

A cluster of occupational mental illness in an NHS trust

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ABSTRACT – A cluster of clinical cases of occupational mental illness has not previously been reported. A prospective cross-sectional study of patients referred for examination and advice about rehabilitation was undertaken to ascertain a variety of employer's rates of occupational mental illness. A background rate of referral for occupational mental illness of 3.1/1,000 employees per year was found apart from in one NHS trust where the rate was 25.6/1,000. Most patients were nurses and diagnoses were anxiety and/or depression with a median length of time off work of four months. There was no evidence that patients from this employer were vulnerable to mental illness. The high rate of occupational mental illness was associated with organisational change and a hostile working climate. This study shows that NHS trusts may be associated with unhealthy working practices. A cluster of occupational mental illness should be statutorily reportable to the Health and Safety Executive for further investigation.

KEY WORDS: ethics, Health and Safety Executive, ill health, medical professionalism, NHS trusts, occupational mental illness, work

Introduction

In the UK, mental illness or psychological distress is now the most common reason for issuing a sick note for work,¹ or referral to an occupational physician.² In a recent survey of the working population, 500,000 employees reported that they were suffering from work-related stress, anxiety or depression and approximately 20% of those surveyed said they were very stressed at work.³

Workplaces that are hazardous to mental health include those where the demands on employees are high but there is little control over the way they do the work,⁴ where social support is poor, there is an imbalance between effort and reward,⁵ or where organisational issues are unsatisfactory, such as a hostile working climate or culture, unsatisfactory working relationships, intrusion of work into home life, or where restructuring or external inspections are occurring.⁶⁻⁸ Less commonly, operational aspects are

reported as the source of stress but these tend to be in extreme circumstances where there is a risk of personal harm from violence or war.⁹ Personal vulnerability is also relevant to the occurrence of mental illness. Risk factors include a family history of mental illness, previous mental illness, recent stressful life events and personality traits of neuroticism.¹⁰

Given the above, one would expect to see clusters of occupational mental illness in clinical practice but this has not been reported. This may be because a suitable methodology has not been described. An opportunity arose when an impression was formed by one of us (CJMP) that a particular employer who used our service appeared to have more staff with occupational mental illness than other users. A prospective study was therefore designed to assess five neighbouring NHS trusts, one local authority and 50 factories/commercial organisations to ascertain their rates of referral for occupational mental illness.

Method

Between April 2003 and March 2004 all patients referred to two neighbouring NHS departments of occupational health from five NHS trusts (two acute, two mental and one community), a large metropolitan local authority, a variety of small factories and commercial organisations were included in the study. Most referrals were from managers and were for advice about the rehabilitation of individuals who were off work due to certificated illness. Consultations took place in a normal clinical setting with three occupational physicians who were familiar with making detailed enquiries about the workplace and with judgements about causal attribution.

Diagnoses were divided into mental or other illness and then sub-divided into occupational or non-occupational in aetiology. Where both work and non-work-related causal factors were present, attribution was made by clinical judgement on a balance of probability and by taking into consideration the reasonableness of management actions or inactions that had triggered the illness. Goldberg scales were used to objectively measure levels of anxiety and depression.¹¹ A score of >5 and >4 respectively being significant with the maximum score being 9 for each diagnosis.

For reasons of sensitivity the five NHS trusts were anonymised A to E. All referrals from Trust A were selected and from the other trusts and local authority according to the relative total number of employees. The number of employees in the factories and commercial organisations was unknown so analysis was made of 50 consecutive referrals by proportion of mental illness to all referrals. The length of time off work when seen was also recorded. Statistical analysis was by confidence intervals using Fisher limits and by Fisher's exact test.

Results

The rates and proportions of referrals for occupational and non-occupational mental illness by each employer are shown in Table 1. The referral rate for work-related mental illness for the employers other than Trust A was 3.1/1,000 (13/4,238), $p < 0.01$ for nine or more referrals. The rate of referral for Trust A of patients with occupational mental illness was eight-fold higher and proportionally significantly greater than the other employers ($p < 0.001$). There was no significant variation in referral for occupational mental illness between the five employers other than Trust A ($p = 0.81$). The median length of time off work from Trust A with occupational mental illness was four months (range 0–12) and the median combined anxiety and depression score was 13 (range 5–18). Nineteen of the 23 patients (83%) with occupational mental illness in Trust A were nurses or nursing assistants. There was no significant difference in the rates or proportions of referrals between employers for mental illness which was not work related ($p = 0.996$).

