

Clinical guideline for the diagnosis and management of work-related mental health conditions in general practice



Disclaimer

This clinical guideline is a general guide to appropriate practice, to be followed subject to the clinician's judgement and the patient's preference in each individual case. This clinical guideline is designed to provide information to assist decision-making and the recommendations included within are based on the best evidence available at the time of development.

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Publication approval



Australian Government

National Health and Medical Research Council

The guideline recommendations on pages 35–114 of this document were approved by the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) on 7 December 2018 under section 14A of the *National Health and Medical Research Council Act 1992*. In approving the guideline recommendations, NHMRC considers that they meet the NHMRC standard for clinical practice guidelines. This approval is valid for a period of five years.

NHMRC is satisfied that the guideline recommendations are systematically derived, based on the identification and synthesis of the best available scientific evidence, and developed for health professionals practising in an Australian health care setting.

This publication reflects the views of the authors and not necessarily the views of the Australian Government.

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Acronyms

4DSQ	Four-Dimensional Symptom Questionnaire	NHMRC	National Health and Medical Research Council
ACRRM	Australian College of Rural and Remote Medicine	NICE	National Institute for Health and Clinical Excellence
ACT	Australian Capital Territory	NSW	New South Wales
AGREE	Appraisal of Guidelines for Research and Evaluation	NT	Northern Territory
AGREE-II	Appraisal of Guidelines for Research and Evaluation II	PCL-5	Post Traumatic Stress Disorder Checklist-5
AMED	Allied and Complementary Medicine Database	PCL-C	Post-Traumatic Stress Disorder CheckList-Civilian version
AMSTAR	A Measurement Tool to Assess Systematic Reviews	PHQ-9	Patient Health Questionnaire-9
APA	American Psychiatric Association	PICO	Population Intervention Comparator Outcome
APQ	Alcohol Problems Questionnaire	PSWQ	Penn State Worry Questionnaire
APS	Australian Psychological Society	PSWQ-3	Penn State Worry Questionnaire-3
AUDIT	Alcohol Use Disorders Identification Test	PTSD	Posttraumatic Stress Disorder
AUDIT-C	AUDIT Alcohol Consumption Questions	QLD	Queensland
BDI	Beck Depression Inventory	QUADAS	Quality Assessment of Diagnostic Accuracy Studies
CBT	Cognitive Behavioural Therapy	RACGP	The Royal Australian College of General Practitioners
CES-D	Center for Epidemiologic Studies Depression	RACP	The Royal Australasian College of Physicians
DASS	Depression Anxiety Stress Scales	RANZCP	The Royal Australian and New Zealand College of Psychiatrists
DOI	Disclosure of Interest	RCT	Randomised Controlled Trial
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition	RTW	Return to Work
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition	SA	South Australia
GAD	Generalised Anxiety Disorder	SADQ	Severity of Alcohol Dependence Questionnaire
GAD-7	Generalised Anxiety Disorder-7	SIRA	(NSW) State Insurance Regulatory Authority
GDG	Guideline Development Group	SNAP	Smoking, Nutrition, Alcohol and Physical activity
GHQ	General Health Questionnaire	TAS	Tasmania
GP	General Practitioner	UK	United Kingdom
GPMHSC	General Practice Mental Health Standards Collaboration	UNSW	University of New South Wales
GRADE	Grading of Recommendations Assessment, Development and Evaluation	USA	United States of America
HADS	Hospital Anxiety and Depression Scale	VIC	Victoria
HBoGW	Health Benefits of Good Work	WA	Western Australia
HIV	Human Immunodeficiency Virus	WES	Work Environment Scales
iCBT	Internet-Based Cognitive Behavioural Therapy	WHC	Work Health Check
ICD	International Classification of Diseases	WHO	World Health Organization
K10	Kessler Psychological Distress Scale	WHODAS	World Health Organization Disability Assessment Schedule
LDQ	Leeds Dependence Questionnaire	WSAQ	Workplace Stressor Assessment Questionnaire



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GP guideline summary

Clinical guideline for the diagnosis and management of work-related mental health conditions in general practice: GP summary

This [guideline](#) has been developed to provide Australian general practitioners (GPs) with the best available evidence to guide their diagnosis and management of patients with work-related mental health conditions.

The [guideline](#) recommendations in this document were approved by the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) on 7 December 2018 under section 14A of the *National Health and Medical Research Council Act 1992* (Cwlth).

ASSESSMENT AND DIAGNOSIS OF A WORK-RELATED MENTAL HEALTH CONDITION



What tools can assist a GP in diagnosing and assessing the severity of a mental health condition?

- For depression, use the Patient Health Questionnaire-9 (PHQ-9).
 - For anxiety, use the Generalized Anxiety Disorder 7 item (GAD-7) or the Depression Anxiety Stress Scales (DASS) – diagnosis only.
 - For posttraumatic stress disorder, use the PTSD Checklist – Civilian Version (PCL-C).
 - For alcohol use disorder, use the Alcohol Use Disorders Identification Test (AUDIT), Severity of Alcohol Dependence Questionnaire (SADQ) or Leeds Dependence Questionnaire (LDQ).
 - For substance use disorders, use the LDQ.
- [Strong recommendations]
- If major depression and anxiety are excluded, consider a diagnosis of an adjustment disorder using the DASS to assess levels of distress and the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 to assess levels of functional impairment.
- [Consensus-based recommendation]
- Use these tools alongside a comprehensive clinical assessment with consideration of cultural issues.
- [Practice point]
- Seek advice from a specialist mental health clinician (e.g. psychiatrist or clinical psychologist) if experiencing difficulties in diagnosis.
- [Practice point]



What would suggest that the patient is developing a comorbid or secondary mental health condition?

Consider the following patient factors:

- greater pain following a physical injury
- insomnia, low mood, anhedonia and suicidal thoughts
- existing substance misuse
- chronic physical condition
- lower self-efficacy

- lack of social support
- existing medical condition
- past experience of, and response to, treatments
- past history of depression
- perception of injustice of the compensation claim process.

[Weak recommendation]

- pre-existing depressive disorder or other anxiety disorder
- any existing medical condition

[Consensus-based recommendation]

Consider the following work-related factors:

- job strain
- failure to return to work.

[Weak recommendation]



Has the mental health condition arisen as a result of work?

The assessment should be made on the basis of:

- a comprehensive clinical assessment

- consideration of factors such as pressures, events and/or changes in the workplace and the temporal relationship between these factors and symptom onset

- consideration of whether the mental health condition is consistent with the description of how the condition arose.

[Consensus-based recommendations]



What should a GP consider when conveying a diagnosis of a mental health condition to the patient?

