

Return To Work Following an Intentional Overdose

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Case Summary

Introduction

Ms. A is a 45-year-old female care assistant who presented after taking an impulsive overdose of 50 tablets of prescribed antidepressant medication.

The overdose was taken following a preceding 6-week period of low mood, reduced energy levels, self-neglect, and reduced interest in pleasurable activities.

She was also experiencing other life stressors such as ongoing left knee pain, significant personal debts, social isolation and had been triggered by the deaths of two residents in her care home due to natural causes.

She was subsequently informally admitted after medical clearance.

Psychiatry Review

She described the overdose as an attempt to make her distress stop because the recent deaths in her care home brought back memories of the COVID-19 pandemic when she spent time in the intensive care unit after she became seriously unwell following an outbreak in her employing care home. This outbreak also led to five of the residents passing away.

She also reported ongoing left knee pain from arthritis and expressed frustration with having to spend time on a waiting list for an orthopaedic procedure.

Past Psychiatric History

She has been open to secondary mental health services over the past few years and has been diagnosed with Recurrent Depressive Disorder and Post Traumatic Stress Disorder following COVID-19. She was concordant with her prescribed antidepressant medication.

Past Medical History

She had a medical history of Type 2 Diabetes, hypertension, high cholesterol, and left knee arthritis. She was prescribed an oral hypoglycaemic agent, statin and painkillers.

Social History

She did not use recreational substances however vaped and drank socially.

She was also working full time and had to do bank shifts every week to get on top of her finances.

She reported being in debt of about £7000 which was causing her stress and was also socially isolated as she lived alone with her teenage son.

Mental State Examination

She presented as a middle aged Caucasian woman who appeared as anxious and teary.

She was able to maintain fair rapport however, had limited eye contact throughout the assessment. Her speech was reduced in volume, rate and tone. Her mood and affect were subjectively and objectively low.

She had no formal thought disorder or hallucination in any modality and was well oriented in time, place and person.

She has good insight into her mental health difficulties and future directions of treatment.

Physical Examination

She presented with persistently elevated blood pressure and also had a painful left knee with a reduced range of movement.

Treatment

Her antidepressant medication was optimized and augmented with a mood stabiliser.

Her antihypertensive and analgesic medications were also reviewed after liaison with the specialty teams.

She had physiotherapy input, an occupational therapy assessment and initial psychology input with the plan being to continue psychological therapy after discharge.

She was linked to the local community hubs team for social inclusion and was also signposted to Stepchange for support with her debt and Peabody for concerns about her accommodation.

Outcome

She was discharged after a 6 week hospital stay and has been able to transition to working as an Art Therapy assistant after being certified fit to work by occupational health services. She continues to find working in care fulfilling.

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Case Discussion and Literature Review

Work can be beneficial to our health as it can provide a source of income, regular routine, opportunities to connect with other people and a sense of purpose (1). Workplace pressures can however trigger and worsen mental health difficulties (2). Work stressors have been associated with psychological distress and post-traumatic stress symptoms (3). This traumatising effect for example can be seen with Ms A where her workplace experiences were directly linked to her mental health difficulties. Mental illness and psychiatric hospitalisation are important causes of long term sickness absence from work (4), with the United Kingdom experiencing the highest rates of sickness absence in a decade (5).

Employees are more likely to return to work productively following long term sickness absence if they are well supported (6). There has been research about the optimal strategies for supporting returning to work after psychiatric hospitalisation with various strategies tried with mixed results however there seems to be consensus that the more individualized the support, the likelier it is for the individual to return to work (7).

Given the increasing number of working age people who are out of work with more than 500,000 under-35s in the UK out of work due to long-term illness and a 44% increase in four years linked to a growing mental health crisis and underinvestment in health services (8), we feel that individualised occupational mental health and wellbeing services can play an important role in keeping people in work and also supporting workers who are on sickness absence to successfully return to work(9).

Conclusion

Ms A is a good example of a motivated worker who was experiencing workplace stressors leading to a deterioration in mental state, suicide attempt and subsequent sickness absence. She however benefitted from individualized support and was able to recover and successfully return to work. Occupational Health and Human Resources have an important role in supporting mental health and wellbeing in the workplace.

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