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)

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Outline

Common mental illness presentations in the workplace

Theory including workplace factors

Best practice treatment and return to work

Employee suicide

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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

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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- Long periods away from her desk, withdrawn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

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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

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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

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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

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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

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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

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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

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Theory including workplace factors

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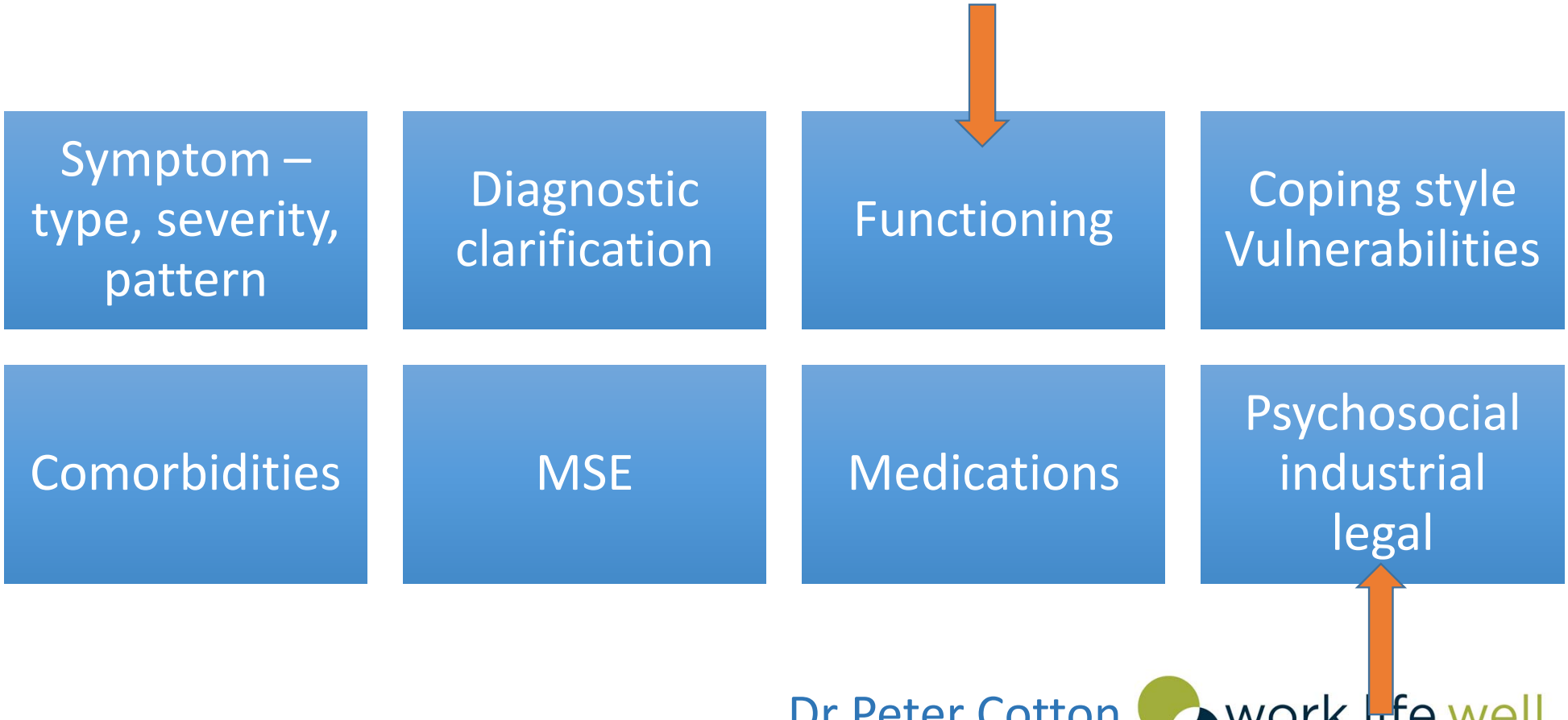
Psychological condition - Assessment