- Have regard to:
 - patient concerns (e.g. stigma, discrimination, loss of employment, isolation and financial insecurity)
 - a patient's socio-cultural background
 - negotiating confidentiality and sharing of information with a patient's family or carer, if necessary.

[Consensus-based recommendation]

- Provide information to the patient about the condition, recovery expectations and the range of treatments available.
- Provide educational material in a format that the patient can understand.

[Strong recommendations]

- Promote a patient-centred recovery-based approach.

[Consensus-based recommendation]

- Establish and maintain a therapeutic alliance.

[Consensus-based recommendation]

For the full list of recommendations, explanation of the grading process and background information, access the full guideline at www.monash.edu/work-related-mental-health-guideline.

MANAGEMENT OF A WORK-RELATED MENTAL HEALTH CONDITION



How can the condition be managed effectively to improve personal recovery or return to work?

- Adopt a patient-centred approach.
[Consensus-based recommendation]
- Refer to existing high-quality clinical guidelines for the management of mental health conditions, while considering work-related factors.
[Consensus-based recommendation]
- In recognition of the health benefits of safe work and in regard to personal recovery, consider whether a patient can remain at or return to work.
[Consensus-based recommendation]
- For a secondary work-related mental health condition, where the primary condition was a musculoskeletal injury, use work-directed cognitive behavioural therapy.
[Weak recommendation]



Can the patient work in some capacity?

- Consider the following patient factors:
- severity of the mental health condition
 - presence of comorbidities
 - presence of sleep disturbance
 - higher conscientiousness pre-injury
 - attitude towards work
 - patient motivation to work
 - work ability
 - personal circumstances
- social deprivation.
[Consensus-based recommendation]
- Consider the following workplace factors:
- work environment
 - GP's knowledge about the workplace
 - suitability of work
 - size of the workplace
 - conflicts with the person's supervisor
 - ongoing work-related stressors
- availability of appropriate and safe duties that are where possible, commensurate with the worker's level of experience and seniority.
[Consensus-based recommendation]
- Consider consulting with a workplace rehabilitation provider to make an assessment of the workplace environment.
[Practice point]



What is appropriate communication with the patient's workplace?

- Use telephone and/or face-to-face methods.
- Consider using a trained workplace rehabilitation provider to coordinate and negotiate return to work, if available.
[Strong recommendations]
- Ensure that communication (with the patient's consent) maintains a focus on the workplace and on the worker's needs and functional capacities.
[Consensus-based recommendation]



What strategies are effective at managing comorbid mental health conditions and substance misuse and addictive disorders?

- Note the presence and severity of comorbidities, during assessment, and consider their implications for treatment planning.
[Consensus-based recommendation]
- Utilise existing high-quality guidelines to manage substance misuse and addictive disorders.
[Consensus-based recommendation]
- Consider using an integrated approach that addresses both work-related mental health conditions and comorbid substance use disorders.
[Consensus-based recommendation]
- Use individual-based trauma-focused psychological therapy delivered along with substance use disorder therapy for work-related posttraumatic stress disorder.
[Weak recommendation]



Why isn't the patient's mental health condition improving as expected?

- The following might affect progress in a patient's condition.
- Patient factors:
- stressful life factors outside of work
 - patients aged >40 years.
[Strong recommendation]
 - perceived injustice
 - poor adherence to recommended treatment.
[Consensus-based recommendation]
- Health behaviours and attitudes:
- attitude towards return to work
 - reduced expectations by the patient towards return to work.
[Strong recommendation]
- Workplace factors:
- job/work stress
 - poor communication with supervisor/employer
 - harassment and bullying.
[Strong recommendation]
- Medical factors:
- alcohol, smoking and drug dependence
 - persistent symptoms pre-injury
 - severity of mental health condition
 - longer symptom duration and longer sick leave duration at baseline
 - extensive physical injury
 - chronic pain
 - overweight/underweight
 - quality of rehabilitation services.
[Strong recommendation]



What can a GP do for a patient whose mental health condition is not improving?

- Investigate the existence of continuing work and non-work stressors, and assist to address them.
- Review the diagnosis and treatment plan to optimise treatment.
- Adopt a patient-centred collaborative care approach between relevant health professionals.
[Consensus-based recommendations]
- Where no stressors are identified, and where persistent depression is present, consider:
 - collaborative care between relevant health professionals
 - cognitive behavioural therapy as an adjunct to pharmacotherapy, for patients with treatment-resistant depression.
[Weak recommendation]



2

Executive summary

People with mental health conditions that have arisen as a result of work factors regularly entrust their general practitioner (GP) to guide their complex clinical journey to recovery. This guideline is intended to complement and extend the existing knowledge and expertise of GPs, and to empower them to assist in the recovery of their patients, with their patients. Its aim is to provide Australian GPs with the best available evidence, which they can apply when assessing and managing patients who have a mental health condition that has arisen due to work factors. Our objective is to accelerate personal recovery in these patients. For most patients this will include participating in good and safe work, as described in the [Consensus Statement on the Health Benefits of Good Work](#)¹.

This guideline focuses on the following mental health conditions that may have arisen as a result of work—depression, anxiety, posttraumatic stress disorder (PTSD), acute stress disorder, adjustment disorder and substance use disorder—and builds upon the key principle articulated in [The Fifth National Mental Health and Suicide Prevention Plan](#) that “consumers and carers have a valuable contribution to make and should be partners in planning and decision-making”².

The key clinical questions addressed in this guideline are based upon clinical dilemmas identified by practicing GPs, particularly those dilemmas that relate to assessing and diagnosing mental health conditions that may have arisen out of work, determining the work-relatedness of the condition, and managing patients to facilitate recovery and return to work. This guideline has been developed according to the National Health and Medical Research Council’s standards for the development of clinical practice guidelines³. As such, all evidence-based recommendations are based on a systematic review of the literature and each recommendation has been given a strength using [Grading of Recommendations, Assessment,](#)

[Development and Evaluation \(GRADE\) methodology](#)⁴.

GRADE considers four criteria to determine the strength given to a recommendation:

- methodological flaws within the component studies
- consistency of results across different studies
- generalisability of research results to the wider patient base
- how effective the treatments have been shown to be.

In this guideline, the strength of evidence-based recommendations is classified as either Strong FOR or Weak FOR.

Strong FOR recommendations are where we are certain that benefits of implementing the evidence-based recommendation will outweigh risks to produce desirable outcomes.

Weak FOR recommendations are where we are less certain that the benefits of implementing the evidence-based recommendation will outweigh risks to produce desirable outcomes.