Discussion

This study shows a particularly high rate of referral for occupational mental illness in one NHS trust. It is unlikely to be due to ascertainment bias as referral policies were similar in the five NHS trusts and there was no suggestion from the patients that those in Trust A were over represented or those from the other employers were under represented. This is the first time that a cluster of cases of occupational mental illness has been reported from one workplace.

The high rate of illness is unlikely to be due to a vulnerable population of employees, as the rate of referral for mental illness which was not work related was no higher in Trust A than in the other employers. Neither were the illnesses trivial, with the median length of time off work when seen being four months and in the form of depression and/or anxiety, sometimes sufficiently severe to warrant specialist psychiatric treatment. Supportive third-party evidence of a serious organisational problem was found from staff representatives in the sentinel trust, who reported their concerns about the way some staff were being treated and of work-related stress to the trust's health and safety committee. In a 2003 staff survey of Trust A, 14% (51/362) of respondents reported bullying or harassment in the previous year. This compared with 9% (40/448) in a similar survey in one of the other trusts.

The cluster of occupational mental illness in Trust A corresponded with a style of management that included a high number of formal grievances, prolonged investigations and suspensions, dismissals and compulsory redeployments of staff. Senior managers' justified their actions on the grounds of a need to bring

Table 1. The rates and proportions of referrals for occupational and non-occupational mental illness by employer. Values in parentheses are 95% confidence intervals.

Employer	Effective sample size	Number of referrals	Number of mental/work-related referrals	Proportion of referrals that are mental/work-related	Rate of mental/work-related referrals (number/1,000 employees/year)	Number of mental/non-work-related referrals	Proportion of referrals that are mental/non-work-related	Rate of mental/non-work-related referrals (number/1,000 employees/year)
Trust A	900	59	23	0.39 (0.27–0.53)	25.6 (16.3–38.1)	12	0.20 (0.11–0.33)	13.3 (6.9–23.2)
Trust B	900	24	2	0.08 (0.01–0.27)	2.2 (0.3–8.0)	5	0.21 (0.07–0.42)	5.6 (1.8–12.9)
Trust C	900	46	4	0.09 (0.02–0.21)	4.4 (1.2–11.3)	10	0.22 (0.11–0.36)	11.1 (5.3–20.3)
Trust D	825	76	4	0.05 (0.01–0.13)	4.8 (1.3–12.4)	17	0.22 (0.14–0.33)	20.6 (12.0–32.8)
Trust E	680	17	2	0.12 (0.01–0.36)	2.9 (0.4–10.6)	4	0.24 (0.07–0.50)	5.9 (1.6–15.0)
Local authority	933	17	1	0.06 (0.00–0.29)	1.1 (0.0–6.0)	4	0.24 (0.07–0.50)	4.3 (1.2–10.9)
Factories/ commercial organisations	NA	50	6	0.12 (0.05–0.24)	NA	13	0.26 (0.15–0.40)	NA

NA = not applicable.

about organisational change and to address the underperformance of specific individuals. The cases seen in the occupational health department are likely to be the tip of an iceberg of emotional distress among staff. Questionnaire surveys in other workplaces have found up to 38% of respondents to be the victims of bullying⁸ but rates of between 3% and 8% per annum are more usually quoted.¹² Coping strategies used by colleagues include 'presentism' and aligning with the bully.⁹ The fact that this cluster occurred in a healthcare organisation is ironic and is unlikely to have occurred without a detrimental effect on patient care.

Occupational mental illness is not statutorily reportable to the Health and Safety Executive (HSE) because of the 'difficulty' in objectively attributing multi-factorial mental illnesses to work. For an experienced occupational physician this should not be too difficult. On the basis of this work there appears to be a background rate of occupational mental illness of about 3/1,000 employees with a rate of more than 8/1,000 being inconsistent with this background rate and likely to indicate a serious organisational problem. This study provides evidence that occupational mental illness should be reported to the HSE for further investigation of the root cause when nine or more cases per 1,000 employees or, for example, three or more cases in a department, are diagnosed by one or more medical practitioners. Psychiatrists, general practitioners and physicians should be prepared to proactively liaise with occupational physicians about cases of occupational mental illness that come to their attention.

Feedback of the results of this research to Trust A was not well received by senior managers and led to an attempt to discredit the occupational physician. Such a situation illustrates the ethical difficulties that may arise for a doctor when reconciling professional and employment responsibilities. Fortunately there have been beneficial effects for staff, as evidenced by a fall in new cases of occupational mental illness to four the following year (2004–5) with no evidence from self-referrals, or from union representatives that potential cases of occupational mental illness were being stopped from seeing the occupational physician. Removal of some of the senior personnel who were instrumental in the organisation's unhealthy style of management may also have been helpful.

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