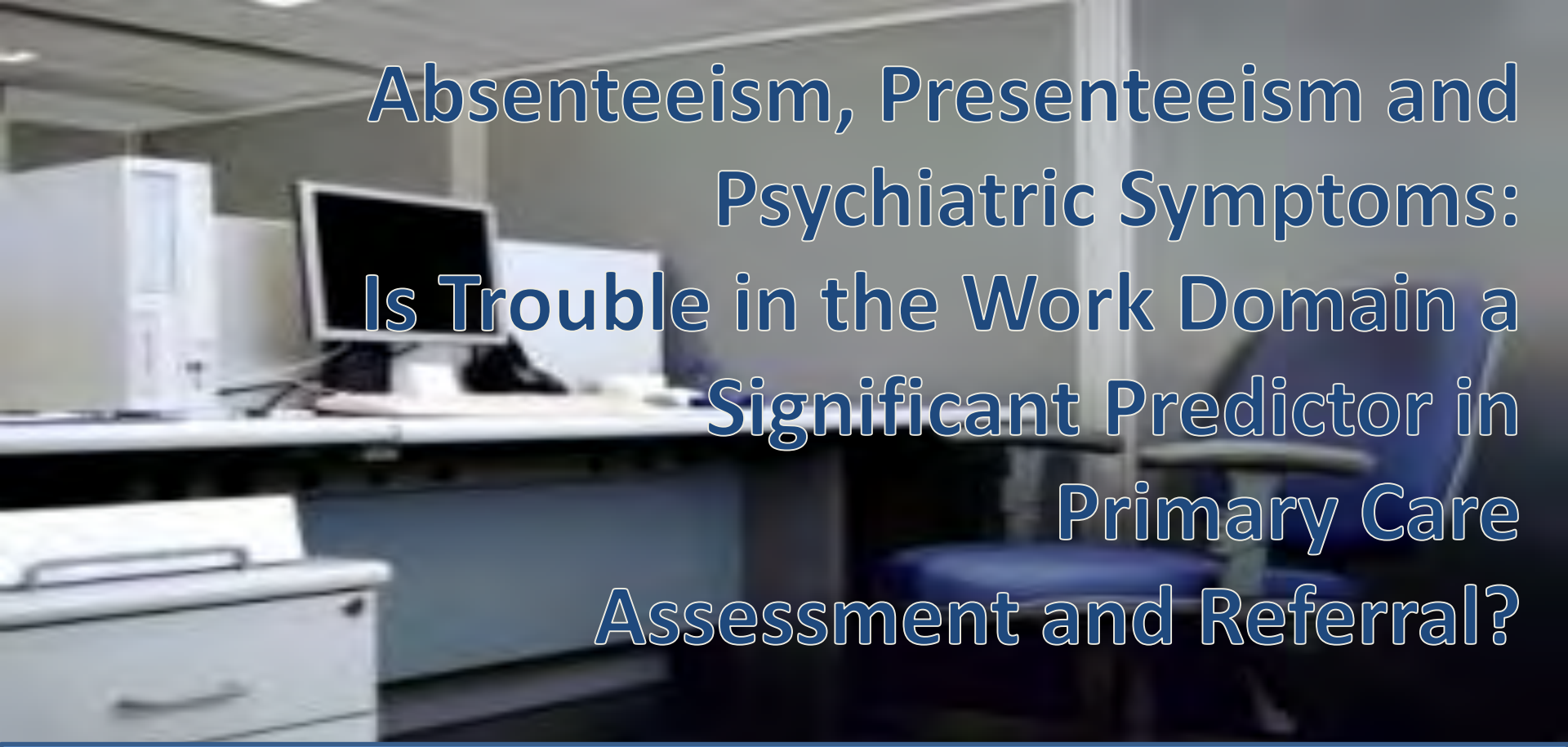


Absenteeism, Presenteeism and Psychiatric Symptoms: Is Trouble in the Work Domain a Significant Predictor in Primary Care Assessment and Referral?

John M. Haggarty, M.D.
St. Joseph's Care Group; Lakehead University, Northern Ontario School of Medicine

S. Kathleen Bailey, M.A., Ph.D. Candidate (Clinical Psychology)
St. Joseph's Care Group; Lakehead University

Sara Kelly, MPH, HBA, MD Candidate 2014
Northern Ontario School of Medicine

14th Canadian Collaborative Mental Health Care Conference
June 2013, Montreal, Canada

Conflict of interest:

None.