Consensus-based recommendations are provided where we did not find suitable evidence to answer a question. These statements are made based on expert opinion and formulated by a consensus process.

Recommendations for future research are provided where we did not find suitable evidence for inclusion in a recommendation, and the Guideline Development Group considered that the existence of such evidence would be very beneficial for clinical practice.

Practice points are provided where a recommendation has been made on a topic outside the scope of the search strategy of the systematic literature review. These recommendations are made based on expert opinion and were formulated by a consensus process.

How to use this guideline

The structure of this guideline has been designed to assist GPs to systematically approach the care of patients with work-related mental health conditions. Recommendations are presented in three formats: (1) a GP guideline summary, (2) an Executive summary and (3) detailed discussion of the recommendations. The GP guideline summary is intended to be used as a quick reference to guide clinical decision making in practice. The Executive summary (chapter 2) includes an overview of the guideline aims, methods, recommendations and practice statements, each of which is accompanied by a note about whether it is a recommendation for practice, a practice point or a recommendation for future research. In addition, for each evidence-based

recommendation, we have indicated the strength of the evidence upon which it is based and finally, a grade for each recommendation has been given. Recommendations are graded either Strong FOR or Weak FOR. Detailed discussions about the recommendations are included in chapters 5–15. These chapters discuss the evidence and factors to consider when implementing the guideline in practice.

Phrases such as ‘recommend’ or ‘should’ are used when the evidence underpinning the recommendation was strong and where the Guideline Development Group judged that the benefits of implementing the recommendation outweighed the harms. Phrases such as ‘suggest’ or ‘may’ are used when the evidence base was weaker and where the balance of benefits over harms was less clear.

This guideline includes 11 evidence-based recommendations, and 19 statements based on consensus (consensus-based recommendations and practice points) as described in chapters 5–14. Although we endeavoured to provide evidence-based advice to address all the clinical questions in this guideline, for some questions no reliable evidence could be identified and recommendations for future research have been made. In addition, the Guideline Development Group (GDG) noted gaps in the evidence on the following areas:

- Management strategies for work-related mental health conditions that are feasible and acceptable for GPs to utilise, including special considerations for GPs practicing in rural and remote Australia
- Specific considerations with regards to work-related mental health conditions for culturally and linguistically diverse populations and Aboriginal and Torres Strait Islander populations
- Evidence to describe the value of work participation for people with a work-related mental health condition
- Tools and strategies to support the diagnosis and management of acute stress disorder and adjustment disorder.

This guideline has benefitted from the considerations, expertise and knowledge generously provided by many groups and individuals including the Guideline Development Group (comprising a consumer, and clinical, content and context experts) and feedback received from a national public consultation. To our knowledge it is the first guideline produced anywhere in the world to assist GPs with the diagnosis and management of work-related mental health conditions in patients presenting in general practice.

Summary of the recommendations and practice points included in this guideline

The following recommendations and practice points are provided to assist GPs with the diagnosis and management of mental health conditions that have arisen as a result of work. Recommendations are numbered to indicate the guideline chapter in which each recommendation is presented.



What tools can assist a GP in diagnosing and assessing the severity of a mental health condition?

- 5.1 For workers with symptoms of mental health conditions, a GP should use:
- the [Patient Health Questionnaire-9](#) to assist in making an accurate diagnosis of depression and assess its severity
 - either the [Generalized Anxiety Disorder 7-item](#) or the [Depression Anxiety Stress Scales \(DASS\)](#) to assist in making an accurate diagnosis of an anxiety disorder
 - the [PTSD CheckList – Civilian Version](#) to assist in making an accurate diagnosis of PTSD and assessing its severity
 - the [Alcohol Use Disorders Identification Test, Severity of Alcohol Dependence Questionnaire](#), or the [Leeds Dependence Questionnaire](#), to assist in making an accurate diagnosis of an alcohol use disorder, and assessing its severity
 - the [Leeds Dependence Questionnaire](#) to assist in making a diagnosis of substance use disorders and assessing their severity.
- [Strong recommendations FOR (high quality of evidence)]*
- 5.2 Adjustment disorder implies a level of distress greater than would otherwise be expected after a certain event(s). It is sometimes diagnosed when other psychiatric illnesses such as major depression and anxiety have been excluded and is time limited. There are no recommended tools for diagnosing adjustment disorder or assessing its severity in general practice. A GP may consider use of the [DASS](#) to assess levels of patient distress and [World Health Organization Disability Assessment Schedule 2.0](#) to assess levels of functional impairment.
- [Consensus-based recommendation]*
- 5.3 Tools should be used alongside a comprehensive clinical assessment, which includes consideration of cultural issues.
- [Practice point]*
- 5.4 The advice of a specialist mental health clinician (e.g. psychiatrist or clinical psychologist) should be sought by a GP if they are experiencing difficulties in diagnosis.
- [Practice point]*

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What would suggest that the patient is developing a comorbid or secondary mental health condition?

- 6.1 For patients with a primary physical or psychological work-related injury, a GP may consider the following factors to assist in the early detection of a comorbid or secondary mental health condition.

Patient-related factors

- Greater pain intensity, where physical injury was the precursor to the mental health condition
- Insomnia, low mood, anhedonia and suicidal thoughts
- Any existing substance misuse
- A chronic physical health problem
- Lower self-efficacy (i.e. the capacity for one to cope with difficult demands through one's own effort)
- Lack of social support and personal relationship status (i.e. relationship problems)
- Past experience of, and response to, treatments
- Past history of depression
- Perception of injustice of the compensation claim process

[Weak recommendation FOR (low quality of evidence)]

- Pre-existing depressive disorder or other anxiety disorder
- Any other existing medical condition

[Consensus-based recommendations]

Work-related factors

- Job strain
- Failure to return to work following injury

[Weak recommendation FOR (low quality of evidence)]

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Has the mental health condition arisen as a result of work?

- 7.1 On the available evidence, there is no clear support for an instrument to indicate the probability that a mental health condition has arisen out of work; therefore, there is an urgent need to promote research in this area.
[Recommendation for future research]
- 7.2 The assessment of whether a diagnosed mental health condition has arisen as a result of work should be made on the basis of:
- a comprehensive clinical assessment
 - consideration of factors such as pressures, events and/or changes in the workplace and the temporal relationship between these factors and symptom onset
 - consideration of whether the mental health condition is consistent with the description of how the condition arose.

[Consensus-based recommendation]

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What should a GP consider when conveying a diagnosis of a mental health condition to the patient?