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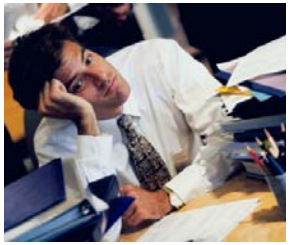
Psychosocial / Industrial factors / Legal

POS (perceived organizational support)

Employee contact

Injustice

Legal



Job dissatisfaction

Performance

Disciplinary

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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

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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
- ‘Its mental health’ – so allow too much leeway – contributes to entrenchment

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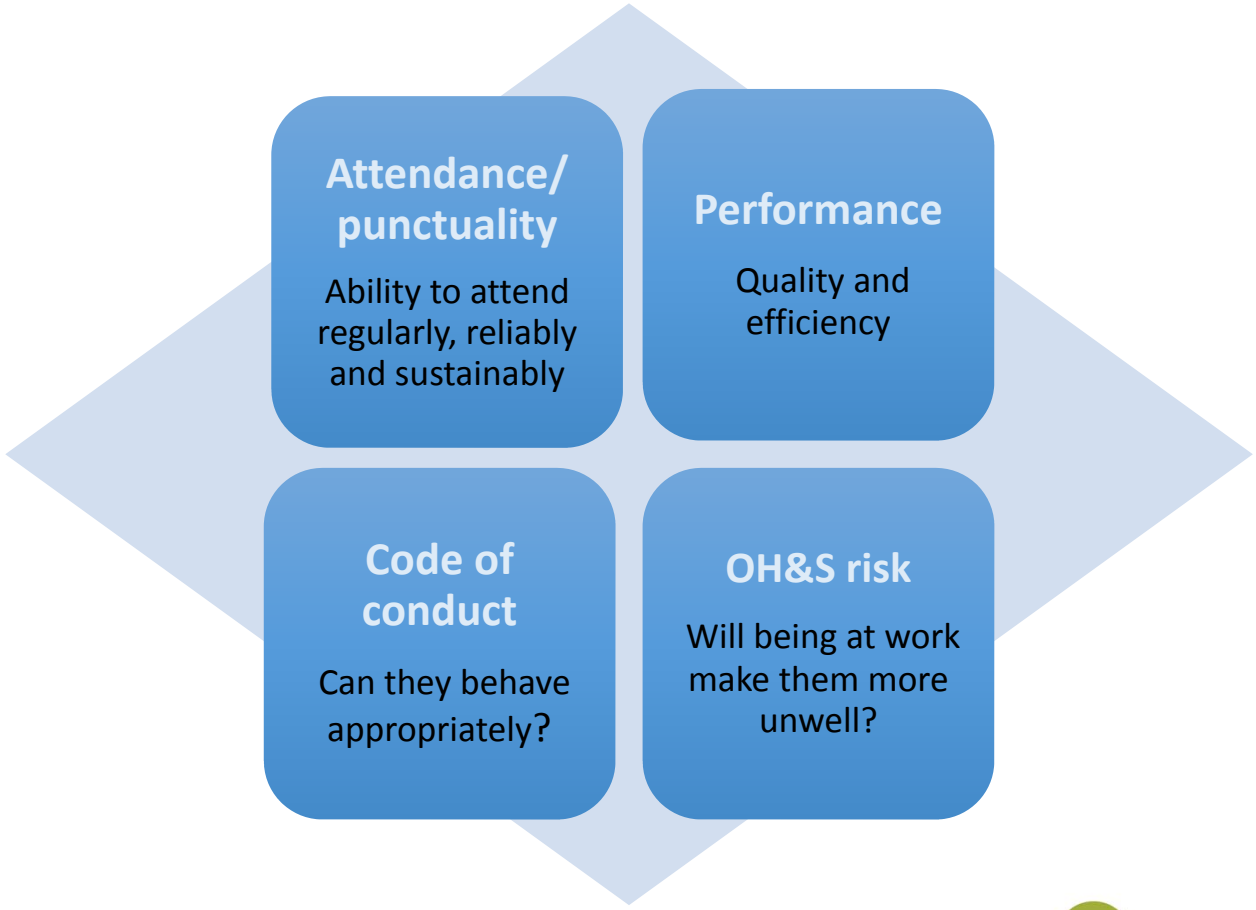
What does it mean to be fit for work?



