

## DRAFT CLINICAL GUIDELINE FOR THE DIAGNOSIS AND MANAGEMENT OF WORK-RELATED MENTAL HEALTH CONDITIONS IN GENERAL PRACTICE

### PUBLIC CONSULTATION SUBMISSION

Proposed for submission to the NHMRC for approval under section 14A of the National Health and Medical Research Council Act 1992.

The Department of General Practice, Monash University has prepared a draft clinical Guideline on the diagnosis and management of work-related mental health conditions in general practice and is welcoming comments and feedback on the draft guideline until the **15<sup>th</sup> of March 2018**.

Please complete the survey below in order to provide feedback on the draft Guideline.

Thank you!

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#### **PART 1: GENERAL INFORMATION**

**1. What is your full name?** Claire Celia

**2. Please indicate if you would like your name to:**

Be published alongside your submission in the supporting documents for the Final Guideline

**3. What is your email address?** Claire.celia@racp.edu.au

*This will only be used to contact you if we need to clarify any details in relation to your submission, and will not be shared or published in any way.*

**4. Are you of Aboriginal or Torres Strait Islander origin?**  No

**5. Are you making this submission as an:**  Organisation

*If you are making this submission as an organisation:*

**What is the official name of your organisation?** Australasian Faculty of Occupational and Environmental Medicine (AFOEM) of The Royal Australasian College of Physicians (RACP)  
*Please be aware that your submission may be verified with the organisation.*

**What is your role within the organisation?** Senior Policy Officer

**Are you authorised to make a submission on behalf of this organisation?**  Yes

**6. Which of the following roles do you identify with in terms of your interest in work-related mental health diagnosis and management?** *(Please select all that apply)*

Other – Please specify: Work-related conditions fall within the expertise of AFOEM Fellows

**7. Please describe your role in your own words:** RACP senior policy officer supporting the policy work of RACP members.

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#### **PART 2: DRAFT GUIDELINE COMMENTARY**

*Please provide comments on any or all of the following aspects of the Guideline:*

##### **Executive Summary**

**8. Are the recommendations pertaining to each question realistic (achievable) and/or appropriate? Why/Why not?**

**9. Which recommendations do you think are most likely to lead to improvements in health outcomes for patients? Why?** *(Note, these may be selected for targeted implementation)*

**10. Please provide any other feedback about the Executive Summary here:**

**Flow Chart**

**11. Please provide your feedback about the Flow Chart here:**

The flow chart is a useful summary/map of the key recommendations for general practitioners to use in practice. However, we have concerns regarding some of its content:

The second box of the flow chart on p.5 with the heading “is the mental health condition work-related?” advises the general practitioner (GP) to ‘undertake a comprehensive clinical assessment’. This appears unrealistic in the current context, and occupational and environmental physicians’ experience from working directly with GPs, workplace insurers, and employers confirms that the professional skills to undertake such an assessment are beyond the current scope, time resources, experience and routine practice of many GPs.

The reasoning for this commentary is discussed further in the “Assessment and Diagnosis” section of this response.

It appears that the proposed guideline assumes that GPs would know, as a matter of course, how to conduct a clinical assessment specifically for a workplace-related mental health condition. An option to address this issue would be to provide explicit guidance material concerning what a comprehensive clinical assessment might entail. See for example the Civil Aviation Safety Authority’s Comprehensive Assessment Guidelines for dealing with the assessment of a person found to be consuming alcohol or other drugs in a safety critical setting.<sup>1</sup>

More feasibly, the GP should refer his or her patient to the relevant agency who can resource an appropriate investigation, before concluding whether or not work was a significant contributor to his or her patient’s mental health condition.

Whilst incomplete, the research to date supports “staying at work” and “early return to work” whenever possible where ‘good work’<sup>2</sup> is available. The evidence suggests this leads to much better occupational outcomes than those following extended absence from work. However, this approach is predicated on effective communication between stakeholders and the existence of a supportive employer with the capacity to accommodate their worker. Assessment of workplace capacity is clearly beyond the scope of skills and experience of most GPs. We recognise GPs’ skills at diagnosing most mental health disorders, but would strongly caution against them moving into the area of causation.