- 8.1 When conveying a diagnosis of a work-related mental health condition, a GP should have regard to:
- patient concerns, such as the potential for stigma or discrimination, loss of employment, isolation and financial insecurity
 - a patient's socio-cultural background, which may affect their acknowledgement of a mental health condition, and
 - negotiating patient confidentiality and sharing of information with a patient's family or carer, if necessary.
- [Consensus-based recommendation]*
- 8.2 To ensure that the diagnosis of a work-related mental health condition is understood by the patient, a GP should:
- provide information to the patient about the nature of the mental health condition, the recovery expectations and the range of treatments available
 - provide the patient with educational material in a format that they can understand.
- [Strong recommendation FOR (low quality of evidence)]*
- 8.3 To ensure that the diagnosis of a work-related mental health condition is understood by the patient, a GP should promote a patient-centred recovery-based approach.
[Consensus-based recommendation]
- 8.4 Before initiating treatment, it is important to establish a therapeutic alliance with the patient regarding diagnosis and treatment. It is important to maintain the alliance so that their patient's care is a collaborative endeavour.
[Consensus-based recommendation]

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How can the condition be managed effectively to improve personal recovery or return to work?

- 9.1 On the available evidence, there is no clear support for an intervention in a general practice setting to improve personal recovery or return to work in patients with a work-related mental health condition; therefore, there is an urgent need to promote research in this area.
[Recommendation for future research]
- 9.2 Adopt a patient-centred approach. Refer to existing high-quality guidelines for the management of mental health conditions, while considering work-related factors.
[Consensus-based recommendation]
- 9.3 In recognition of the health benefits of safe work and in regards to personal recovery, consideration should be given, where appropriate, to whether a patient can remain at or return to work (this may include transition back to work or work modification).
[Consensus-based recommendation]
- 9.4 In patients with a secondary work-related mental health condition, where the primary condition was a musculoskeletal injury, a GP may consider work-directed cognitive behavioural therapy.
[Weak recommendation FOR (moderate quality of evidence)]

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Can the patient work in some capacity?

- 10.1 A GP should consider the following patient and work factors when determining whether a patient has the capacity to work.
- | Patient factors | Work-related factors |
|---|---|
| <ul style="list-style-type: none"> • Severity of the mental health condition • Presence of comorbidities • Presence of sleep disturbance • Higher conscientiousness pre-injury • Attitude towards work • Patient motivation to work • Work ability • Personal circumstances (personal relationships, finances, housing arrangements, level of physical activity) • Social deprivation (social/cultural disadvantage) | <ul style="list-style-type: none"> • Work environment • GP's knowledge about the patient's workplace and its limitations • Suitability of work • Size of the workplace • Conflicts with the person's supervisor • Ongoing work-related stressors (e.g. conflict with colleagues in the workplace) • Availability of duties that are non-stigmatising and, where possible, commensurate with the worker's level of experience and seniority |
- [Consensus-based recommendation]*
- 10.2 A GP should consider consulting with a workplace rehabilitation provider in order to make an assessment of the workplace environment.
[Practice point]

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What is appropriate communication with the patient's workplace?

- 11.1 A GP 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.
[Strong recommendation FOR (moderate quality of evidence)]
- 11.2 A GP should consider using a trained workplace rehabilitation provider, if available, to coordinate and negotiate return to work among stakeholders.
[Strong recommendation FOR (high quality of evidence)]
- 11.3 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-based recommendation]

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What strategies are effective at managing comorbid mental health conditions and substance misuse and addictive disorders?

- 12.1 On the available evidence, there is no clear support for an intervention in a general practice setting to manage comorbid substance misuse and addictive disorders; therefore, there is an urgent need to promote research in this area.
[Recommendation for future research]
- 12.2 A GP should note the presence and severity of comorbidities in their assessments, with a view to considering their implications for treatment planning.
[Consensus-based recommendation]
- 12.3 A GP should utilise existing high-quality guidelines for the management of substance misuse and addictive disorders.
[Consensus-based recommendation]
- 12.4 A GP should consider using an integrated approach that addresses both work-related mental health conditions and comorbid substance use disorders.
[Consensus-based recommendation]
- 12.5 For work-related PTSD, a GP may consider individual-based trauma-focused psychological therapy delivered with substance use disorder therapy.
[Weak recommendation FOR (very low quality of evidence)]

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*Communication between a GP and their patient's workplace should only occur with a patient's consent.



Why isn't the patient's mental health condition improving as expected?

- 13.1 A GP should consider the following factors that might affect progress in a patient's condition.

Personal/patient factors

- Stressful life factors outside of work
- Patients aged > 40 years
[Strong recommendation FOR (high quality of evidence)]
- perceived injustice
[Consensus-based recommendation]
- poor adherence to recommended treatment.
[Consensus-based recommendation]

Health behaviours and attitudes

- Attitude towards return to work
- Reduced expectations by patients about being able to return to work

Employment/workplace factors

- Job/work stress
- Poor communication with supervisor/employer
- Harassment and bullying as a precursor to the mental health condition.

Medical factors

- Alcohol intake, smoking, drug dependence
- Persistent symptoms prior to going on sick leave
- Higher degree of severity of mental health conditions (distress, depression, anxiety and somatisation)
- Longer duration of symptoms and longer sick leave duration at baseline
- Extensive physical injury
- Chronic pain
- Overweight, underweight
- Quality of rehabilitation services

[Strong recommendation FOR (high quality of evidence)]

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What can a GP do for a patient whose mental health condition is not improving?

- 14.1 On the available evidence, there is no clear support for an intervention in a general practice setting to improve personal recovery or return to work in patients with a work-related mental health condition who are not improving; therefore, there is an urgent need to promote research in this area.
[Recommendation for future research]
- 14.2 In patients with a persistent mental health condition that has arisen out of work, a GP should:
- investigate the existence of continuing work-related and non-work-related stressors that may contribute to delayed patient recovery and assist to address them
 - review the diagnosis and treatment plan to ensure that the patient is receiving optimal treatment, and
 - adopt a patient-centred collaborative care approach with relevant health professionals.
- [Consensus-based recommendation]*
- 14.3 Where no work-related or non-work-related stressors can be identified, and where persistent depression is present, a GP may consider the following evidence-based approaches to treat the persistent depression:
- collaborative care between relevant health professionals for patients with persistent depression
 - cognitive behavioural therapy as an adjunct to pharmacotherapy for patients with treatment-resistant depression.
- [Weak recommendation FOR (high quality of evidence)]*

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3

Introduction

Background

It is estimated that, at any time, one in six working-age people suffer from a mental health condition¹. Mental health conditions are typically complex and can have an impact on the individual, their families and the community.