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Functional assessment

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

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Best practice treatment and return to work

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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

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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

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Psychological treatment interventions

Challenging avoidance behaviors
(CBT cognitive restructuring, desensitization, arousal management skills)

Exposure-based interventions
(workplace/perpetrator focus: imaginal and in-vivo exposure; may include EMDR)

Development of self-management coping skills
(e.g., assertiveness skills, emotional self-regulation skills, cognitive rehearsal coping skills re possible future situations encountered)

Contra-indicated!
(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.

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Pharmacological management

Medication	Class	Dose range	Side effects
Citalopram (cipramil)	SSRI	20 - 40mg	GI symptoms, insomnia, sedation, sexual dysfunction.
Escitalopram (lexapro)	SSRI	10 -20mg	GI symptoms, Possibly better tolerated
Sertraline (zoloft)	SSRI	50- 200mg	GI symptoms diarrhea pronounced, insomnia, sexual dysfunction.
Venlefaxine (effexor)	SNRI	75- 375mg	GI symptoms, insomnia, agitation, sedation, sexual dysfunction,
Desvenlefaxine (pristiq)	SNRI	100mg	GI symptoms, insomnia, agitation, sedation, less sexual side effects
Duloxetine (cymbalta)	SNRI	30-60mg	Pain reducing properties
Mirtazapine (avanza)	NaSSA	30-60mg	Weight gain and sedation, less sexual dysfunction.
Agomelatine (Valdoxen)	M agonist	25-50mg	Promotes sleep
Amitriptyline (Endep)	TCA	75- 150mg	Pain reducing and sedative properties. Toxic in overdose (cardiogenic) Side effects of blurred vision, urinary retention, constipation, sedation
Moclobemine	MAO- A	300mg	
Augmenting agents			
Lithium			Thyroid and renal problems, toxicity, needs monitoring, tremor, cognitive slowing
Thyroxine			
Olanzapine Quetiapine Risperidone Aripiprazole	Anti psychotics	12.5mg 600mg 2mg 20mg	Weight gain, sedation, metabolic effects Weight gain, sedation, metabolic effects Hypotension, restlessness Restlessness
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.

Physical treatments

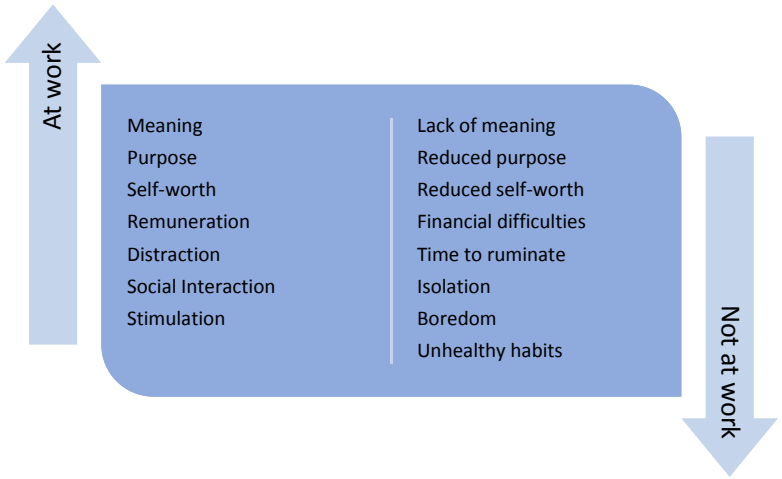
Electroconvulsive therapy (ECT)