The box titled “what to do for a patient who is not improving” on p. 6 implies the use of a multidisciplinary approach as a last resort. Our view is that these cases need earlier recourse to a multidisciplinary team than the guideline indicates to optimise the outcome for the patient. We also recommend that referral to an occupational or rehabilitation physician, or a psychiatrist or psychologist with experience in occupational health be considered when confronted with a patient whose return to work is not progressing as well as expected. As outlined already, the evidence shows early return to work is associated with better outcomes.

In addition, we suggest that other health professionals (particularly organisational and occupational psychologists), would be better placed to conduct some of the interventions outlined in the guideline.

**Introduction**

**12. Are the clinical questions presented clear and relevant?**

<sup>1</sup> Available online: <https://www.casa.gov.au/file/169836/download?token=uSHjvPIZ> [last accessed 20/02/2018]

<sup>2</sup> Note: To find out more about ‘good work’, please refer to AFOEM’s position statement *What is Good Work?* 2013. Available online: <https://www.racp.edu.au/docs/default-source/resources/afoem-pos-what-is-good-work-2013.pdf> [last accessed 27/02/2018]

**13. Please provide any other feedback about the Introduction here:****Methodology****14. Are the processes used to develop this Guideline clear? If not, can you identify any areas of concern or items that require greater clarification?**

AFOEM notes the considerable emphasis with respect to developing an evidence-based approach to the management of workplace-related mental health conditions by general practitioners and the robust methodology used by the Guideline Reference Group.

We commend the Guideline Reference Group's identification of specific areas for further research.

The guideline demonstrates the paucity of published research regarding the value of occupational physicians and we would recommend including specific recognition concerning the provision of funding for well-designed studies to confirm or otherwise find what occupational physicians have learned empirically.

**15. Please provide any other feedback about the Methodology here:**

We have some concerns regarding the translation of the guideline into clinical practice. Our view is that the length of the guideline itself may prove a barrier for its applicability in practice, particularly given the very small number of patients with work-related mental health conditions individual GPs are likely to see on a regular basis.

**Assessment and Diagnosis Section:****16. Are the recommendations and/or discussion likely to be useful and achievable in clinical practice? Why/Why not?**

We are concerned that some of the recommendations in the guideline may not be useful and achievable in clinical practice. While it is well within the clinical competence of GPs to make a clinical diagnosis, especially with the aid of the instruments identified, it is neither within the statutory responsibility nor within the clinical competence of most GPs to attribute causation.

In all medicolegal jurisdictions across Australia, it is a statutory responsibility of insurance agencies to determine if a mental health condition is work-related: it is not a decision within the scope of practice of a GP. This is evident when considering the number of psychological injury lodgements and intimations<sup>3</sup> that do not proceed to a claim decision (and not including "cancelled intimations").

The BEACH study of general practice<sup>4</sup> identified that all work-related injuries constitute less than 5% of the case load of general practice, and mental health related injuries are a subset of this limited case load. Consequently, most GPs will not have the case exposure to maintain competency even if they have been trained to undertake such assessments. Thus, this appears an unrealistic recommendation as it is currently contextualised.

**17. Are there any individuals or groups who are likely to be worse-off as a result of these recommendations?**

We do believe some patients are likely to be worse off as a result of the guidelines' recommendations.

<sup>3</sup> Note: In the insurance industry an "intimation" is where a potential claim is notified to the insurer, but there is insufficient information available to enable processing of the claim. Notification of "potential claims" is used for actuarial budgeting. "Lodgement" is where sufficient information has been provided to process a claim, i.e. claims that are pending a decision, or subsequently withdrawn or suspended for any reason.

<sup>4</sup> Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, Wong C, Gordon J, Pollack AJ, Pan Y, Charles J. (2015) General practice activity in Australia 2014–15. General practice series no. 38. Bettering the Evaluation and Care of Health (BEACH), Sydney: Sydney University Press, 2015.  
[http://ses.library.usyd.edu.au/bitstream/2123/13765/4/9781743324530\\_ONLINE.pdf](http://ses.library.usyd.edu.au/bitstream/2123/13765/4/9781743324530_ONLINE.pdf) [last accessed 23/02/2018]

One of our Fellows, Dr Graeme Edwards (2016),<sup>5</sup> analysed the data from Queensland between 2009 through to 2015<sup>6</sup> and showed that the number of withdrawn and rejected psychological claims represented over 70% of all psychological injury lodgements and intimations. We are not aware of similar analyses in other jurisdictions and it would be valuable to see if similar circumstances exist across the various jurisdictions in Australia.

