Mental Illness and Health in the Workplace

ASM – AFOEM – Melbourne May 2017

Dr Peter Cotton – Organizational and Clinical Psychologist
Dr Dielle Felman – Consultant Psychiatrist (Occupational)
Outline

Common mental illness presentations in the workplace

Theory including workplace factors

Best practice treatment and return to work

Employee suicide
Common mental illness presentations

Mary - Depression
Yasmina - Anxiety
Terrence - Post Traumatic Stress Disorder

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Mary

52 y.o FT admin worker in a small office
14 years in the job. 1 prior period of prolonged leave
Recent relationship breakdown and ill mother
New Manager and new computer system
Mary’s symptoms

- Lowered mood, emotional, tearful
- Sleep disturbance, fatigued
- Lack of motivation – hard to get out of bed. Lack of interest
- Slowed thinking, distracted, poor memory, poor decision making
- Low self esteem
- Feels unable to cope
- Suicidal ideation without intent

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Mary at work

- Not attending work at least one day per week
- Not proactive, forgetting to do things, making errors
- Unable to master new computer system
- Looks tired and reduced attention to appearance
- Long periods away from her desk, withdrawn
- Smelt of alcohol

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Mary – two months later

- Support wearing thin; manager starting to check up on her
- Threatened with performance management
- Brings in a medical certificate for “medical condition” – unfit until further notice
- Referred for psychological therapy under mental health care plan
Mary - three months later

- No contact from workplace, feels discarded
- Spending time mostly at home
- Ruminating, lacking meaning and purpose
- Increasing self medication
- 2 sessions with the psychologist

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Yasmina

32 y.o woman living with boyfriend

Call centre operator; works for a large company

Attends her GP at end of 2 weeks annual leave stating she can't go back to work

Reports bullying from her Manager
Yasmina’s report

- New Manager is “micro-managing” her
- Constantly checking up on her work and her whereabouts
- Criticises her work in front of others
- One episode of being stood over and screamed at in closed office
- Threatened with job loss
Yasmina’s symptoms

- Ruminating about her manager and job security
- Feeling sick in the stomach, knots, nausea
- Unable to sleep – lying awake worrying, bad dreams
- Saturdays are better, Sunday night dread
- Difficult walking in to the building
- Edgy at her desk, hypervigilant, thinking her manager is watching her
- Mind racing, hard to concentrate on calls
- Headaches and rash
- Panic attacks before annual leave ending
Yasmina off work

Given medical certificate

Lodges work cover claim

Feels better away from work; high anxiety at reminders

Recurring dreams about work, ruminating

Weekly calls from work - feels harassed

Workcover claim declined - reasonable management action
Terrence

45 year old married customer service operator

Assaulted and threatened by a customer in store

Store manager asked him to finish shift

Knife held to him in car park

Has not returned to work
Terrence

- Preoccupied with assault
- Highly anxious, worse with reminders. Panic attacks
- Poor sleep, nightmares about the assailant, hypervigilant
- Flashbacks
- Weight loss and poor concentration
- Difficulty entering the store - vomiting in the car park
- Increasing time spent at home – “safe place”
- Drinking 1.5 bottles of wine per day

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Terrence

- Not responding to calls from store
- Partner emailing in medical certificates – a month off at a time
- Very angry at employer, high levels of perceived injustice
- Restriction of no contact from the store
- Mirtazapine prescribed but poor adherence
Theory including workplace factors
Psychological condition - Assessment

Symptom – type, severity, pattern
Diagnostic clarification
Functioning
Coping style Vulnerabilities
Comorbidities
MSE
Medications
Psychosocial industrial legal

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Psychosocial / Industrial factors / Legal

- POS (perceived organizational support)
- Employee contact
- Injustice
- Legal
- Job dissatisfaction
- Performance Disciplinary
Psychological health and safety

Psychological aspects of work health and safety are currently being accentuated by all Australian regulators

Safe work Australia – 8 Key psychosocial factors:

- Job demands
- Job control
- Coworker and supervisor support
- Work relationships
- Role clarity
- Org change management
- Recognition and support
- Organizational justice
Current major issues in workplace mental health

- Avoidance in addressing mental health issues in the workplace
- “We have an EAP so we don’t need to do anything else”
- Managers are generally ill-equipped – as people leaders in appropriately engaging with at-risk employees
- Go straight to performance management
- ‘It’s mental health’ – so allow too much leeway – contributes to entrenchment

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What does it mean to be fit for work?