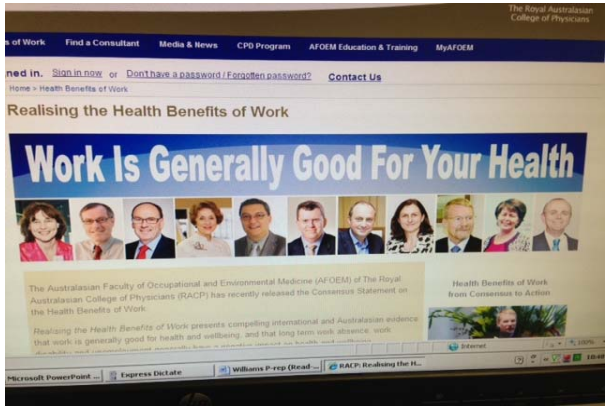
- Highest rate of response of any form of treatment
  - 80-90% improve
- Medication resistant cases respond 50% of time.
- Indicated for severe depression with psychotic features, catatonia, severe suicidality or food refusal, contraindications to medications, previous effect and patient choice.
- Safe 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

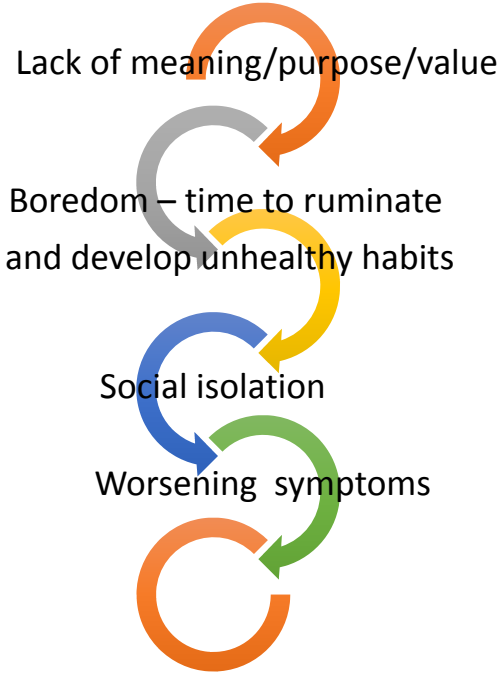
Trans magnetic stimulation (TMS)

- Increasing evidence for role of this in depression.
- Better tolerated than ECT.

Role of work in mental health and recovery







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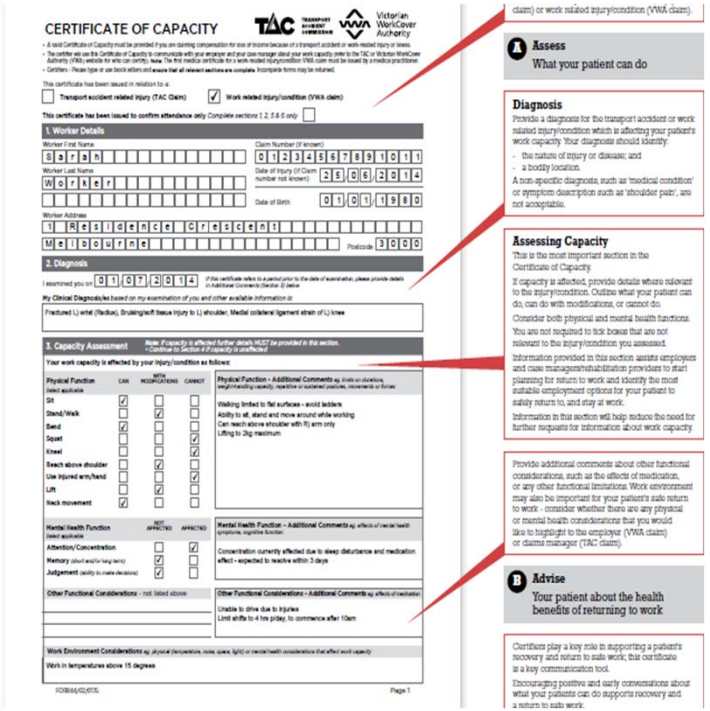
Certification