Most cases start as medically certified work-related mental health conditions. Effectively, when considering lodgement and intimation data for workers' compensation, Edwards (2016) showed that for each claim accepted as work-related, there are at least two people whose claims were initially thought to be attributed to a work-related mental health problem that do *not* proceed as an accepted work-related mental health disorder.

These are either claims withdrawn or rejected after investigation. As these cases are not a statutory responsibility for insurers, they do not appear in the work-related injury statistics (except those few claims overturned by review processes). However, they remain a significant concern for the GPs who still need to manage them.

This constitutes evidence of the difficulties facing GPs when forming opinions regarding the work-relatedness of a claim.

**The adverse consequences for the patient if they are inappropriately labelled as having a work-related mental health disorder can be catastrophic.** It is directly harmful for the individual as it adversely, and not uncommonly permanently, affects the employer/employee relationship. This is detrimental for all involved. Even when there is a good outcome after redressing the inappropriate label, it is at the expense of a protracted and usually difficult clinical course.

To our knowledge, the research to quantify the degree of harm caused by inappropriate labelling of mental health disorders as work-related, when they are not, has not yet been undertaken. We would urge that such research should be performed.

**18. Please provide any other feedback about the Assessment and Diagnosis Sections here:**

There is no doubt that good work is good for the psychological wellbeing of workers. There is equally no doubt that some workplaces are psychologically harmful to some people. However, empirically, we believe the greatest value the guideline could offer the Australian working population is to reduce the potential harm caused by inappropriately attributing to work the cause of a mental health condition for an affected individual.

**Management Section**

**19. Are the recommendations and/or discussion likely to be useful and achievable in clinical practice? Why/Why not?**

**20. Are there any individuals or groups who are likely to be worse-off as a result of these recommendations?**

**21. Please provide any other feedback about the Management Section here:**

<sup>5</sup> Edwards, G (2016) *Mental Health and the Workplace*, Workplace Relations Special Interest Group, The Brisbane Club, 19 February 2016

<sup>6</sup> Note: From 2011, the public reporting requirement of the Workers' Compensation Scheme in Queensland stopped including intimations in the data set. Consequently, the denominator for data analysis changed. For the Edwards (2016) data analysis it was assumed there was no difference in the ratio of psychological to non-psychological claims between intimations and lodgements. However, given the nature of the injury, it is plausible the number of intimated psychological injury claims that do not proceed to lodgement was significantly higher than non-psychological injury claims. Even so, the percentage of withdrawn and rejected claims for psychological injuries associated with workers in Queensland increased over the 5 years prior to the 2016 data analysis. The reason for this is complex and warrants further investigation.

We have some concerns regarding the reason outlined for rejecting the Finnish article (Reference 138: Kinnunen-Amoroso M, Liira J. Work-related stress management between workplace and occupational health care. *Work* 2016;54(3):507-15).

Some GPs in both Australian and New Zealand have very effective relationships with employers, evident by the GP membership of the Australian and New Zealand Society of Occupational Medicine (ANZSOM), as do many occupational physicians. Empirically our experience reflects the Finnish study as evidence as to what actually works. It is therefore strongly recommended that you reconsider the intrinsic value of this study in the Australian setting. While the number of suitably experienced Australian practitioners may be relatively small, it highlights to both GPs and insurers the benefits to be gained by a GP enlisting the support of an occupational physician in his or her patient's care.

This links in with our concerns expressed earlier, regarding the flow chart not including an option to refer to a specialist occupational physician when a patient's condition and return to work are not progressing as expected. As previously mentioned, we recommend that referral to an occupational physician be an option GPs should consider when confronted with a patient whose return to work is not progressing as well as expected. The evidence shows early return to work is associated with better outcomes.

