An integrated approach to returning to work with mental illness

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Outline

Mental illness in the workplace

Mary – case study

Some occupational psychiatry

Best practice treatment and return to work

Secondary psychological conditions
Mental health in Australian workplaces

1 in 6 working age Australians have a mental illness at any one time. An additional 1/6 of population suffer from symptoms of a mental health condition affecting work capacity.*

*Source: Black Dog Institute

Likely to be a ‘high incidence’ of disorders, eg anxiety, depression, adjustment disorders and substance misuse disorders, in workplaces.

At work mental ill health may potentially:
- manifest without any work contribution;
- be contained through appropriate treatment and not apparent;
- be contributed to by workplace factors.
Common work-related distress triggers

- Heavy workload
- Tight deadlines
- Changes to duties
- Job insecurity
- Lack of autonomy
- Monotonous work
- Insufficient skills for the job
- Over-supervision
- Inadequate working environment
- Lack of proper resources
- Few promotional opportunities
- Harassment
- Discrimination
- Poor relationships
- Limited reward and recognition
- Crisis incidents
- Organisational restructures
## Mental illness presentations in the workplace

<table>
<thead>
<tr>
<th>Decline in performance</th>
<th>Excessive emotional reactions</th>
<th>Change in presentation</th>
<th>Disengagement and avoidance behaviours</th>
<th>Increased use of psychoactive substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of work</td>
<td>Irritable</td>
<td>Reduced self-care</td>
<td>Unscheduled absences</td>
<td>Caffeine</td>
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<tr>
<td>Efficiency</td>
<td>Upset</td>
<td></td>
<td>Late attendance</td>
<td>Cigarettes</td>
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<tr>
<td>Prioritisation</td>
<td>Tearful</td>
<td></td>
<td>Avoidance of tasks</td>
<td>Alcohol</td>
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<tr>
<td></td>
<td>Panicky</td>
<td></td>
<td>Withdrawal from activities</td>
<td>Other drugs</td>
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</table>
A case study - Mary
Mary

46-year-old, lives alone, FT admin worker in a medium sized office

14 years in the job, usually loves her role

Chronically ill mother and recent relationship breakdown

Increased work volumes since a colleague left due to being unvaccinated and not replaced

New computer system that she is finding hard to use

New manager
Mary –
the first conversation

Mary tries, on a few occasions, to speak to her new manager about her difficulties.

Eventually, the manager (under pressure) has a quick conversation with Mary and is dismissive of her concerns and tells her to step up.

Mary is upset by the interaction and feels unsupported and criticised by her manager.

Mary begins avoiding the manager.

She feels overwhelmed and anxious and finds it increasingly difficult to manage her work demands.
Mary’s symptoms

- Lowered mood, emotional, tearful.
- Sleep disturbance and fatigue.
- Lack of motivation – hard to get out of bed. Lack of interest.
- Slowed thinking, distracted, poor memory decision making more challenging.
- Low self-esteem and confidence.
- Feels unable to cope.
Mary’s presentation at work

- Increased absenteeism
- Not proactive, forgetting to do things, making errors
- Unable to master new computer system and is afraid to ask for help
- Looks tired and has reduced self-care
- Long periods away from her desk, withdrawn
- Smelled of alcohol
One month later ....
The workplace perspective

Manager gets a colleague to start checking Mary’s work.

Manager notices that she is taking longer to complete tasks and she misses deadlines.

Manager expresses concern about her work performance.

The manager declines Mary’s WFH request.

Mary’s absences increase.

The team start to resent Mary for not pulling her weight.
Mary’s perspective

Mary feels micro-managed.

She starts second guessing herself and double checking her work. It is hard to stay focussed

It takes her longer to complete tasks and she misses deadlines.

Mary starts to feel excluded from new projects.

She is resentful that her WFH is not approved.

She finds it harder to get to work.
What happens next?

A. Mary brings in a cake hoping to win people over.

B. Mary sends in a medical certificate stating “Medical condition” – unfit until further notice.

C. Mary friend requests her manager on Facebook.

D. Mary decides to take an impromptu holiday to Bali and sends a postcard.

E. Mary is referred to a psychologist under a MHCP.
Mary – another month later

No contact from workplace - Mary feels discarded.

Spending time mostly at home.

Ruminating, lacking meaning and purpose.

Increasing self-medication with alcohol.