There is no published epidemiology of the most common mental health conditions arising from work-related factors. However, the most common work-related mental health conditions on claims databases—as classified according to Diagnostic and Statistical Manual of mental Disorders fifth edition (DSM-5)² criteria—include trauma and stressor-related disorders, anxiety disorders and depression³. In addition, approximately 50% of workers with a physical injury develop symptoms of depression in the 12 months post injury⁴.

Participation in good and safe work is instrumental in achieving good health^{5,6}, so when a mental health condition arises as a result of work factors the negative consequences can be compounded, unless they are addressed appropriately and promptly⁷. GPs have a crucial role in assessing and diagnosing patients with mental health conditions that are a result of work and assisting these patients to manage the condition and to meet their personal recovery goals.

In Australia, mental health conditions are one of the main reasons for long-term sick leave and long-term work incapacity. According to claims data, people who are on sick leave due to a work-related mental injury take three times longer to return to work compared with people who sustain a work-related musculoskeletal injury. People who sustain work-related physical injuries are also at risk of developing a comorbid or secondary mental health condition, thus hampering their recovery⁸.

A person's GP plays a significant role in their recovery after a work-related injury. As the primary provider of care, the GP can shape a positive recovery pathway for the patient. Further, as a coordinator of a patient's clinical care, the GP can facilitate the necessary access to allied or specialist care for their patient, and ensure that management approaches are patient-centred. As the primary certifier of capacity to work, the GP also guides the patient as to when and in what capacity they can return to work, and works with others to ensure that the work context is safe and beneficial for the patient. Finally, for patients who decide to submit a worker's compensation claim, the GP's opinion forms part of the evidence that is considered by a compensation scheme, and thus has the potential to improve the claim outcome.



Clinical need for this guideline

In Australia, work-related mental health conditions are the second most common cause of workers' compensation claims after musculoskeletal disorders⁹. At present, GPs are more likely to certify workers with a mental health condition as unfit for work compared to workers with physical conditions^{10–12}.

This guideline has been developed in response to a call-to-action by Australian GPs for a diagnosis and management pathway for patients with work-related mental health conditions. In the only pre-existing Australian study of GP perceptions about sickness certification, members of the guideline development project team found that GPs encountered knowledge barriers with regards to managing patients with work-related mental health conditions; including a patient's capacity to work and facilitating a patient's return to work¹³. In this study, GPs declared that it would be useful to have guidance in this area to enhance their management of patients with work-related mental health conditions.

To date, there are no clinical practice guidelines that address the clinical complexities associated with diagnosing and managing potentially compensable work-related mental health conditions in the general practice setting¹⁴. There are, however, several position statements and guidelines that are relevant for Australian clinicians who have patients with work-related mental health conditions. Of these, [The Fifth National Mental Health and Suicide Prevention Plan](#) (2017)¹⁵ and the [Health Benefits of Good Work \(HBoGW\) consensus statement](#) (2011)¹⁶ are the most pertinent.

[The Fifth National Mental Health and Suicide Prevention Plan](#)¹⁵ commits all governments in Australia, and consequently services, to work collaboratively to improve the integration and delivery of mental health care. Importantly, it mandates that consumers and carers are central to the way in which health care is planned, delivered and evaluated.

Recognising the significant contribution of good work to a person's wellbeing, the [HBoGW](#) consensus statement states:

“Good work is engaging, fair, respectful and balances job demands, autonomy and job security. Good work accepts the importance of culture and traditional beliefs. It is characterised by safe and healthy work practices and it strikes a balance between the interests of individuals, employers and society. It requires effective change management, clear and realistic performance indicators, matches the work to the individual and uses transparent productivity metrics.”¹⁶

The [HBoGW](#) statement is co-signed by the Royal Australian College of General Practitioners (RACGP), Office of Industrial Relations – Queensland Government (OIR QLD), Royal Australian College of Physicians (RACP), ReturnToWorkSA, NSW State Insurance Regulatory Authority (SIRA), WorkCover WA, Comcare and others.

Australian workers' compensation schemes

In Australia, there are 11 workers' compensation schemes. Of these, eight are state and territory compensation schemes (NSW, VIC, QLD, WA, SA, TAS NT, ACT) and three are workers' compensation schemes administered by the Commonwealth (Comcare, Seacare and Department of Veterans' Affairs).

Employers are obligated to comply with existing workers' compensation legislation in jurisdictions in which they operate. For instance, some jurisdictions do not accept mental health conditions as a secondary claim to a physical injury¹⁷. It is also noteworthy that not all workers can receive compensation through workers' compensation schemes. For example, people who participate in Work for the Dole activities are not eligible to access compensation through workers' compensation schemes.

Purpose

We hope that this guideline will provide GPs with the best available evidence, which they can apply when diagnosing and managing patients with a possible or confirmed mental health condition that has arisen as a result of work. The guideline is intended to serve as an aid to GPs and should not replace their clinical judgement. Rather, the advice provided here aims to enhance their clinical judgement. We would like to highlight that personal recovery is the key patient outcome that we aim to affect with this guideline. For most patients, this will include the additional recovery goal of participating in work.

This guideline has been developed according to the [National Health and Medical Research Council's Standards for Guideline Development 2011](#)¹⁸.

Development of the guideline has also been informed by learnings in implementation science to increase its usefulness and usability. A number of the methods were used to develop this guideline. (a) Interviews with GPs and key informants were used to identify the key clinical dilemmas faced by GPs when diagnosing and managing patients. These were then used to formulate the key clinical questions that are addressed in the guideline. (b) A clinical reasoning framework was used as a blueprint for the structure of the guideline document, thus replicating the nature of consultations in a clinical setting. (c) An evidence-based implementation and dissemination plan was developed that can be used to effect knowledge translation.

Scope

The guideline addresses the clinical dilemmas of assessing and diagnosing work-related mental health conditions, determining the work-relatedness of a condition, and managing patients to facilitate their recovery and return to work (RTW). We identified the specific clinical challenges faced by Australian GPs when diagnosing and managing patients with work-related mental health conditions and used these clinical challenges as the basis for this guideline. Further detail on this process can be found in the [Methodology](#) section. The following ten questions were answered through a systematic review of the literature:

1. In workers presenting with symptoms of mental health conditions, what tools can assist a GP to make an accurate (sensitive and specific) diagnosis of a mental health disorder and its severity?
2. In workers, what factors assist in the early detection of a comorbid work-related mental health condition?
3. In patients with a diagnosed mental health condition, what methods are effective at indicating the probability that the diagnosed mental health condition has arisen as a result of work?
4. When conveying a diagnosis of a work-related mental health condition to a patient, what factors should GPs consider, to ensure that their diagnosis is understood and acknowledged by the patient?
5. In patients with a work-related mental health condition, what GP strategies result in the highest level of personal recovery and/or return to work?