CERTIFICATE OF CAPACITY

TAC Transport Accident Commission

Victorian WorkCover Authority

Transport accident related injury (TAC Claim) ☐ Work related injury/condition (VWA claim) ☑

This certificate has been issued to confirm attendance only Complete sections 1, 2, 5 & 6 only ☐

1. Worker Details

Worker First Name: Sarah — Claim Number (if known): 01234567891011

Worker Last Name: Worker — Date of Injury (if Claim number not known): 25/06/2014

Worker Address: 1 Residence Crescent, Melbourne — Postcode: 3000

Date of Birth: 01/01/1980

2. Diagnosis

I examined you on: 01/07/2014 (if this certificate refers to a period prior to the date of examination, please provide details in Additional Comments (Section 6) below)

My Clinical Diagnosis/es based on my examination of you and other available information is:

Fractured L) wrist (Radius), Bruising/soft tissue injury to L) shoulder, Medial collateral ligament strain of L) knee

3. Capacity Assessment — Note: If capacity is affected further details MUST be provided in this section. • Continue to Section 4 if capacity is unaffected

Your work capacity is affected by your injury/condition as follows:

Physical Function (Select applicable)	CAN	MAY WITH MODIFICATIONS	CANNOT
Sit	☑	☐	☐
Stand/Walk	☐	☑	☐
Bend	☑	☐	☐
Squat	☐	☐	☑
Kneel	☐	☐	☑
Reach above shoulder	☐	☑	☐
Use injured arm/hand	☐	☐	☑
Lift	☐	☑	☐
Neck movement	☑	☐	☐

Physical Function - Additional Comments eg. limits on duration, weight/handling capacity, repetitive or sustained postures, movements or forces:

Walking limited to flat surfaces - avoid ladders
Ability to sit, stand and move around while working
Can reach above shoulder with R) arm only
Lifting to 2kg maximum

Mental Health Function (Select applicable)	NOT AFFECTED	AFFECTED
Attention/Concentration	☐	☑
Memory (short and/or long term)	☑	☐
Judgement (ability to make decision)	☑	☐

Mental Health Function - Additional Comments eg. effects of mental health symptoms, cognitive function:

Concentration currently effected due to sleep disturbance and medication effect - expected to resolve within 3 days

Other Functional Considerations - not listed above:

Other Functional Considerations - Additional Comments eg. effects of medication:

Unable to drive due to injuries
Limit shifts to 4 hrs p/day, to commence after 10am

Work Environment Considerations eg. physical (temperature, noise, space, light) or mental health considerations that affect work capacity:

Work in temperatures above 15 degrees

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claim) or work related injury/condition (VWA claim).

A Assess What your patient can do

Diagnosis
Provide a diagnosis for the transport accident or work related injury/condition which is affecting your patient's work capacity. Your diagnosis should identify:
- the nature of injury or disease; and
- a bodily location.

A non-specific diagnosis, such as 'medical condition' or symptom description such as 'shoulder pain', are not acceptable.

Assessing Capacity
This is the most important section in the Certificate of Capacity.
If capacity is affected, provide details where relevant to the injury/condition. Outline what your patient can do, can do with modifications, or cannot do.
Consider both physical and mental health functions.
You are not required to tick boxes that are not relevant to the injury/condition you assessed.
Information provided in this section assists employers and case managers/rehabilitation providers to start planning for return to work and identify the most suitable employment options for your patient to safely return to, and stay at work.
Information in this section will help reduce the need for further requests for information about work capacity.

Provide additional comments about other functional considerations, such as the effects of medication, or any other functional limitations. Work environment may also be important for your patient's safe return to work - consider whether there are any physical or mental health considerations that you would like to highlight to the employer (VWA claim) or claims manager (TAC claim).

B Advise Your patient about the health benefits of returning to work

Certifiers play a key role in supporting a patient's recovery and return to safe work; this certificate is a key communication tool.
Encouraging positive and early conversations about what your patients can do supports recovery and a return to safe work.

