Return to the workplace after experiencing a mental health problem

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Who am I? – T:@profngreenberg

• Psychiatrist and Professor at King’s College London

• RC Psychiatrists Chair of Occupational Psychiatry SIG

• Served in the Royal Navy for 23+ years

• Managing Director of March on Stress Ltd

• Provide psychological clinical support, advice, training and assessments for organisations such as:
  – FCO
  – BBC,
  – Emergency Services,
  – PSCs
Workplace stress

Workplace stress is on the up

![Graph showing stress, depression or anxiety per 100,000 workers: new and long-standing. The rate of self-reported work-related stress, depression or anxiety was broadly flat but has shown signs of increasing in recent years.](image)
Adult Psychiatric Morbidity Survey: 2014

CMD symptoms:
One in 6 overall
One in 5 women
One in 8 men

And so are cases of significant mental ill health (APMS)
Bigger organisations appear more stressful

Professional workers report most stress
Not all industries are the same

Presenteeism

The practice of coming to work despite illness, often resulting in reduced productivity
Impact of poor mental health at work

IN 2018

£29.7 Bn

£47.8 Bn

Very bad outcomes
Impact of MH on leaving the workforce

Sources of ‘Stress’
What are ‘Common’ Mental Health Disorders

- Anxiety
- Depression
- Adjustment Disorders
- Post Traumatic Stress Disorder
- Alcohol misuse

Anxiety Disorders

- A disorder when
  - more than ‘normal anxiety’
  - interferes with everyday function
  - Last for weeks rather than days
- Types include: Phobias, Obsessive Compulsive Disorder and Generalised Anxiety Disorder (GAD)
- Severe feelings of tension, fear, agitation
- Panic attacks often manifest as physical ill health
  Note: anxiety disorders can be ‘infectious’ or cause colleagues considerable irritation
Depression

• A disorder when
  – Last for more than 2 weeks
  – Affects day to day function

• Three key symptoms:
  • Low mood
  • (Tiredness)
  • Lack of enjoyment
    • and poor sleep, concentration, appetite & sex-drive; negative views of the future; worthlessness

• Depression is importantly a risk factor for self-harm and suicide especially when associated with hopelessness

Adjustment Disorders (AD)

• Relatively common; usually short-lived.

• Disturbance of
  • Thoughts
  • Emotions
  • Behaviours
    • Impairs day to day function

• Represent the ‘extreme ends of the normal spectrum

• Once stressor removed ADs tend to improve

• LT problems may result from ‘unhelpful’ behaviour whilst distressed

• People who have a AD may well act “out of character”
What is a Potentially Traumatic Event (PTE)?

- **Being exposed to:**
  - Death
  - Threatened death
  - Actual or threatened serious injury
  - Actual or threatened sexual violence

- **By**
  - Direct exposure
  - Witnessing in person
  - Indirectly learning of a close relative/friend’s trauma
  - Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties
Type 1 and type 2 traumas

Stigma

People suffering with depression think it's their fault.
Who in their right mind would think that?
Journey to mental health support

Rafferty et al, 2017
A smorgasbord of evidence

• Predictors of RTW
  – Primarily - severity of the problem
  – Duration of the problem before sick leave
  – Duration of sick leave before seeking help
  – High baseline somatisation and anxiety
  – High depression remaining 3 months after the onset of illness

• Recommendation for supervisors to keep in touch with employees on sick leave
• Self-reported stressed/burned out staff returned to work quicker than self-reported depression (HR = 0.76) or other MHPs (HR = 0.56).

• A positive RTW expectancy of the sick-listed person (HR = 1.27)

• No prior absence with MHPs (HR = 1.29) were associated with a shorter time to RTW

Mean time to RTW was 25 weeks (median = 21) and at the end of follow-up (52 weeks) 85% had returned to work (n~300)

DSM-IV for depression predicted a longer time to RTW (HR: 0.61)

Better self-rated health predicted a shorter time to RTW (HR: 1.18), CI: 1.03–1.34

Employees working in the local council (HR: 0.62) and private sector (HR: 0.65) returned to work slower compared to the government staff
Summary of key RTW risk factors

• Severe MH problems (esp. depression) have a worse outcome
• The longer that a condition goes on without treatment, the worse the outcome
• Positive employee views of RTW suggest a better outcome

What sort of treatment
Results from a RCT (n=122) showed that a brief CBT-derived intervention combined with both individual-focused and workplace interventions was superior to standard CBT 10 months after applying for sickness benefit.

Partial return occurred 17 - 30 days earlier and full return to work occurred 200 days earlier.
What outcome can you expect?

What might help with RTW (post MH problems)
Social Support – How does it work?

- Stress Buffering: There when you need
  - Support from those around you

- Main effect: There all the time
  - Peer pressure, “resilient organisation”

Who did peacekeepers talk to?

Greenberg et al, JMH, 2003
Supervisory leadership and PTSD – Afghanistan 2010

**Good leadership 3+ of:**

- **‘my leaders never or seldom…**
  - a. ‘embarrass unit members in front of others’
  - b. ‘accept extra unit duties in order to impress their seniors’
- **‘my leaders often or always…’**
  - c. ‘treat all members of the unit fairly’
  - d. ‘show concern about the safety of unit members’

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**Psychologically Savvy Supervisors**

- Evidence from FRNSW on benefits of training supervisors

- Confidence to discuss MH was key
- ½ day training (but shorter also possible)
- Benefits from training managers (£1 for £10; Milligan-Saville, *Lancet Psychiatry, 2017*)
REACT<sub>MH</sub> – active listening skills training

One hour's remote active listening skills training led to a substantial improvement in supervisor's confidence to recognise, speak with and support distressed colleagues which was still evident one month after the training.

REACT<sub>MH</sub> evaluation
Workplace factors to consider
(HSE Management Standards)

• **Demands** – e.g. workload, work patterns and the work environment
• **Control** – choice over the way someone works
• **Support** – this includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues
• **Relationships** – e.g. promoting positive working to avoid conflict and dealing with unacceptable behaviour
• **Role** – clarity, role conflict and change
• **Change** – the management and communication of organisational change

Practical considerations

– Treatment progression (when to restart work)
– Flexibility (hours, tasks inc. trauma exposure)
– Supervisor and colleagues support (what can they know)
– Occupational health oversight (+/- Occ Psych)
– Risk management (inc to self & others)
– Responsibility (not too much or little)
– Persistent work stressors (esp. relationships)
– Other life stressors
Summary

- Workplace stress and frank MH problems are on the increase
- They can lead to loss of employment and productivity
- Especially important in safety critical roles
- Longer, more severe illness leads to worse outcomes
- Work focused treatment has a better outcome
- Adjustments (reasonable) can make a big difference
- So can social support (esp. supervisors)
- Risks need to be actively managed
- Expect a good outcome if RTW handled proper and employee is motivated to return

Any Questions? - Fire Away!

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