Two sessions with a Psychologist.
The distress cycle

Event/Situation → Emotional reaction (fear, anger, anxiety) → Dissatisfaction → Rumination → Distress → Disengagement → Event/Situation
Most people can handle work stressors when they feel:

- Valued
- Supported
- Understood
- Connected
Mary – on sick leave

Mary finds it hard to stop ruminating about what happened at work. She is angry and preoccupied. She is worried about her job security and finances.

Her GP prescribes a sleeping tablet and completes a worker’s compensation COC for work stress due to bullying.

Mary is having sleep difficulties, not eating well, trouble concentrating, she is tearful, her mood is low and she feels worthless. She withdraws from her friends. She is highly anxious at the prospect of returning to work.

Mary lodges a claim for lack of training, lack of manager support and being marginalised and bullied at work. She cites feeling alienated by her colleagues and manager.
Mary – the claim process

An investigation and IME are organised via the insurer. The employer submits a reasonable management action defense.

Mary finds the IME and investigation process to be distressing experiences and her sleep deteriorates further.

Mary feels aggrieved that she was put through these processes.
Do you think Mary’s claim is accepted?

Yes  No
Mary – what happens next

Mary’s claim is accepted.

The manager feels resentful about the allegations in the claim and is cautious about having Mary back in his team.

Mary’s Psychologist expresses concern that the relationship with the employer has broken down. “Removal” from the “toxic” workplace is recommended. Mary is certified unfit for work by the GP for a month and recommends no contact with the employer.
Which of the following work-related factors are most likely to contribute to Mary lodging a claim?

A. Work stressors not acknowledged by management.

B. Manager’s tone and style.

C. Mary’s WFH request being declined.

D. Mary’s work colleagues not sharing their morning tea with her.
As a treating health professional, which of the following would have been helpful for the management of Mary?

A. Write a medical certificate with two months’ off work.
B. With Mary’s permission, contacting her employer to discuss her situation.
C. Advise Mary not to have coffee with a work colleague.
D. Advise Mary not to return the insurance agent or employer’s calls because she finds contact distressing.
Mary – points of inflection

Personal stressors -> vulnerability

Negative experience with IME, investigation and RMA

Increasing disengagement. Preoccupation, loss of confidence and anxiety.

Priming events

Work cessation and claim lodgement

COC - unfit

Increasing disability

Lack of training

Manager’s approach

Threat of performance management

No contact from employer

Lack of appreciation of difficulties/emerging illness and focus on performance management

Treaters supporting avoidance. No focus on resolution and RTW

Lack of support

Increased pressure

Personal stressors -> vulnerability
Mary – where to from here?

Avoidance “treatment”
Monthly certificate extensions
Disengagement/isolation
Rumination
Worsening anxiety and avoidance
Prolong absence, increasing symptoms and disability

Active treatment
Engagement, exploration and resolution of stressors
Supported return to work
Recovery and resumption of full function
Occupational psychiatry - some theory
Assessing capacity 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>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure / routine</td>
<td>• Sleep/wake cycle, activities of daily living – cooking, cleaning, shopping, management of children/school, other activities.</td>
</tr>
<tr>
<td>Energy / endurance</td>
<td>• Rest / napping during day / after activity, exercise, hobbies, energy to get through day.</td>
</tr>
<tr>
<td>Cognitive capacity</td>
<td>• Read newspapers, books, watch television, emails, interaction with social media (Facebook), remember things</td>
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<tr>
<td>Interpersonal functioning</td>
<td>• Engagement with family and friends, social activities, group recreational activities</td>
</tr>
<tr>
<td>Coping</td>
<td>• Frustration tolerance, avoidance behaviours, substance use</td>
</tr>
<tr>
<td>Evidence of work capacity</td>
<td>• Involvement in study, volunteer work</td>
</tr>
<tr>
<td>Side effects of medications</td>
<td>• Medication effects on daily routine</td>
</tr>
</tbody>
</table>
Reasonable adjustments