- **Attendance/punctuality**: Ability to attend regularly, reliably and sustainably
- **Performance**: Quality and efficiency
- **Code of conduct**: Can they behave appropriately?
- **OH&S risk**: Will being at work make them more unwell?
# Functional assessment

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure / Routine</strong></td>
<td>• Sleep/wake cycle, activities of daily living – cooking, cleaning,</td>
</tr>
<tr>
<td></td>
<td>shopping, management of children/school, other activities.</td>
</tr>
<tr>
<td><strong>Energy / Endurance</strong></td>
<td>• Rest / napping during day / after activity, exercise, hobbies, energy</td>
</tr>
<tr>
<td></td>
<td>to get through day.</td>
</tr>
<tr>
<td><strong>Cognitive capacity</strong></td>
<td>• Read newspapers, books, watch television, emails, interaction with</td>
</tr>
<tr>
<td></td>
<td>social media (Facebook), remember things</td>
</tr>
<tr>
<td><strong>Interpersonal functioning</strong></td>
<td>• Engagement with family and friends, social activities, group</td>
</tr>
<tr>
<td></td>
<td>recreational activities</td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>• Frustration tolerance, Avoidance behaviours, substance use</td>
</tr>
<tr>
<td><strong>Evidence of work capacity</strong></td>
<td>• Involvement in study, volunteer work</td>
</tr>
<tr>
<td><strong>Side effects of medications</strong></td>
<td>• Medication effects on daily routine</td>
</tr>
</tbody>
</table>

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Best practice treatment and return to work
Specific treatments

- Self care
- Psychological therapy
- Biological treatments
- Return to work as a treatment!

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Self care

Address psychosocial factors

Improve mental health literacy

Healthy lifestyle
- Exercise
- Sleep hygiene
- Reduce caffeine
- Limit alcohol
- Avoid having to make significant decisions

Rally supports

Pathways to treatment
Psychological therapies - overview

All psychological therapies are not the same

- MHCP – double edged sword
- Therapist drift

Evidenced based:

- Cognitive behavioral therapy
- Acceptance and commitment therapy
- Mindfulness
- Trauma focused CBT
- Work focused CBT
## Psychological treatment interventions

| **Challenging avoidance behaviors**<br>(CBT cognitive restructuring, desensitization, arousal management skills) |
| **Exposure-based interventions**<br>(workplace/perpetrator focus: imaginal and in-vivo exposure; may include EMDR) |
| **Development of self-management coping skills**<br>(e.g., assertiveness skills, emotional self-regulation skills, cognitive rehearsal coping skills re possible future situations encountered) |
| **Contra-indicated!**<br>(Passive supportive psychological counselling – risk of reinforcing victim mentality) |
| **Is treatment aligned with Clinical Framework??** |

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Standard treatment versus work focused treatment

Over and above individual, injury and compensation system characteristics – treatment services still explain a significant proportion of the variance in return to work outcomes ... Lagerveld et al (2012)

Utilising a network of RTW focused healthcare providers achieved significantly reduced costs and lost time (by approximately 50% compared with standard healthcare... Bernacki et al (2005)

‘Work focused’ CBT compared with standard CBT achieved full return to work 65 days earlier.
**Pharmacological management**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Class</th>
<th>Dose range</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram (cipramil)</td>
<td>SSRI</td>
<td>20 - 40mg</td>
<td>GI symptoms, insomnia, sedation, sexual dysfunction.</td>
</tr>
<tr>
<td>Escitalopram (lexapro)</td>
<td>SSRI</td>
<td>10 -20mg</td>
<td>GI symptoms, Possibly better tolerated</td>
</tr>
<tr>
<td>Sertraline (zoloft)</td>
<td>SSRI</td>
<td>50- 200mg</td>
<td>GI symptoms diarrhea pronounced, insomnia, sexual dysfunction.</td>
</tr>
<tr>
<td>Venlafaxine (effexor)</td>
<td>SNRI</td>
<td>75- 375mg</td>
<td>GI symptoms, insomnia, agitation, sedation, sexual dysfunction,</td>
</tr>
<tr>
<td>Desvenlafaxine (pristiq)</td>
<td>SNRI</td>
<td>100mg</td>
<td>GI symptoms, insomnia, agitation, sedation, less sexual side effects</td>
</tr>
<tr>
<td>Duloxetine (cymbalta)</td>
<td>SNRI</td>
<td>30-60mg</td>
<td>Pain reducing properties</td>
</tr>
<tr>
<td>Mirtazapine (avanza)</td>
<td>NaSSA</td>
<td>30-60mg</td>
<td>Weight gain and sedation, less sexual dysfunction.</td>
</tr>
<tr>
<td>Agomelatine (Valdoxen)</td>
<td>MA agonist</td>
<td>25-50mg</td>
<td>Promotes sleep</td>
</tr>
<tr>
<td>Amitriptyline (Endep)</td>
<td>TCA</td>
<td>75- 150mg</td>
<td>Pain reducing and sedative properties. Toxic in overdose (cardiogenic) Side effects of blurred vision, urinary retention, constipation, sedation</td>
</tr>
<tr>
<td>Moclobemine</td>
<td>MAO- A</td>
<td>300mg</td>
<td></td>
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</table>

**Augmenting agents**

| Lithium               | Thyroid and renal problems, toxicity, needs monitoring, tremor, cognitive slowing |
| Thyroxine             |                                                                                   |
| Olanzapine | Anti psychotics | 12.5mg 600mg Weight gain, sedation, metabolic effects |
| Quetiapine           |                                                                                   |
| Risperidone          |                                                                                   |
| Aripiprazole         |                                                                                   |
| amphetamines         | addictive                                                                       |
# Prescribing principles

Diagnostic clarity, identify and treat comorbidities, address external factors.

