Australian Government
National Mental Health Commission

Submission to Clinical Guidelines for the Diagnosis and Management of Work-related Mental Health Conditions in General Practice

National Mental Health Commission

March 2018

Introduction

The National Mental Health Commission (NMHC) welcomes the opportunity to provide comment on the *Clinical Guidelines for the Diagnosis and Management of Work-related Mental Health Conditions in General Practice*.

The NMHC provides cross sectoral leadership on policy, programs, services, and systems that support better mental health, and social and emotional wellbeing in Australia. There are three main strands to the NMHC's work: monitoring and reporting on Australia's mental health and suicide prevention systems, providing independent advice to government and the community, and acting as a catalyst for change.

Specific to the current submission, the NMHC established on 1 July 2013 the Mentally Healthy Workplace Alliance (the Alliance), a national approach by business, community and government to encourage Australian workplaces to become mentally healthy for the benefit of the whole community and businesses, big and small.

The Alliance aims to make sure all people in the workplace, including those who experience mental health difficulties, their families and those who support them, are supported. This includes minimising harm, promoting protective factors and having positive cultures that are conducive to mental wellbeing. It also recognises that a mentally healthy workplace is not just good for people: it is also very good for business.

The NMHC agrees that the role of GP, as first point of contact, is pivotal in the lives of people who experience work-related mental injury and believe that when a person-centred, recovery-oriented and trauma-informed response is employed by GP's there is capacity to change the recovery trajectory for the individual and their families.

Draft Guideline Commentary

Overall, the NMHC applauds the methodological rigour used in developing these guidelines outlined in the technical report and the dissemination strategy outlined in the implementation plan. The NMHC would like to provide the following comments on the sections detailed below.

Executive Summary and Flow Chart

Recommendation: Stronger inclusion of person-centred care

The NMHC actively promotes the right of all people to participate in the decisions that affect their care and conditions that enable them to live contributing lives.

As stated in the NMHC's 2014 review[i], a person-centred mental health system is one where services are designed around the needs of people, rather than people having to organise themselves to find their way around what the system provides.

It shifts the locus of control away from providers and towards meeting the needs of users. That does not mean that people make all the decisions about their care and support, but rather that they are involved in decision-making at all levels of planning, designing and delivering services —"nothing about us without us".

The NHMC recommends stronger inclusion of person-centred approaches in the guidelines, this implicitly includes their active participation in decision making, entailing mutual respect, sharing of power and attempts to understand the person's needs. Within the medical context, Mead and Bower (2000)[ii] identified five aspects of person-centred care including:

1. bio-psycho-social perspective: broadening the focus of the doctor-patient interaction to include psychological and social factors as well as physical symptoms
2. patient as a person: exploring the meaning of illness and health to each individual patient
3. sharing power and responsibility: including the patient in decision making and considering them to be an expert in their own health
4. therapeutic alliance: valuing the relationship between doctor and patient as a means of promoting health
5. doctor as a person. Doctors are not interchangeable, the particular qualities, attitudes and values of the doctor are important and will suit one patient better than another.

These factors can be implemented in assessment and management planning through ensuring medical professionals asks questions around the person's understanding of their concern, how they are feeling about, offering support, providing clear information and willingness to share decision making. [iii] A central theme in the person-centred care literature within the field of mental health is that of empowerment, when people feel empowered they report better outcomes.

The NMHC notes that the guidelines acknowledge person-centred approaches in ensuring that the diagnosis is clearly communicated and understood as detailed below.

How can I ensure that the patient understands and acknowledges the diagnosis?
When conveying a diagnosis of a work-related mental health condition, GPs should have regard to:
a. Patient concerns such as the potential for stigma or discrimination;

b. A patient's socio-cultural background which may affect their acknowledgement of a mental health condition;

c. Negotiating patient confidentiality and sharing of information with a person's family or carer, if necessary.

(*Consensus statement*) (page 9)

However, the NMHC believes the guidelines could be strengthened through incorporating person-centred approaches into the appropriate communication with the person's workplace healthcare providers or management stakeholders' section (page 12). It would be essential that meaningful consent was received, not only initial consent as mentioned in the guidelines, but ongoing participation in decision-making to ensure the individual is comfortable with the stakeholders involved in their care, and what information is communicated.

For example, GPs should ask the individual about work place dynamics, such as perpetrators of workplace bullying that may have contributed to the work-related mental injury, and allow for clear communication on preferences for who is and is not involved in return to work planning at their workplace. Due to work-related mental injury requiring GP's to engage with various stakeholders as part of the individual's care, we believe person-centred approaches are required at the centre of all communication with stakeholders.

What is appropriate communication with the patient's workplace?
GPs should use telephone and / or face-to-face methods to communicate between a worker, supervisor, healthcare provider(s), union representatives and other disability management stakeholders.
(*Recommendation* based on MODERATE quality evidence and given a GRADE of Strong FOR)
GPs should consider using a trained return-to-work coordinator to coordinate and negotiate return to work amongst stakeholders, if available.
(*Recommendation* based on HIGH quality evidence and given a GRADE of Strong FOR)
When discussing the care of a patient who has a work-related mental health condition with their workplace, ensure that communication maintains a focus on the workplace and on the worker's needs and functional capacities.