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.

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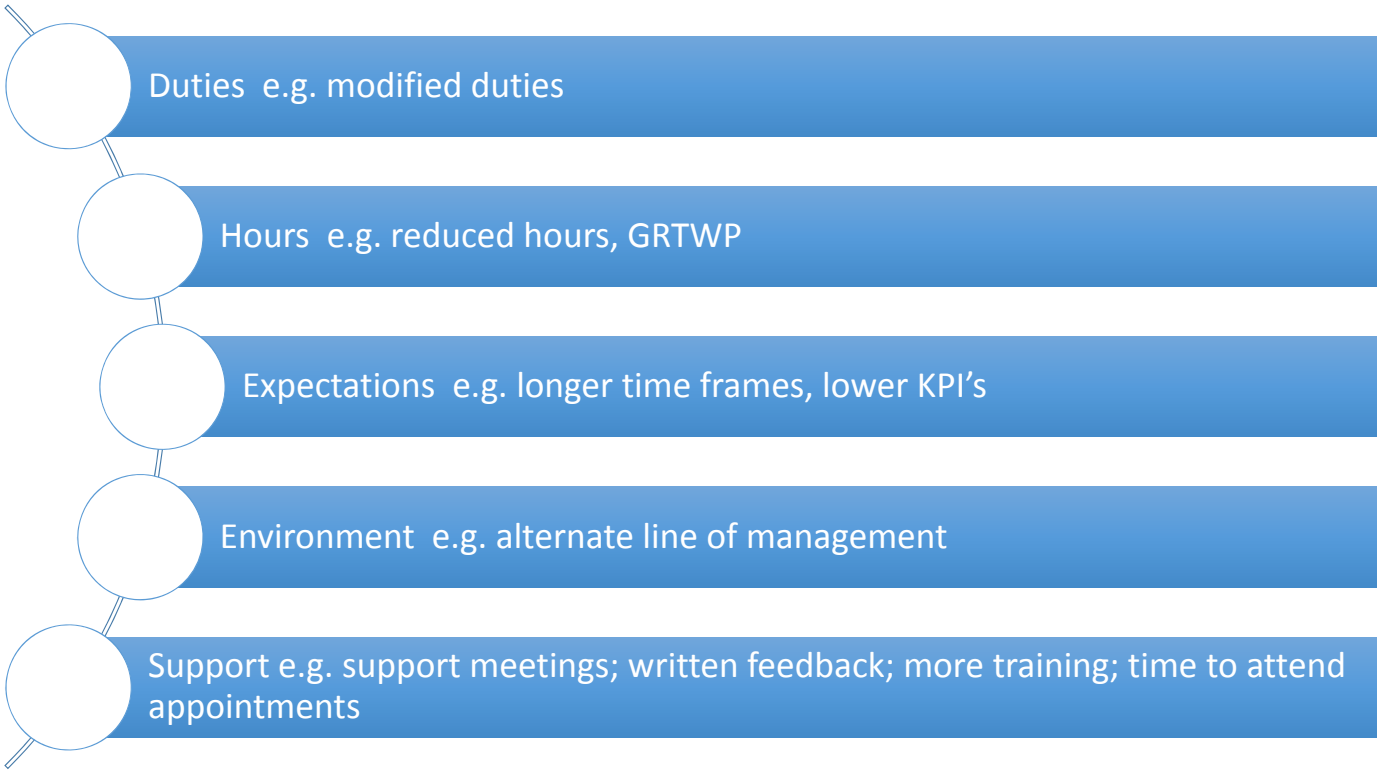
Reasonable adjustments



