Does having an occupational mental health service make any difference?

Neil Greenberg¹, Max Henderson¹, Shazid Karim² and Kevin Holland-Elliott³

Background  The effects of mental disorder on UK's workforce are increasing, yet most occupational health (OH) providers have limited expertise in dealing with mental health issues.

Aims  To examine the effectiveness in terms of organizational and clinical outcomes, of an OH liaison psychiatry service in an inner city area.

Methods  A retrospective survey of case notes from the first 2 years of an OH liaison psychiatry service was carried out.

Results  Seventy-six cases were identified and 68% were seen within 1 month of referral. After assessment, females were significantly more likely to be given a formal psychiatric diagnosis than males. Overall, 45% of patients had mood disorders, 14% anxiety disorders and two cases of psychosis were identified. Advice was offered to the referring OH practitioner in 80% of cases.

Conclusions  This study found that liaison psychiatrists were able to fulfil a useful role in an OH department. Most of the cases seen within the department would not be classed as serious mental illness and therefore it is unlikely that community mental health teams would become involved in their routine care. Specialist mental health support from an ‘in house’ service is likely to be of considerable benefit from both occupational and medical perspectives.

Key words  Mental health; occupational medicine; service provision; survey.

Introduction  The effects of mental disorder on the UK's workforce are becoming increasingly important [1] and costly [2]. Studies have linked work-related mental health problems with physical disorders including cardiovascular and musculoskeletal problems [3–5].

Common mental disorders do not feature highly during the training of occupational health (OH) professionals and occupational issues feature only sparsely on the curriculum of psychiatric trainees [6]. Although general practitioners (GPs) provide mental health care for their patients, the steady increase in mental-health-related sickness absence suggests that such management is ineffective at keeping people fit for work. The Health & Safety Executive (HSE) estimate that about 500 000 people in the UK experience work-related stress at a level they believe is making them ill and up to 5 million people in the UK feel ‘very’ or ‘extremely’ stressed by their work [7].

The Department of Occupational Health and Safety, King's College Hospital set up a liaison psychiatry service in 2001. The OH Department provides services to a variety of National Health Service (NHS) organizations, local councils and small businesses. Liaison psychiatry referrals came from OH professionals within the Department, but were funded directly by the customer organization. Costs for the assessment were agreed with the referring organization before the liaison psychiatrist saw the patient. These were usually for 3 h of the psychiatrist’s time and the time taken to prepare a report. This covered the initial assessment, the use of any relevant assessment tools and time spent liaising with other professionals. Guidelines for referral were agreed between the psychiatrists and the OH professionals at the outset.

The role of the liaison psychiatrists was to provide a psychiatric assessment to support the OH advice to the client organization. The client organization, despite paying for the report, did not see it, as this was kept medical-in-confidence in the OH department. However the OH report to the referring organization incorporated any relevant psychiatric issues identified by the psychiatrist. The liaison psychiatrists did not provide any
treatment. If necessary they liaised with GPs and community mental health teams (CMHTs), aiming to maximize treatment opportunities.

This report details the first 2 years of the service.

Methods
A retrospective survey was conducted of all patients referred to liaison psychiatry at the Department of Occupational Health and Safety, King’s College London, from April 2001 until March 2003. Patients were identified from the confidential database within the department and by asking the liaison psychiatrists themselves.

Data were collected from the OH notes and recorded anonymously on a study form and included basic demographics, source of referral, length of time from referral to seeing a psychiatrist, length of time with each patient’s current employer, reason for referral, name of the psychiatrist, psychiatrist’s diagnosis and resultant medical management.

Data were analysed with SPSS (v11.0). Categorical variables were analysed with Chi-squared tests and continuous variables using the independent samples t-test.

Results
During the study period, 34 (45%) male and 42 (55%) female patients were seen. Liaison psychiatric consultations accounted for about 3% of the total doctor–patient consultation episodes within the Department. Eighty percent were white (Caucasian), 8% Asian and 12% were black. The mean duration of the problem prior to referral was just 13 months. Sixty-eight percent were seen within 1 month of referral. Other details are shown in Table 1.