Learning Objectives

- 1) Gain a broader understanding of the importance of and unique challenges to identifying and treating MH problems of workers.
- 2) Be presented with empirical evidence from 10 years of MH referrals and treatment at our own interprofessional SMHC practice, emphasizing clinical presentation and outcomes when the referral problem is work and employment-related.
- 3) Engage in a dialogue about the role of collaborative & primary care in early detection and treatment/intervention for workers.

- 30% disability claims are due to Mental Health complaints
- Most MH problems are undocumented

KAREN BAILEY, "Surgery on Afghan Boy" (2007-2009)

Most common among workers:

- Depressive disorders
- Anxiety disorders
- Substance Use disorders

KAREN BAILEY, “Sleeping Cook” (2005)

Mental Health and the Workplace

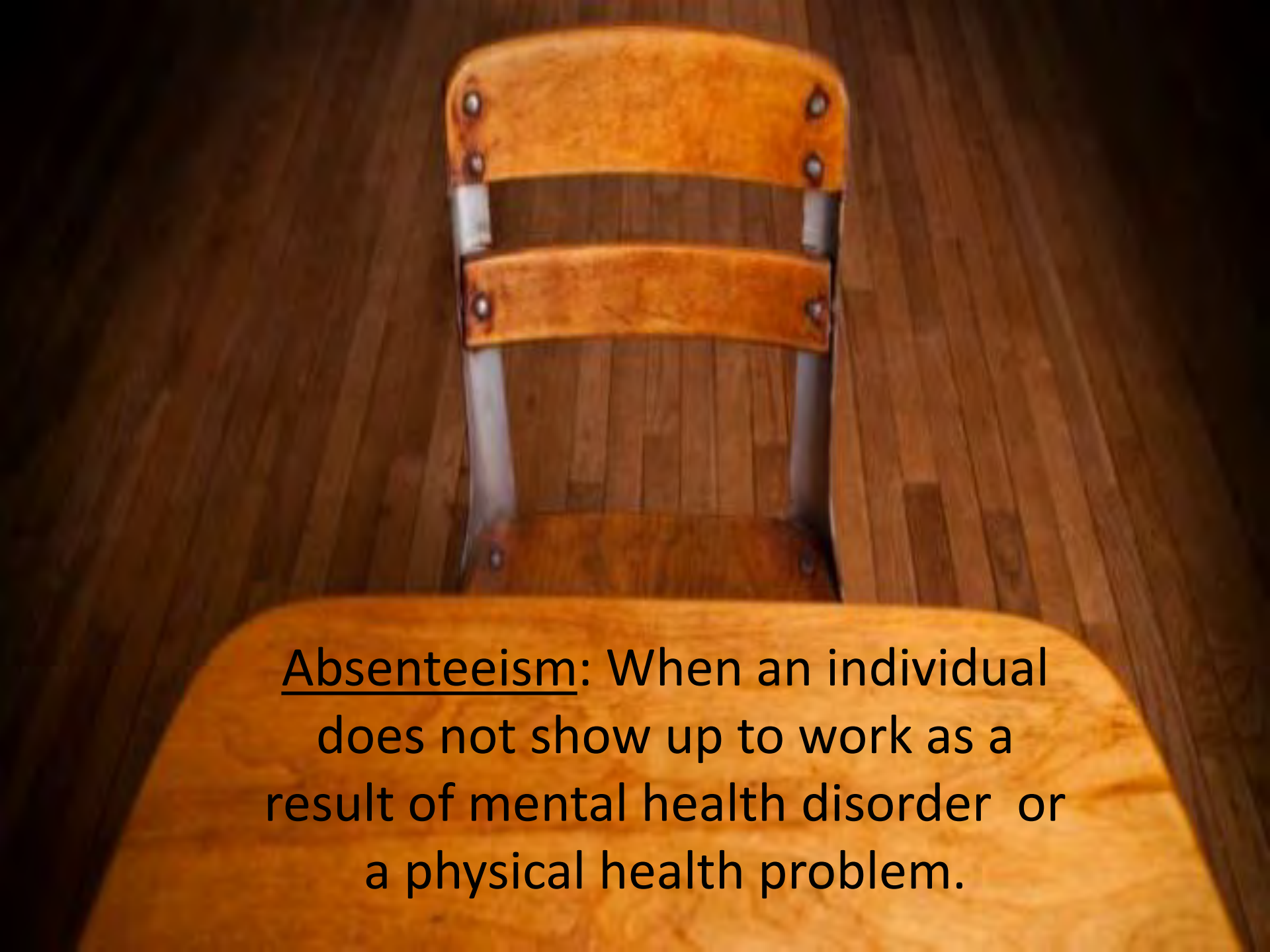
↓ functioning

↓ job satisfaction

↓ QoL

↑ loss of work

↑ sick days

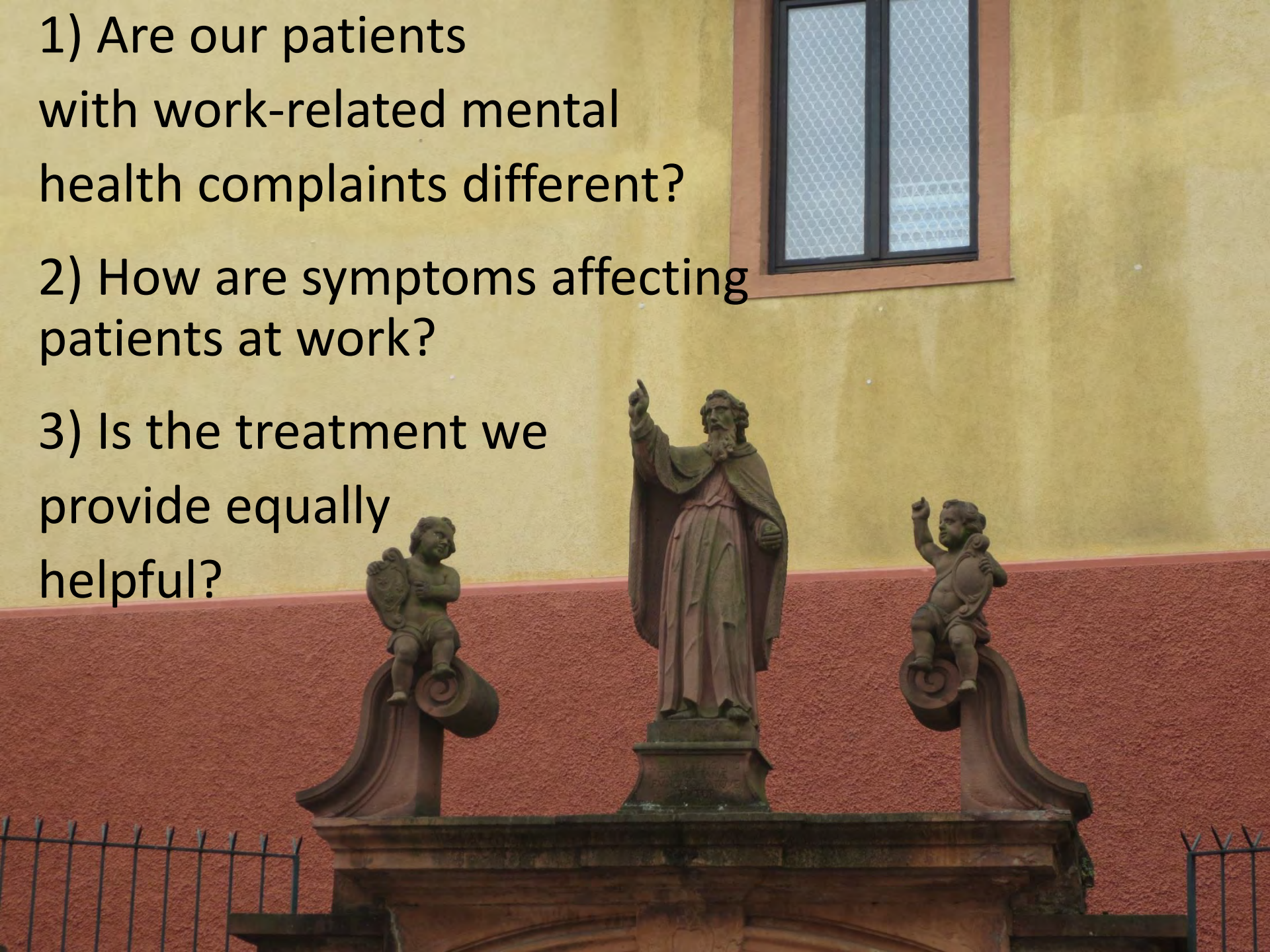

Absenteeism: When an individual does not show up to work as a result of mental health disorder or a physical health problem.

Presenteeism: When an individual is physically present in the workplace, but performing below what would reasonably be expected because of an inability to work productively.

1) Are our patients with work-related mental health complaints different?

2) How are symptoms affecting patients at work?

3) Is the treatment we provide equally helpful?



