an organisational level

TEAM/ORGANISATIONAL

Promoting and facilitating early help seeking

ORGANISATIONAL

Increasing awareness of mental health and reducing stigma

ORGANISATIONAL

"Doctors are one of the most unattended populations in terms of health care"

Understanding why doctors present late

1st European Conference PAIMM 2001.

Dr Daksha Emson

Specialist registrar in community and rehabilitation psychiatry Oxleas NHS Trust

b 1966; q Royal London Hospital 1992;

BSc, MSc, MRCPsych,

d 27 October 2000

Myths....?

- Doctors are invincible
- Sick doctors always know when they are sick
- Sick doctors who know they're sick always know what they need to get better
- Sick doctors always get excellent Rx
- Doctors always follow doctors advice
- Doctors look after themselves

The reality

- Doctors are invincible X
- Sick doctors always know when they are sick X
- Sick doctors who know they're sick always know what they need to get better X
- Sick doctors always get excellent Rx X
- Doctors always follow doctors advice X
- Doctors look after themselves X

How are doctors different?

1. Higher risk of psychiatric disorder
2. Less likely to access standard medical care
3. More likely to access non-standard care
4. Personality -access to medicine is non-random!
5. Relationship between work and identity

How are doctors different?

1. Higher risk of psychiatric disorder
    a. Drugs and alcohol
    b. How are they managed
2. Less likely to access standard medical care
    a. Stigma, including self stigma
    b. Confidentiality
3. More likely to access non-standard care
    a. Medical knowledge / opinions
    b. Psychiatric ignorance.....
4. Personality -access to medicine is non-random!
    a. Not always easy...!
5. Relationship between work and identity
    a. Control
    b. Good/bad doctor/patient/person

Strategies from PHP

- What's left of the patient's life?

- Antidepressants get the patient in a position to **re-engage** with those things but **structured psychological therapy** can make that reality

- "symptom improvement" ≠ "functional recovery"

Strategies – flexibility

- We model RTW as a process and warn them up front about variable progress – often expectations too high

- Rigid 4 week RTW plans often too inflexible for MH patients who may have been off work several months

- What made the patient better? Can hours be adjusted if on sedative medication? Can the employee have time off for CBT?

Strategies

- We hate failed returned to works

Strategies

- **Anxiety** matters
- Commonly associated with depression but not asked about, not volunteered or just ignored
- May still be there when mood lifts
- Avoidant coping strategies easily developed when mood low, then difficult to shift
- Exposure +support – hold hands

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