6. In workers with a mental health condition, what information should a GP consider to determine whether a person has capacity to work?
7. What is appropriate communication with the patient's workplace, in order to appropriately manage a work-related mental health condition?
8. In patients with a work-related mental health condition, what GP interventions are effective at managing comorbid substance misuse and addictive disorders?
9. In patients with a diagnosis of a work-related mental health condition, what factors adversely affect progress in the patient's condition?
10. In patients with work-related mental health conditions who are not improving, what strategies should a GP undertake to improve the patient's condition?

In this guideline, work-related mental health conditions are defined as:

- those mental health conditions that developed as a direct result of a work-related stressor, or
- mental health conditions that developed concurrently or as a consequence of a primary (physical or psychological) work-related injury, or
- a pre-existing mental health condition that was exacerbated by a workplace stressor.

In this guideline, work is defined as any activity that a person undertakes in order to receive a financial reimbursement.

This guideline addresses the mental health conditions of depression, anxiety, posttraumatic stress disorder, acute stress disorder, adjustment disorder and substance use disorder in all people who present in general practice with a possible work-related mental

health condition. It also addresses the management of mental health comorbidities (for example, substance use disorder). It does not address the detailed management of other comorbidities that frequently exist alongside mental health conditions, such as chronic pain and other chronic illness.

We used a broad and inclusive approach in the design of the search criteria to capture any studies that addressed work-related mental health conditions in minority groups or vulnerable populations. We anticipated that any published studies pertaining to Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse populations, and gay, lesbian, bi-sexual, transgender and intersex people would be identified using this approach.

What this guideline does not address

This guideline does not provide advice to GPs with regards to engaging with or navigating workers' compensation claims processes across Australia. The patient's decision to submit a claim for worker's compensation is based on many factors, which are unique to each patient and their context. By implementing the recommendations in this guideline GPs will be better equipped to assist their patient in this area.

Clinical practices that are not addressed in this guideline include: (1) those that are considered to be part of usual care, and which were not highlighted as a clinical dilemma requiring guidance, or (2) were too extensive to be considered in a single guideline. Such topics included how to conduct a comprehensive clinical history, outlining diagnostic criteria for mental health conditions (refer to the [DSM-5](#) for detailed diagnostic criterion), and effectiveness of treatment delivery options for general (non-work related) mental health conditions.

Guiding principles

Scope of practice and when to refer

Guiding principle: It is important that the GP provides care that is within their expertise, knowledge and capabilities, and is the optimal care option for the patient.

- For most patients, the GP will be adept at leading or coordinating this care. In some instances, the GP will have competency to provide more specialised mental health and occupational care; in others, collaboration with appropriate health care providers, community members and other individuals, as appropriate for the patient, should be sought to ensure the best patient-centred approaches are used.
- Care should be focused on the patient's needs, values and beliefs. This can be aided by including the patient in all collaborations, and by ensuring that communications are accurate and factual.
- We acknowledge that access to clinicians with expertise in mental health and/or occupational health may be limited in rural and remote Australia.

Considerations regarding the care of young people

Guiding principle: The GP should ensure that young people receive appropriate care throughout recovery, and should work with the patient and relevant others to determine how best to provide this care.

- The [Guidelines for adults on how to communicate with adolescents about mental health problems and other sensitive topics](#)¹⁹ state that “*each adolescent's needs are different and decisions should be made according to what is believed to be in the best interests of the adolescent.*”
- The guidelines [Communicating with an Aboriginal or Torres Strait Islander Adolescent: Guidelines for being culturally appropriate when providing mental health first aid](#)²⁰ emphasises the importance of being aware of the impacts of culture and history including “Social, cultural and historical factors all have an impact on the health and wellbeing of Aboriginal and Torres Strait Islander people. You should be aware of the adolescent's cultural background, local cultural norms and the hierarchy

of decision making power within their community. It is important to recognise that there are cultural differences among Aboriginal and Torres Strait Islander communities.”

- The guidelines [Depression in children and young people: identification and management](#)²¹ provide recommendations for appropriate management of depression in adolescents.

Cultural considerations

Guiding principle: The GP should ensure that the patient receives culturally appropriate care throughout their recovery, and should work with the patient and relevant others to determine how best to provide this care.

- Patients with complex mental health needs and vulnerable groups (e.g. Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse populations) are the most likely to be at risk of slower recovery outcomes due to the potential for inadequate assessment and diagnosis¹⁵. For example, language barriers can hinder communication and accurate assessment, and gaps in cultural knowledge and understanding can lead to misdiagnosis or inappropriate management.
- The [Fifth Mental Health and Suicide Prevention Plan](#)¹⁵ stresses the importance of providing access to mental health services for people from culturally and linguistically diverse backgrounds, as well as for their carers and families. This may involve medical staff who work in practices that see high numbers of patients from culturally and linguistically diverse backgrounds undertaking mental health cultural competency training.
- To provide culturally appropriate care for Aboriginal and Torres Strait Islander people, the GP should seek advice and guidance from Aboriginal and Torres Strait Islander health and mental health practitioners, social-emotional wellbeing workers, Elders, cultural consultants, traditional healers or Aboriginal Community Controlled Health Services²².
- To provide appropriate care for culturally and linguistically diverse people, GPs should seek advice and guidance from community leaders, who may include traditional healers, elders or religious leaders, or the person's family members²².

Useful resources

Additional resources which GPs might find the following helpful:

- The [National framework for recovery-oriented mental health services \(2013\)](#)²³ outlines key aspects of recovery-oriented practice and describes practice domains that are necessary to provide recovery-oriented care. It provides key relevant definitions for the delivery of mental health services.
 - Personal recovery is defined as “being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues”.
 - Recovery-oriented mental health practice refers to the systems and processes that “support people to recognise and take responsibility of their own recovery and wellbeing and to define their goals, wishes and aspirations”.
 - Recovery-oriented mental health service delivery is “centred on and adapts to the aspirations and needs of the patient”. It requires a shared vision and commitment from all those involved in the person’s care.
- The [Clinical Framework for the Delivery of Health Services in Compensable Injury](#)²⁴ sets out guiding principles for the delivery of health services for people with an injury. It endorses the concepts of person-centred and recovery-oriented care, and the adoption of a biopsychosocial approach in diagnosis and management. This framework was developed by the Transport Accident Commission and WorkSafe Victoria and is endorsed by the Commonwealth, all states and territories and a range of peak bodies.
- [Taking Action – A Best Practice Framework for the Management of Psychological Claims in the Australian workers’ compensation sector](#)²⁵ was produced for use in the compensation setting, and provides recommendations to employers and compensation agencies about facilitating recovery and return to work for people with work-related mental health conditions.
- [National Safety and Quality Health Service Standards: User Guide for Aboriginal and Torres Strait Islander Health](#)²² produced for health service providers to consider and implement six actions that meet the needs of Aboriginal and Torres Strait Islander people within the National Safety and Quality Health Service Standards.



