Managing common mental health disorders in healthcare workers

Abstract

Background: Approximately a quarter of sickness absence in the UK National Health Service (NHS) is attributed to common mental health disorders (CMHD). This is costly to the NHS and impacts on patient care and staff morale. Little is known about the occupational health (OH) management of NHS staff who take sick leave due to CMHD.

Aims: To explore the current OH management of NHS staff who take sick leave for CMHD.

Methods: We invited providers of NHS OH services identified from the NHS Health at Work Network and Commercial OH Providers Association to complete a survey on the management of employees off work because of CMHD. Analysis involved descriptive statistics and content analysis.

Results: Forty-nine (39%) of the 126 OH departments approached responded. The majority (98%) had an organisational sickness absence policy that included triggers for referral for staff absent with CMHD. In 63%, referral occurred 8-28 days after the onset of absence; in 92% the consultation was completed by an OH nurse or OH physician. Content of the first consultation often included assessment of symptoms and medication for CMHD. Case-management and regular reviews were least commonly used despite evidence on their effectiveness in supporting return to work. All providers offered some support for managers of staff with CMHD.

Conclusion: Variation existed between providers of NHS OH services in the timing of referrals, use of case-management, and regular reviews for staff with CMHD. Our findings suggest that current evidence-based guidance on interventions to improve return to work is not being implemented consistently.

Key words: Occupational health; mental health; NHS; sickness absence; return to work

Introduction

The UK National Health Service (NHS) is the world's fifth largest employer with a workforce of 1.7 million. Its reported sickness absence rate is 3-4% [1], with over a quarter of staff illness attributable to poor mental health [2]. High rates of staff absence have important economic consequences, with Public Health England estimating that staff sickness costs the NHS £2.4bn annually. Poor health and wellbeing of NHS staff is also negatively associated with healthcare service quality, including patient safety and effective patient care [2].

Evidence indicates that interventions to reduce absence from work due to common mental health disorders (CMHD) are effective when focused on multiple domains and delivered early [3, 4]. Intervention should include identifying obstacles to return to work (RTW) [5]; work-focused cognitive behavioural therapy and problem solving [6]; a written personalised RTW plan; and maintenance of contact by the line manager [7]. Workplace adjustments, regular reviews, and communicating the RTW plan with staff members' general practitioners (GP) [8] and mental health professionals are also important.

Little is known about usual care by occupational health (OH) providers to manage healthcare staff on sick leave with CMHDs. In particular, the extent to which the OH management follows evidence-based standards that have been developed within the NHS is unknown [9]. Some standards have been incorporated into a national online benchmarking tool for OH providers [Management of Health at Work Knowledge (MoHaWK)] [10], but MoHaWK data is not specific to the management of CMHDs. This study aimed to establish the usual service provision for NHS staff who take sick leave due to CMHDs, and whether it is evidence-based.

Methods

Providers of NHS OH services were identified from the NHS Health at Work Network (NHSH@WN) (122 providers) and the Commercial OH Providers Association (COHPA) (4 providers). Each provider was sent a questionnaire that was developed based on the OH standards developed for the NHS [9]. The questionnaire included questions about elements covered in the first consultation for staff off work with a CMHD (see table 1 for details), the qualifications of OH staff undertaking initial consultations, the mode of OH service delivery (face-to-face or telephone), communication channels with managers and other healthcare providers, and their Trust's sickness absence policy.

Data were collected between November 2016 and January 2017 either online or via paper questionnaire, with reminders sent after 3 and 5 weeks. Data were analysed using SPSS Statistics 23, including descriptive statistics and content analysis.

Results

Forty-nine (39%) of the 126 identified OH providers responded. All but one responder (98%) reported that they had an organisational sickness absence policy that includes trigger points for referring staff who are off sick with a CMHD for OH management. For approximately two thirds (63%) of providers, the first OH consultation occurs between 8 and 28 days after absence begins. However, there was wide variation in the number of days to OH referral. Ten respondents (20%) accepted referrals on the first day of absence and one as soon as a fit note was received. Timely access to assessment by a psychiatrist or therapist was available to 82% of respondents, while early access to treatment by a mental health professional, through online cognitive behavioural therapy, or via counselling or employee assistance programme services was available to 88%.

Forty-five OH providers (92% of responders) reported that a qualified OH professional, usually an OH nurse, undertook the first consultation. Seventeen (35%) always used face-to-face appointments for first consultations, while 22 (45%) used face-to-face consultations more than half of the time. The remainder predominantly used telephone consultations.

Table 1 details the usual aspects addressed during the first consultation. Exploration of typical CMHD symptoms and recording medication were the most frequent. Conversely, the use of standardised questionnaires, case management and the arrangement of regular reviews were least common.

[Insert table 1 here]

All respondents provided contact and support for line managers of staff referred for CMHDs. The most frequent advice provided was to maintain contact with sick-listed staff (86%). Most (80%) provided training for managers to better support staff with CMHDs. Contact with the staff member's GP or mental health professional was less consistent, and when it occurred was most commonly made by e-mail (see figure 1).

[Insert figure 1 here]

Discussion

This survey of OH providers showed that there is variation in the support for NHS staff who are off work with a CMHD, particularly regarding the time between absence onset and their initial OH consultation. All responding OH providers reported good practice in contacting the referring line managers, but less than half contacted the staff member's GP or mental

health professional. Additionally, less than a third of providers used case-management approaches or regular reviews.