Patient Health Questionnaire (PHQ)

- Clinical Scales

WHO Disability Assessment Schedule 2 (WHO DAS 2)

- Disability
- Absenteeism
- Presenteeism

Differences in Reasons for Referral Among Work and Non-Work SMHC Patients

Reason for Referral	Work Group (%)	Non-Work Group (%)
Depressed Mood	73.6	59.6
Fluctuating Mood	17.6	12.2
Suicidal Thoughts	7.9	5.4
Phobia*	1.3	2.5
Other Anxiety Symptoms	55.2	40.4
Sleep Disturbance	38.4	22.4
Disorganized Thought Processes	2.4	1.1
Alcohol Abuse	6.5	3.6
Other Substance Abuse	6.3	3.4

[a]Fisher's Exact test; unless otherwise noted, all displayed results are significant at the $p<.01$ level, $*p<.05$.
[b]Reasons for referral that did not differ significantly between the two groups were: elevated mood, obsessive thoughts, compulsive behaviour, panic symptoms and/or attacks, excessive somatic symptoms, delusions, hallucinations, memory impairment, confusion, attention deficits, problematic personality traits, unusual behaviour, abnormal eating behaviours, developmental disability, or "other" psychological symptoms.


1st visit was the
patient's 1st *treatment* visit
(either counselling or Psychiatrist)
***Mean* #visits: 3**
(SD=3.98; 95% CI: 3.10-3.36)
Median #visits: 2; Range: 0 – 47
SMHC Visits

Patients' Overall Level of Disability in Previous 30 Days at Baseline and Exit from SMHC

- WHO DAS II Simple Sum Scoring[1]:
  - 0 = no disability, 48 = complete disability

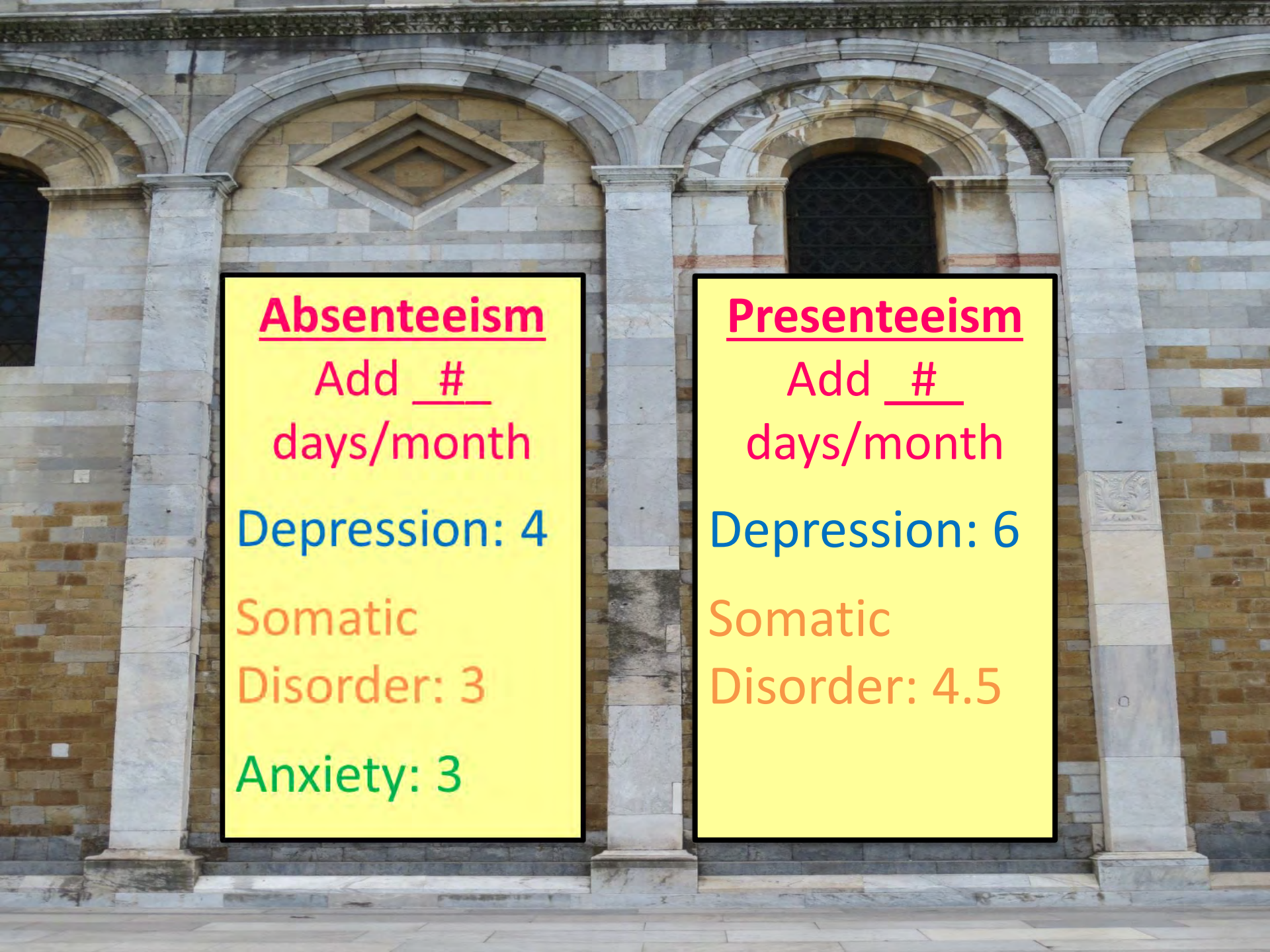
	Work Group		**Non-Work Group**		
	Mean *(N)*	*SD*	Mean *(N)*	*SD*	*p*
Baseline	**13.85** (447)	8.71	**11.14** (1878)	8.42	**sig.***
Exit	7.05 (133)	7.44	6.04 (529)	6.96	n.s.
*t(2323)=6.077, p<.001; Mean Difference = 2.71, (SE = .446, 95% CI: 1.836-3.585)					