Table 1. Timings for referrals

<table>
<thead>
<tr>
<th>Duration from referral to appointment</th>
<th>N  (%)</th>
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<tbody>
<tr>
<td>&lt;1 month</td>
<td>46 (66)</td>
</tr>
<tr>
<td>1–3 months</td>
<td>20 (28)</td>
</tr>
<tr>
<td>3–6 months</td>
<td>2 (3)</td>
</tr>
<tr>
<td>&gt;6 months</td>
<td>2 (3)</td>
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</table>

Table 2. Clinical data

<table>
<thead>
<tr>
<th>Grouped diagnosis given by liaison psychiatrist</th>
<th>N (%)</th>
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</thead>
<tbody>
<tr>
<td>Mood disorder</td>
<td>34 (45)</td>
</tr>
<tr>
<td>Other psychiatric disorder</td>
<td>17 (23)</td>
</tr>
<tr>
<td>No formal psychiatric disorder</td>
<td>14 (18)</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>11 (14)</td>
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<table>
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<tr>
<th>Management plan</th>
<th>N (%)</th>
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<tbody>
<tr>
<td>Liaison with GP</td>
<td>18 (24)</td>
</tr>
<tr>
<td>No advice given</td>
<td>15 (20)</td>
</tr>
<tr>
<td>Referred for psychotherapy</td>
<td>14 (18)</td>
</tr>
<tr>
<td>Liaison with CMHT</td>
<td>12 (16)</td>
</tr>
<tr>
<td>Re-start work</td>
<td>11 (14)</td>
</tr>
<tr>
<td>Other advice</td>
<td>6 (8)</td>
</tr>
</tbody>
</table>

Discussion
Our study found that liaison psychiatrists identified a psychiatric diagnosis in most patients referred to them. The majority of diagnoses were relatively minor mental health problems and clinical depression (n = 32, 42%) and anxiety disorders were common as they are in the general population [8,9]. Liaison psychiatrists were able to see referrals rapidly and provided useful advice to occupational physicians in the majority of cases (80%).

Although this study is limited by small numbers and a limited variety of occupations, the results suggest that an occupational psychiatric service can offer rapid assessments and a case management service to a busy OH department. We believe that a service such as the one described may have considerable benefits in terms of both organizational efficiency and workforce health. In-house psychiatrists were effective brokers and case managed employees who suffered with significant mental disorders. By encouraging CMHTs to provide treatment where required, providing expert advice on prognosis and mental-health-related risk management and where applicable supervising in-house psychotherapy services,
we argue that liaison psychiatrists had a distinct and useful role. Although we did not examine the cost-effectiveness of the service, we believe that relying on the NHS services, which prioritize their time towards caring for the ‘seriously mentally ill’, would be insufficient to meet the needs of most organizations. Both the UK Armed Forces [10] and some UK police forces use ‘in house’ psychiatric professionals and report them as being effective.

We suggest that OH professionals are often unfamiliar with the workings of CMHTs or making prognostic statements regarding more serious disorders. Considering prognosis is important when assessing someone’s future employability. A liaison psychiatry service, which is cognizant with organizational working practices, is also likely to be well placed to assist occupational physicians in advising organizations more effectively on their obligations under the Disability Discrimination Act 1995.

Liaison psychiatrists who work regularly with an organization are likely to have a greater understanding of working practices and be better placed to assist OH professionals in making appropriate workplace recommendations than might a CMHT or ad hoc use of psychiatrists working in private practice. Advice on prognosis or treatment needs is likely to be useful to OH physicians. Clearly written reports can encourage CMHTs to provide relevant treatment. Where a treatable disorder is identified, early referral for specialist therapies (such as cognitive behavioural therapy) can ensure that employees regain their fitness to work as quickly as possible. This will benefit both the employee and the employer. For example the early provision of trauma-focused therapies has been found to be both effective and cost effective for patients who suffer from PTSD [11]. Finding no psychiatric disorder can be helpful in advising that an employee is ready to restart work, as we found in 14% of cases.

Although we could not clarify whether the six PTSD cases identified were work related, some occupations, such as working in the emergency services or in the military, are associated with predictable exposure to potentially traumatic events. The ramifications of work-related PTSD can be costly and therefore having rapid access to professional mental health services can have both medical and legal utility. For example the Ministry of Defence recently successfully defended a PTSD class action against it. Despite having an in house psychiatric service the associated costs were about £20 million (Multiple Claimants versus The Ministry of Defence, 2003). Had the case been lost, costs would have been considerably higher.

We believe that there is a need for further research, especially in determining the cost-effectiveness of running a liaison service as described in this paper. Organizations should consider whether they can rely on community mental health services to ensure that their personnel receive rapid work-focused mental health interventions.

Conflicts of interest
None declared.

References