The main weakness of this study is non-response bias (61% of providers did not respond). Our findings may, therefore, not be representative of the usual OH management provided to all NHS employees with CMHDs. If better quality providers were more likely to respond, we may have overestimated the compliance with evidence-based practice.

The variations revealed by this national survey suggest inconsistent application of some evidence-based OH standards for managing NHS staff with CMHDs. Particularly, the recommendations for a case management approach and regular reviews were not commonly practiced. Differences in mode of first consultation (face-to-face versus telephone) may reflect variation in OH service delivery models; the widespread use of telephone consultations could indicate an appropriate operationalisation of OH delivery for organisations that are rural-based or have a dispersed workforce, and may not necessarily be an indicator of poor practice.

To our knowledge, this is the first national survey to investigate the current OH management for NHS staff with CMHDs. The findings highlight a need to improve consistent and early intervention of case management to promote early and sustained return to work, with potential benefit to the individual and considerable cost-savings for the NHS. Establishing usual OH management for NHS staff with CMHDs, as a baseline, will also allow the future evaluation of the efficacy and cost effectiveness of work-focused interventions for this group.

Key Points

What is already known about this subject:

- Evidence indicates that interventions to reduce sickness absence due to common mental health disorders (CMHD) are effective when focused on multiple domains and delivered early.
- Although over a quarter of staff illness in the NHS is attributable to poor mental health, little is known about the usual occupational health (OH) management of NHS staff on sick leave with CMHDs, including whether they follow evidence-based standards.

What this study adds:

- This cross-sectional study found wide variation in the OH management of NHS staff who are absent due to CMHDs.
- Evidence-based strategies for early return to work, such as case-management, regular reviews and communication with staff members' GPs and mental health professionals, are not consistently implemented.

What impact this may have on practice or policy:

- This is the first national survey to investigate the current occupational health management for NHS staff with CMHDs, and its findings highlight a need to improve consistent and early intervention of case management to promote return to work.
- The establishment of the usual OH management for NHS staff with CMHDs through this study serves to provide a baseline for the future evaluation of work-focused interventions for this group.

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References

1. Comer M. Sickness absence in the UK labour market: 2016. Newport: Office for National Statistics; 2017. [accessed 12 January 2019] Available from https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2016.
2. Boorman S. NHS health and well-being review: interim report. London: Department of Health; 2009.
3. National Institute for Health and Care Excellence. Workplace health: long-term sickness absence and incapacity to work. Manchester: NICE; 2009.
4. Pomaki G, Franche R, Khushrushahi N, Murray E, Lampinen T, Mah P. Best practices for return-to-work/ stay-at-work interventions for workers with mental health conditions. Vancouver: Occupational Health and Safety Agency for Healthcare in BC; 2010.
5. Waddell G, Burton AK, Kendall NA. Vocational rehabilitation: what works, for whom, and when? London: TSO; 2008.
6. Nieuwenhuijsen K, Faber B, Verbeek JH, Neumeyer-Gromen A, Hees HL, Verhoeven AC, et al. Interventions to improve return to work in depressed people. Cochrane Database Syst Rev 2014; (12):CD006237.
7. Waddell G, Burton AK. Concepts of rehabilitation for the management of common health problems. London: TSO; 2004.
8. Stern AF, Madan I. Optimal communication from occupational physicians to GPs: a cross-sectional survey. Br J Gen Pract 2012, 62(605):e833-9.
9. Stilz R, Baker A, Madan I. Evidence based quality indicators for the NHS standards – core services; 2012.
10. NHS Health at Work Network. Clinical governance – MoHaWK. [accessed 12 January 2019] Available from https://www.nhshealthatwork.co.uk/clinical-governance.asp.

Table 1: Elements of the first OH consultation for staff members off work with a CMHD.

	Never	Some-times	Often	Always	Don't know
	n (%)	n (%)	n (%)	n (%)	n (%)
Exploration of typical symptoms of common mental health disorders	0	0	4 (8)	45 (92)	0
Administration of standardised questionnaires (e.g., PHQ-9)	4 (8)	16 (33)	14 (29)	15 (31)	0
Assessment of medication	1 (2)	0	2 (4)	46 (94)	0
Assessment of non-pharmacological treatment	0	4 (8)	4 (8)	40 (82)	1 (2)
Assessment of drug and alcohol misuse	0	4 (8)	9 (18)	36 (74)	0
Assessment of risk to self (i.e., suicide and self-harm)	0	3 (6)	5 (10)	40 (82)	1 (2)
Assessment of risk to colleagues and patients	0	4 (8)	9 (18)	36 (74)	0
Assessment of support needs	0	1 (2)	5 (10)	43 (88)	0
Signposting to support services (e.g., employee assistance programme)	0	2 (4)	6 (12)	40 (82)	1 (2)
Identifying workplace barriers to a return to work	0	0	11 (22)	38 (78)	0
Identifying non-workplace barriers to a return to work	0	2 (4)	10 (20)	37 (76)	0
Problem solving and goal setting for return to work	0	5 (10)	19 (39)	24 (49)	1 (2)
Consideration of workplace adjustments	0	1 (2)	7 (14)	41 (84)	0
Return to work planning with staff member and their manager	0	4 (8)	13 (27)	31 (63)	1 (2)
Case-management	3 (6)	16 (33)	14 (29)	15 (31)	1 (2)
Arranging regular timed reviews	1 (2)	17 (35)	13 (26)	18 (37)	0