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4

Methodology

NHMRC procedures

The National Health and Medical Research Council (NHMRC) has set standards in clinical practice guideline development. These are outlined in [The Procedures and requirements for meeting the 2011 NHMRC standard for clinical practice guidelines](#)¹. This document outlines the procedures for NHMRC approval of clinical practice guidelines developed by external organisations and sets out the requirements that must be met in preparation of clinical practice guidelines to ensure that the NHMRC standards are upheld. In undertaking the development of this guideline we adhered to the NHMRC procedures as outlined below.

Governance

Guideline Development Group

A Guideline Development Group (GDG) was responsible for overseeing development of the guideline (see [Appendix A](#) for the activities undertaken at key stages throughout the guideline development process). The GDG convened eight times over the course of the guideline development process. GDG meetings were held either face to face (five meetings) or via teleconference (three meetings).

Membership of the GDG is listed in [Table 1](#).

Conflicts of interest

All members completed and signed a declaration of interest form ([Appendix B](#)) prior to commencing their membership of the GDG. In addition, the Chair asked members at the beginning of each meeting to advise if any new conflicts of interest had arisen since the previous meeting. Where a conflict of interest was declared, the respective member stepped out of the room for the duration of the discussion.

Steering Group

A Steering Group was established, which comprised of representatives from each of the agencies that funded or supported the development of the clinical practice guideline. The role of the Steering Group was to ensure completion of the project according to milestones. In addition, members were involved in the scoping study by drawing upon their existing networks to invite participation from psychiatrists and compensation scheme workers to the study. The Steering Group also had a key role in guideline dissemination, where the members again drew upon existing networks to tailor guideline implementation, state by state. Members of the Steering Group are listed in [Table 2](#).

Editorial independence

The organisations that funded the development of this guideline did not participate in its development, except when invited. Representatives for the GDG were sought from Comcare, to provide a national policy perspective, and from the Office of Industrial Relations – Queensland Government, to provide a state-based policy perspective for the GDG. During the scope-development stage, funding agencies were invited to nominate agency staff to participate in an interview to offer their perceptions of the clinical needs of GPs. Finally funding agencies helped ensure wide dissemination of the draft guideline across Australia during the public consultation period.

Table 1 Membership of the project Guideline Development Group

Affiliation, role	Member
Monash University, GP, content expert (Chair)	Prof Danielle Mazza
Monash University / National Aging Research Institute, content expert	Dr Bianca Brijnath
Mental Health Australia, consumer with a lived experience of a work-related mental health condition	Ms Heather Nowak
RACGP representative, GP with content expertise	Dr Cate Howell
Private GP with content expertise	Dr Trevor Brott
AFOEM Australasian Faculty of Occupational and Environmental Medicine	
RACP (AFOEM), occupational physician	Dr David Gras
RANZCP representative, psychiatrist	Dr Michelle Atchison
Australian Psychological Society, clinical psychologist with content expertise	Prof Justin Kenardy
Office of Industrial Relations – Queensland Government, state-based policy maker	Ms Fiona Emery (meetings 1 and 2) Mr Richard Buchanan (meetings 3–6)
Comcare, national workers compensation scheme representative	Mr Seyram Tawia

Table 2 Membership of the project Steering Group

Organisation	Member
Monash University – Department of General Practice	Prof Danielle Mazza, Dr Bianca Brijnath and Dr Samantha Chakraborty
Monash University – Institute of Safety, Compensation and Recovery Research	Andrea DeSilva (until April 2018), Samantha Barker
Department of Jobs and Small Business (Commonwealth)	Monica Sapra (until January 2018), Henry Jones
Comcare (Commonwealth)	Rebecca Parton, Ngaire Anderson
State Insurance Regulatory Authority NSW	Henry Ko, Liane Steele
ReturntoWorkSA (SA)	Marcia Vernon (until July 2017), Julianne Flower
Office of Industrial Relations – Queensland Government (QLD)	Rachel Hawkins, Allicia Cress
WorkCover (WA)	Chris White

Development of the key clinical questions addressed in the guideline

The key clinical questions that are addressed in this guideline were developed through a two-phase process.

Phase one involved an electronic search of major guideline development groups in Australia, the US, Canada and Europe to identify best-practice approaches for prioritising key questions for clinical practice guidelines. This process identified 12 guideline-development protocols. The two most comprehensive protocols^{2,3} were then selected and used as a framework for generating the questions for the guideline would address.

In phase two, the framework was augmented by incorporating the views of the end users of the guidelines (GPs and other stakeholders, including compensation scheme workers and psychiatrists), using a qualitative research approach. The Clinical Reasoning Framework⁴ (Figure 1) was used to guide the development of the interview questions and the analysis of the findings (i.e. grouping of the clinical challenges into key questions). Based on the results of this qualitative study, an initial list of questions was generated for the guideline to address. The full methodology for developing key clinical guideline questions is in the process of publication [unpublished manuscript].

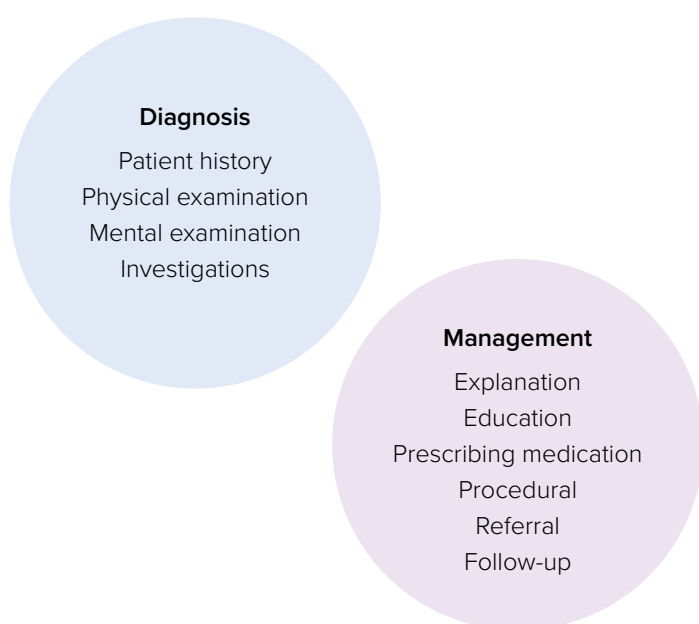


Figure 1: The Clinical Reasoning Framework⁴

Systematic literature review of existing evidence

A detailed report outlining the search strategies, search outcomes and review methods used for the literature review is included in a technical report that accompanies this guideline; however, a brief summary is provided here.