### **General Feedback on the draft Guideline**

**22. Please provide your feedback about the Abbreviations Section here:**

**23. Please provide your feedback about the Appendices Section here:**

**24. Please provide your feedback about the References Section here:**

The publication date for the reference to AFOEM's Australasian consensus statement on the health benefits of good work [Reference #1 in the guideline] needs to be updated to 2017. The revised consensus statement is available online: <https://www.racp.edu.au/docs/default-source/advocacy-library/afoem-realising-the-health-benefits-of-work-consensus-statement.pdf?sfvrsn=14>

**25. Is the structure and layout of the Guideline logical and easy to navigate? If not, how could this be improved?**

**26. Do you agree with the recommendations and/or consensus statements in the Guideline?**  
*(Please comment)*

**27. Are the recommendations in this guideline appropriate for Aboriginal and Torres Strait Islander individuals?**

**28. Please provide any other feedback about the appropriateness of the Guideline for Aboriginal and Torres Strait Islander people:**

*For those who selected 'General Practitioner' in question 6 only:*

**29. About how many patients with work-related mental health conditions do you see in a year?**

**30. Will you be able to apply the recommendations in your practice? *(Please comment)***


**31. What barriers do you anticipate to prevent you applying the recommendations in practice?**

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**32. What will assist you to apply these recommendations in practice?**

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### **Accessing the Guideline**

**33. Aside from being on the NHMRC website, how else do you suggest this Guideline be accessed? (Specific websites, journals etc.)**

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### **General Feedback**

**34. Please feel free to make any additional comments:**

Occupational Medicine is interested in all workers with mental health problems, not just those with a work-related (caused) condition. Extrapolating from the WORC Project<sup>7</sup> data, around 1 in 30 workers have sufficient psychological symptoms that could meet the criteria of a diagnosable mental health disorder. Approximately 80% of these workers were either not being treated or appeared undertreated.<sup>8</sup>

As outlined in our response to questions 16 and 18, we would caution that, while it is well within the clinical competence of GPs to make a clinical diagnosis, especially with the aid of the instruments identified, it is neither within the statutory responsibility nor within the clinical competence of most GPs to decide about causation. We feel the greatest value the guideline could offer the Australian working population is to reduce the potential harm caused by inappropriately attributing to work the cause of a mental health condition for an affected individual.

We also feel that the guideline would benefit from giving attention to preventing work-related mental health conditions in the first place. In addition to encouraging advocacy from GPs with regards to the health benefits of good work<sup>9</sup>, the guideline could also document a practicable approach that encompasses some initial 'workplace mental health crisis management / first aid', a key component of which is to prevent or materially limit the time away from their workplace, and early referral / coordination with the relevant mental health providers using a multidisciplinary team approach from when patients first present and before the severity of the disorder escalates into a clinical crisis.

We commend Monash University's Department of General Practice for the development of this comprehensive guideline to address work-related mental health conditions. Thank you for the opportunity to provide feedback on the draft guideline. Should you require further information about AFOEM's submission, please do not hesitate to contact Ms Claire Celia, Senior Policy Officer, on [Claire.Celia@racp.edu.au](mailto:Claire.Celia@racp.edu.au) or 0481 348 617.

<sup>7</sup> Whiteford, H (2009), *The WORC project – summary of findings to date*, Australian and New Zealand Society of Occupational Medicine – 39th Annual Scientific Meeting, Hyatt Coolum. See also: Hilton MF, Scuffham PA, Sheridan J, Cleary CM, Vecchio N, Whiteford HA. (2009) *The association between mental disorders and productivity in treated and untreated employees*. **Journal of Occupational and Environmental Medicine**. 51(9):996-1003.

<sup>8</sup> Note: The WORC Project used a validated question set embedded in a larger survey to assess the magnitude of mental health concerns in the workplace. Evidence shows that 80% of people who rated "High" on the K6 questionnaire have a diagnosable psychiatric disorder. Of the 2610 respondees (4.3% of the 60,556 participants) with self-reported psychological distress rated as high: 30.5% did not recognise they needed help; 28.5% recognised they had a problem but had not sought help, and 19.2% recognised they had a problem but did not need help. Only 21.9% declared they were actually receiving treatment.

<sup>9</sup> Please refer to this webpage for further information about the Health Benefits of Good Work initiative: <https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work>

**Thank you for taking the time to complete this survey and provide your valuable feedback on the draft Guideline.**

Please email your PDF survey responses to [generalpracticeguidelines@monash.edu](mailto:generalpracticeguidelines@monash.edu).

Alternatively, hardcopy comments to the draft Guideline may be sent to:

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c/o Dr Samantha Chakraborty  
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Notting Hill, VIC 3168

**If you'd like to contact the project team, you may contact our Project Manager, Dr Samantha Chakraborty, by email at [generalpracticeguidelines@monash.edu](mailto:generalpracticeguidelines@monash.edu) or by phone on (03) 9902 9698**