- Duties, eg: modified duties
- Hours, eg: reduced hours, GRTWP, later start time
- Expectations, eg: longer timeframes, lower KPIs
- Environment, eg: alternate line of management, non-customer facing
- Support, eg: support meetings, written feedback, more training, time to attend appointments
<table>
<thead>
<tr>
<th>Condition</th>
<th>Practical Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor sleep, fatigue, low energy</td>
<td>• Vary hours, eg reduced hours, later start time</td>
</tr>
<tr>
<td>Poor concentration and focus</td>
<td>• Longer timeframes to complete tasks, less multitasking</td>
</tr>
<tr>
<td>Irritability, anger, sensitivity</td>
<td>• Consider working more autonomously for a period of time</td>
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<tr>
<td>Traumatisation</td>
<td>• Period of removal from triggering situations/environment, eg back office work, with plan to gradually return</td>
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<tr>
<td>Phobic avoidance</td>
<td>• Gradual reintroduction</td>
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<tr>
<td>Performance management</td>
<td>• Increased training and support, lower KPIs for a defined period</td>
</tr>
<tr>
<td>Interpersonal conflict</td>
<td>• Facilitated discussion, support person, different line of reporting</td>
</tr>
<tr>
<td>Covid / RTO anxiety:</td>
<td>• Ensure WP safety measures, graduated return, off peak hours</td>
</tr>
</tbody>
</table>
Management framework

Make time

Provide support and education

Engage and collaborate
Avoid blind advocacy

Careful documentation

Expectations for recovery
/ Goal setting / Timeframes

Encourage activity
Functional restoration

Obtain collateral information

Communication – employers, rehabilitation providers

Address issues

Avoc/ voc rehab/ GRTWP

Regular review

Close follow up during return to work
Information required

- History of presenting complaint
- Symptom – type, severity, pattern
- Diagnostic clarification
- Coping style
- Vulnerabilities
- Comorbidities
- Prior history
- Functioning
- MSE
- Medications
- Psychosocial
- Industrial
- Legal
- Employer information - job description, performance, attendance, concerns, supports etc
To certify or not – the considerations

- **Type of Certificate**
- **Duration**
- **Purpose**
- **Benefits**
- **Disadvantages**
Management approaches

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

**Address psychosocial factors**

**Set realistic goals and make self-care part of routine**

- Exercise
- Engage in activities
- Sleep hygiene
- Reduce caffeine
- Limit alcohol
- Avoid having to make significant decisions

**Healthy lifestyle – mood improves**

**Rally supports**

**Pathways to treatment**
Psychological treatment

All psychological therapies are not the same

Therapy needs to be targeted and regular

Evidenced-based:

- Cognitive Behavioral Therapy including graded exposure
- Acceptance and Commitment Therapy
- Mindfulness
- Trauma Focused CBT
- Work Focused CBT (achieves significantly better outcomes)
Medication - overview

Choice depends on preference and side effect profile

Therapeutic alliance

Address barriers

Start low, go slow

Education is key

Patient input

This is my employer’s fault. Why should I have to take medication?

A pill won’t take my problems away

Stigma / Weakness

Side effects

Time for effect “Not like taking a Panadol”

Impact of intermittent compliance
Setting expectations for recovery

Role of Occ Physician / Occ Psychiatrist to help set expectations for all parties

Recovery trajectory – not a straight line

Setbacks ¬ catastrophisation
Facilitating a safe and sustainable return to work

- Return to safe work environment – worker input
- Consider role of rehabilitation provider and/or additional employer support
- Facilitated discussion versus new manager
- Psycho-education and normalisation of symptom escalation
- Pre-empt and address issues, eg interactions with colleagues
- Gradual exposure to workplace with support
- Increase treatment around time of RTW (resurgent anxiety, address issues as they arise)
- Start slow Set up for success
Facilitating a safe and sustainable return to work – for the employee

- Ensure adequate training.
- Task lists – for cognitive symptoms, sense of accomplishment.
- Longer timeframes to complete tasks, limit multitasking (to manage residual symptoms including cognitive)
- Written communication – for cognitive symptoms
- Ability to move around, retreat, time out
- Support meetings / check-ins
- Flexibility to attend appointments
- Collaboration with treatment team / feedback loop
Setting expectations for return to work - employer

Threshold anxiety – don’t judge on first impression - may present as more unwell

Time to re-familiarise

Performance should improve (often exponentially)

Sensitivity

Privacy considerations
Mary – path to recovery

Weekly sessions with Psychologist to build trust, rapport, validation, challenging unhelpful thoughts, psychoeducation. Activity encouraged – socialising and exercise.

Fortnightly appointments with GP to review symptoms, functioning and treatment needs.