(*Consensus statement*) (page 12)

In addition, the NMHC recommends the guidelines consider the role of support people and families from a person-centred perspective. Work-related mental injury can have significant impact on support people and family members. Therefore, ascertaining the wishes of the injured individual as to the level of inclusion of support people and family members would additionally be an important consideration.

Recommendation: Increased focus on Adjustment Disorder

Is this a mental health condition?

For workers with symptoms of mental health conditions a GP:

- Should use the *Patient Health Questionnaire-9 (PHQ-9)* to assist in making an accurate diagnosis of depression and assess its severity.
- May use either *Generalized Anxiety Disorder 7 (GAD-7) item* or the *Depression Anxiety Stress Scales* to assist in making an accurate diagnosis of an anxiety disorder.
- Should use the *PTSD CheckList – Civilian Version (PCL-C)* to assist in making an accurate diagnosis of post-traumatic stress disorder (PTSD) and assessing its severity.
- May use the *Alcohol Use Disorders Identification Test (AUDIT), Severity Of Alcohol Dependence Questionnaire (SADQ), Leeds Dependence Questionnaire (LDQ)*, to assist in making an accurate diagnosis of an alcohol use disorder, and assessing its severity.
- May use the *LDQ* to assist in making a diagnosis of substance use disorders and assessing their severity.

(page 8)

The NHMC recommends the inclusion of Adjustment Disorder in the summary of recommendations when referring to specific diagnoses and assessment tools in the executive summary and flow chart.

While Adjustment Disorder is considered by many to be transient diagnosis, or sub-clinical diagnosis, the guidelines state on page 27 “national claims database records of mental health conditions that were attributable to work, which include ‘reaction to stressors – other, multiple or not specified’ (41%)”, indicating that the most frequent mental health presentation attributable to work, would be that of Adjustment Disorder, or Acute Stress Disorder. This is likely due to the acute nature of work-related mental injury, when first presenting to their GP. Additionally, the guidelines make it clear that Adjustment Disorder was included in the review, however has not been included in the executive summary/flow chart.

It would be important to ensure appropriate tools and information is available for an accurate diagnosis, given diagnoses such as Generalised Anxiety Disorder require the presence of symptoms for a six month period,[iv] Adjustment Disorder is a common presentation and GPs limited time make it most likely the flow chart will be referred to most frequently.

Management Section

Recommendation: Stronger focus on graded return to work strategies

Additionally, some GPs have expressed concern with regards discontinuing sickness certificates for their patient where the patient is not 100% fit, as this may cause the patient to feel as though the GP is undermining their therapeutic alliance and thus could put a strain on the doctor-patient relationship. (page 67)

In 2014 the NMHC conducted an Australian-first review of research around workplace mental health.[v] The following recommendations and strategies for supporting workers recovery from mental illness were detailed in this review. Of particular importance to the medical practitioner, is understanding that when mental illness is concerned, the notion that one must be 'fully' recovered to return to work is out of date. In fact, such an approach may indeed hinder the recovery of the individual.

In order to facilitate the functional recovery from a mental health issue there are a number of approaches to be implemented with employers that have a large evidence base. Creating flexibility around hours, duties, and responsibilities may be the best form of support for the individual. There is evidence the longer someone is away from work, the more difficult it is to return and increasing anxiety can occur. The GP's role in collaborating with the workplace and other professionals to ensure partial or graded return to work, including alternative duties is fundamentally important.

Traditionally, when an individual feels they may be too unwell to be at work, they consult with their medical practitioner (usually a GP) who declares they are either fit or unfit for work. If the GP feels an individual may be unfit for work, a medical certificate is issued which directs how long that individual should remain away from work. A number of European countries are now promoting more flexible approaches to sickness absence certification, which may allow more focus on what an ill worker *can* do, rather than what they cannot. Such approaches have been called 'fit notes' or partial sickness absence. Rather than encouraging an extended period of absence from work, employers and organisations can play an active role in helping the return-to-work process by considering a range of work adjustments, including partial sickness absence.

Specifically, it has been noted that avoidance of the place or context where the work-related injury occurred can become a barrier to recovery for many people. Return to work programs that may include Cognitive Behavioural Therapy (CBT) or exposure therapy, both rely on a gradual return to work strategy and GP support to ensure appropriate medical documentation to facilitate this, and support the health professional delivering the therapeutic strategies.

Finally, it is necessary to acknowledge the importance of clinical judgement to assessment the appropriateness of graded return to work as in some cases the work place may not be a safe place for the individual to return to. This may involve liaison with allied health professionals or return to work coordinators in order to make an educated assessment of the workplace environment to ensure safety, ensuring a person-centred approach is maintained.

In summary, the NMHC recommend that an additional focus on assessing severity of injury and what the individual can do, to facilitate *graded* return to work or partial sickness absence be added to the guidelines.

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[i] National Mental Health Commission (2014). The National Review of Mental Health Programmes and Services: Sydney: NMHC

[ii] Mead, N, & Bower, P 2000, 'Patient-centredness: a conceptual framework and review of the empirical literature', *Social Science and Medicine*, vol. 51, no. 7, pp. 1087-110.

[iii] Victorian Department of Human Services. (2006). What is person-centred health care? A literature review

[iv] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

[v] The National Mental Health Commission (2014) *Developing a mentally healthy workplace: A review of the literature, A report for the National Mental Health Commission and the Mentally Healthy Workplace Alliance*, Prepared by: Harvey, S., Joyce, S., Tan, L., Johnson, A., et al.