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Enabling recovery

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Specifics of treatment

Mary

Depression

Yasmina

Anxiety

Terrence

Post Traumatic Stress Disorder

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Mary - Treatment

Mindfulness and work focused CBT – weekly then fortnightly

- Psychoeducation
- Cognitive restructuring
- Activity scheduling

Alcohol councelling

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 …

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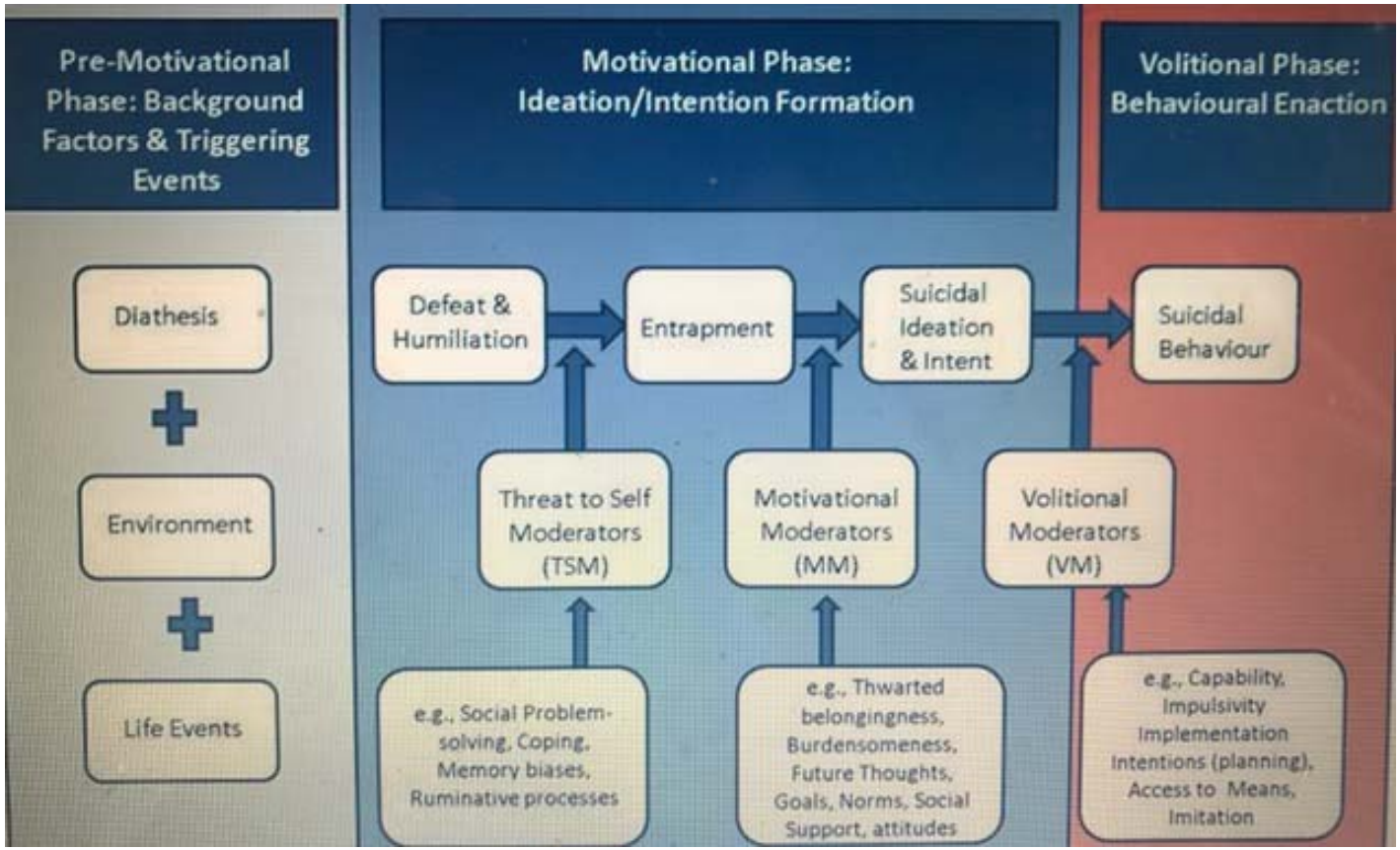
Suicide



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Suicide

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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