**Education and alignment**
- Antidepressants take time to work (1-4 weeks).
- Need to be taken consistently.
- Initiation and withdrawal effects.

**Choice**
- Severity
- Side effect profile
- Family response
- Preference

**Start low. Go slow**
- Regular follow up and enquiry into side effect profile.

**Continue for 6 to 12 months after first episode. Longer for recurrent episodes.**
- If stopped on recovery, increased rates of relapse.

**Withdraw slowly**
- Discontinuation is not the same as addiction.
- Rapid discontinuation may be associated with a higher risk of relapse.

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Physical treatments

**Electroconvulsive therapy (ECT)**
- Highest rate of response of any form of treatment
  - 80-90% improve
  - Medication resistant cases respond 50% of time.
  - Indicated for severe depression with psychotic features, catatonia, severe suicidality or food refusal, contraindications to medications, previous effect and patient choice.
- Safe treatment.
- Side effect – cognitive – memory disturbance is usually self-limiting within a few weeks. Retrograde amnesia may continue. Reports of more persistent cognitive difficulties. Ultra brief pulse wave options

**Trans magnetic stimulation (TMS)**
- Increasing evidence for role of this in depression.
- Better tolerated than ECT.

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Role of work in mental health and recovery

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- At work
  - Meaning
  - Purpose
  - Self-worth
  - Remuneration
  - Distraction
  - Social Interaction
  - Stimulation

- Not at work
  - Lack of meaning
  - Reduced purpose
  - Reduced self-worth
  - Financial difficulties
  - Time to ruminate
  - Isolation
  - Boredom
  - Unhealthy habits

Lack of meaning/purpose/value

Boredom – time to ruminate and develop unhealthy habits

Social isolation

Worsening symptoms

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94% of initial certificates of capacity issued by GPs for mental injury are “unfit for all work”.

- Lack of awareness of options
- Believe they are protecting patient
- Not aware of risks

Many of these individuals actually have work capacity and will have better long-term health outcomes if they continue/return to work.
Reasonable adjustments

- Duties e.g. modified duties
- Hours e.g. reduced hours, GRTWP
- Expectations e.g. longer time frames, lower KPI’s
- Environment e.g. alternate line of management
- Support e.g. support meetings; written feedback; more training; time to attend appointments

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Enabling recovery
Specifics of treatment

- Mary: Depression
- Yasmina: Anxiety
- Terrence: Post Traumatic Stress Disorder
Mary - Treatment

Mindfulness and work focused CBT – weekly then fortnightly
- Psychoeducation
- Cognitive restructuring
- Activity scheduling

Alcohol counselling

Specific work focused interventions
- Identification of issues/work barriers
- Problem solving / solutions
- Ongoing exposure to work
- Goal setting for recovery

Antidepressant – SSRI or SNRI

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Mary – Returning to work

Partial work capacity for 2-3 months
- Graduated return to work program
- Shorter days, four days per week – Wednesday’s off
- Further training on computer system
- Longer time frames to complete tasks

Information to workplace regarding prognosis/timeframes

Increased treatment provider input at time of returning

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Yasmina – Treatment and returning to work

Cognitive behavioral therapy including work focused

- Psychoeducation
- Exposure based treatment to manage phobic anxiety and avoidance
- Reframe contact with employer

Return to work focused interventions

- Facilitated discussion/mediation
- Alternate line of reporting
- Initial meeting - With support
- First couple of weeks reduced hours for threshold anxiety, then increase
- Longer time frames initially

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Terrence - Treatment

Ensure safety

Trauma focused CBT/EMDR

- Psychoeducation
- General anxiety management strategies
- Exposure therapy – imaginal and in vivo. Hierarchy of exposures
- Re-exposure to the workplace? Same versus alternate workplace

Medication

- SSRI
- Quetiapine (low dose) PRN
- Alternate medications – e.g. Prasocin

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Terrence’s return to work

- Return to safe work environment – worker input
- Gradual exposure to work place with support
- Psycho-education and normalization of symptom escalation
- Increase treatment around time of RTW (resurgent anxiety)
- Longer time frames due to anxiety symptoms
- Ability to move around, retreat
- Address concerns with manager

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Suicide

Contributing factors are always ‘multi-factorial’ e.g.;

- Background vulnerability;
- Past experience of life stressors;
- Current mental health status;
- Contemporary experience of defeat/humiliation;
- Leading to feeling of entrapment (e.g., burdensomeness and/or thwarted belonging);
- Giving rise to suicidal ideation and intent
- Access to means ...
Suicide

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Suicide prevention programs work

- mental health literacy programs,
- developing mentally healthy workplace culture etc

Pathways to care

Impact on others...

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Key goals for any organizational mental health strategy

- Validate and increase early help seeking behaviour
- Ensure multiple pathways available to appropriate care
- Protect mental health through reducing psychological health and safety risk factors at the source
- Promote positive mental health through building workplace protective factors

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