Educated by THP re the need to keep engaged in exercise, social, recreational pursuits and have communication with work. Supported to cut down her alcohol use.

Week Four – antidepressant encouraged to assist with sleep disturbance, high anxiety, tearfulness and poor concentration. Lexapro commenced after discussion.

Week Six – some improvement in symptoms. Increased activity. Anxiety about work ongoing. Uncertainty. Encouraged to engage in return-to-work meeting.
Mary – returning to work

Return-to-work meeting goes well. Supports offered.

Facilitated discussion goes better than expected.

Certified fit for GRWTP.

Three six-hour shifts, gradually increasing.

Further training on computer system and review of workload.

Longer timeframes to complete tasks.

Information to workplace regarding expectations/prognosis/timeframes.

Increased treatment provider input at time of returning.
Secondary Psychological Conditions in Worker’s Compensation

Why is it important

Factors contributing to distress

Worker response and impact on recovery

Recommendations for prevention and early intervention
Why is it important?

Commonly occurring.

Often not recognised early.

Negative consequences for patient – health outcomes, quality of life, financial, return to work.

Early intervention and prevention is possible.

Costly for workers compensation schemes.

Stigmatised.
Research

38% of 3160 Australian workers reported moderate to severe psychological distress (Collie et al, 2020)

Prevalence of high depressive symptoms in a Canadian cohort was 42.9% at 1 month and 26.5% at 6 months post injury (Franche et al, 2009).

29.4% of Victorian workers met case definition for serious mental illness within ~2 years post injury (Orchard et al, 2020)
Factors contributing to distress/psychological ill health in MSC - the injury

- Pain
- Loss of function
- Trauma
- Treatment
Factors contributing to distress/psychological ill health in MSC - the individual

- Vulnerability including genetic, prior history, comorbidities, past experience etc
- Resources - internal and external
- Comorbid stressors
- Pain catastrophising and avoidance
Factors contributing to distress/psychological ill health in MSC - the system

- Employer factors eg RMA/investigation/contact/proving disability, RTW focus
- Insurer eg investigation, proving disability, contact
- Treater behaviours
Possible worker responses to work-related MSC injury

- Anger
- Traumatisation
- Breakdown of coping including self-medication
- Preoccupation / catastrophisation / generalisation
- Depression
- Anxiety
- Hopelessness
- Integrity threat / injustice
Barriers to accessing support/treatment

- Stigma
- Somatisation
- Denial coping
- Negative judgements/past experience
- Focus on physical condition/time limitations
- Lack of available resources
Impact on recovery and return to work trajectory

- Pain and reduced functioning
- Avoidance
- Deteriorating mental health
- Increased avoidance, loss of meaning/purpose/increased pain focus etc
- Worsening pain
- Worsening mental health
- Worsening functioning
What does the injured worker need?

<table>
<thead>
<tr>
<th>Focus on symptomatic and functional improvement/recovery</th>
<th>Reduce risks for declining state</th>
<th>Early identification and pathways to support/treatment</th>
</tr>
</thead>
</table>
| • Engagement in treatments and activities that promote recovery | • Reduced avoidance and isolation and time to ruminate/focus on pain/lose confidence and self-esteem  
• Reduce adversary and perceived injustice  
• Reduce need to focus on disability | • Psychoeducation and normalisation/destigmatisation  
• Check ins  
• Avenues for help seeking |

Right treatment at the right time, to feel useful and able to focus on a way forward
What can you do?

- Make more time
- Assess and treat the person not just the injury
- Screen for psychological symptoms, normalise, educate and create pathways
- Avoid passive / avoidance treatment
- Focus on what they can do
- Promote activities that provide meaning/purpose/identity/distraction
- Encourage remaining at work; suggest supports and modifications from outset
- Regularly review
  Refer early
Some take home messages for registrars

- Ask open ended questions and LISTEN to the worker’s answers
- It may take more than one consultation to gain rapport/trust and be able to discuss MH symptoms and causative factors
- Seek to understand how they FEEL about their work, workplace relationships and employer
- Identify psychosocial factors early in all workplace injury and illness
- Know the difference between anxiety, depression and stress
- Take care with your communication to workers/patients and employers – choose your words carefully
Acknowledgements

• Our thanks goes to Dr Peter Cotton and Mr Mark Belanti who have contributed to elements of this presentation.

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