[1]Andrews, G., Kemp, A., Sunderland, M., Von Korff, M., & Ustun, T.B. (2009). Normative data for the 12 item WHO Disability Assessment Schedule 2.0. PLoS ONE 4(12): e8343. doi:10.1371/journal.pone.0008343

Patients' Reported Days of Absenteeism and Presenteeism in Previous 30 Days at Baseline

	Work Group			Non-Work Group		
	Mean (N)	*SD*	95%CI	*Mean (N)*	*SD*	95%CI
Absenteeism days[a]	**8.02** (467)	10.11	7.07 – 8.97	**4.62** (1955)	7.90	4.26 – 4.98
Presenteeism days[b]	**11.42** (449)	10.77	10.41 – 12.43	**8.85** (1894)	9.80	8.41 – 9.30

[a]t(df=2420)=7.81, p<.001 [b]t(df=2341)=5.06, p<.001


Absenteeism
Add _#_
days/month
Depression: 4
Somatic
Disorder: 3
Anxiety: 3
Presenteeism
Add _#_
days/month
Depression: 6
Somatic
Disorder: 4.5

Patients' Reported Total Disability, and Days of Absenteeism and Presenteeism in Previous 30 Days ***at Exit*** from SMHC were ***Not Different*** *Between Work and Non-Work Groups*.

- **Mean WHO DAS 2 Score: 6.25**
- **Mean Days Absenteeism: 2.1**
- **Mean Days Presenteeism: 4.4**

Now, let's talk about this:

- How can/will you use this information?
- What more would you like to know?
- Why do you think the SMHC model was important for identifying/treating patients with work-related MH problems?
- What does it mean for your patients?

  Your coworkers? Your employer?
- How does the CSA Standard on Psychological Health and Safety in the Workplace fit in?
- ?

Thank you.

haggartyj@tbh.net

Abstract

The clinical profile and functional impairment of 11 years of patients referred to a co-located mental health (MH) service through primary care were examined. We investigated whether patients referred for MH complaints related to work and employment (work group) were demonstrably different from patients referred to the same clinic during the same time for non-work-related complaints. Patients in the work group were significantly more likely than patients in the non-work group to meet clinical cutoffs for Somatic Disorder (27.7% and 20.8%, $p<.01$), Major Depressive Syndrome (34.2% and 25.3%, $p<.01$), Panic (18.2% and 14%, $p<.01$), Other Anxiety (25.4% and 18.8%, $p<.01$), and approached significance for Alcohol Abuse (13.8% and 11.3%, $p=.057$). Work-related functioning was also more impaired in the work group, with these patients reporting mean days of absenteeism and presenteeism in the previous month (8 days and 12 days, respectively) at a higher rate than the comparison group (5 days and 9 days). Clinical and disability profiles were equal in the two groups after M=3 treatment visits in the MH clinic. This study has important implications for promoting regular assessment and ongoing use of valid screening tools in primary care and emphasizes the value of co-located MH service for timely and effective treatment.