A systematic review of the literature was carried out to build the evidence base for the development of this guideline. The review was conducted by the Evidence Review Team with the GDG. The Evidence Review Team comprised the Project Manager, an Evidence Reviewer and a Project Officer. The review processes involved a search of the literature in Ovid-hosted databases (Embase, Medline, PsycINFO and AMED) and CINAHL Plus. The search was performed over two rounds. In round one, all searches were performed from the inception date (date 0) of the respective databases to 31 January 2017. Preliminary evidence findings from this round were reviewed by the GDG at the meeting of 30 April 2017. The GDG made recommendations to revise some questions, and to modify the literature search strategy or the inclusion/exclusion criteria, depending on the review question. A second-round search incorporating these changes was then performed and, where applicable, the search either updated the results for the period 1 February to 30 April 2017, or involved a new search with a modified search strategy from database inception to 30 April 2017. Supplementary searches were carried out for questions 3, 4 and 7 from database inception to 22 August 2017.

The project Evidence Reviewer conducted the literature search. Critical appraisal and review of the literature was performed by two independent reviewers, who developed the evidence base for the guideline recommendations.

The Population Intervention Comparator Outcome (PICO) approach was used to develop and finalise the key questions and search eligibility criteria.

Inclusion criteria

Each review question addressed a different aspect of clinical practice in the guideline, and therefore different outcomes, but there were some common and general inclusion criteria, while others were specific to a given review question. The broad, general inclusion criteria were:

- population – patients with depression, anxiety, posttraumatic stress disorders, acute stress disorder, adjustment disorder, stress or substance use disorders
- types of studies – studies of all types of design published in English
- outcomes – diagnosis, risk factors and management of patients with depression, anxiety, posttraumatic stress disorders, stress, adjustment disorder or substance use disorders in the working population.

Exclusion criteria

The exclusion criteria were:

- mental health conditions other than depression, anxiety, posttraumatic stress disorders, stress, adjustment disorder or substance use disorders (e.g. schizoaffective disorders)
- studies that had limited scope of application (i.e. studies conducted in highly specific contexts and deemed to have low generalisability and/or studies involving distinct, homogenous and highly selective populations or groups).
- non-English language publications or full-text articles that could not be located or sourced.

Literature screening and identifying eligible studies

Titles and abstracts of the search results were collated in EndNote X8™ (Clarivate Analytics, Philadelphia) and exported to Covidence (<https://www.covidence.org/>) for screening. The Evidence Reviewer and a second reviewer independently screened the titles and abstracts (or full-text articles where there were no abstracts, or if relevance could not be determined from the title and abstract only) for relevance. The Project Manager mediated any conflicts in review decisions. The reviewers then proceeded to full text article review for further elimination of irrelevant publications and assessment of studies for inclusion or exclusion. Screening for guidelines and systematic reviews, where applicable, followed a similar screening and review process.

Search for existing evidence-based guidelines and systematic literature reviews

Where the evidence base was small, the team conducted an internet search of guideline clearing houses and systematic review databases to identify potentially relevant and high-quality evidence-based guidelines and systematic literature reviews that could be considered for adaptation in this guideline. The search for high-quality guidelines and systematic reviews included a broader inclusion criteria as follows:

- population – patients with depression, anxiety, posttraumatic stress disorders, stress, adjustment disorder or substance use disorders
- types of guidelines – clinical practice guidelines or systematic reviews published in English
- outcomes – diagnosis, risk factors and management of patients with depression, anxiety, posttraumatic stress disorders, stress, adjustment disorder or substance use disorders in the general population. Or any mental health condition in the working population.

The exclusion criteria for guidelines and systematic literature reviews were:

- mental health conditions other than depression, anxiety, posttraumatic stress disorders, stress, adjustment disorder or substance use disorders (e.g. schizoaffective disorders)
- non-English language publications or full-text articles that could not be located or sourced.

Appraising and summarising the evidence

Studies for inclusion were assessed for methodological quality using the [Downs and Black checklist](#)⁵ for interventional and prognostic studies. The [Quality Assessment of Diagnostic Accuracy Studies version \(QUADAS\) tool](#)⁶ was used to test studies for diagnostic accuracy, and [A Measurement Tool to Assess Systematic Reviews \(AMSTAR\)](#)⁷ was used for systematic reviews. The two reviewers then extracted quantitative and/or qualitative data from relevant included studies, and the Evidence Reviewer, in discussion with the Project Manager, collated and summarised the data using the [Grading of Recommendations Assessment, Development and Evaluation \(GRADE\) evidence](#)⁸ tables. Where the evidence was supplemented with existing clinical practice guidelines, the [Appraisal of Guidelines for Research and Evaluation II \(AGREE-II\) tool](#)⁹ was used to assess the quality of those guidelines.

Development of guidance

Development of evidence-based recommendations

GDG members used [GRADE](#)⁸ to review evidence base and assign a strength to each recommendation. The body of evidence for each question was assessed first by the project team and given a preliminary certainty of evidence (HIGH, MODERATE, LOW or VERY LOW) rating following the ([GRADE criteria Table 3](#))⁸. For each question, the GDG was presented with a table outlining the strength of the evidence, and an accompanying draft recommendation, at a face-to-face meeting. The GDG reviewed the evidence and adjusted the rating. The GDG also confirmed the wording of each recommendation and assigned a strength to the recommendation using [GRADE](#)⁸. The strength assigned to each recommendation reflects both our confidence in the evidence, as well as the desirable and undesirable consequences of implementing each recommendation⁸.

Development of consensus-based recommendations

Where a systematic review was conducted and no high-quality evidence was identified, the GDG devised a consensus-based recommendation based on their clinical, consumer, policy and content expertise. Where high-quality clinical guidelines offered relevant consensus statements to address a clinical question, the GDG considered the applicability of these consensus statements before adapting or adopting these into this guideline.

Development of practice points

Where the GDG or feedback from the public consultation recommended including advice on a topic outside the scope of the search strategy, the GDG devised a practice point based on their clinical, consumer, policy and content expertise.

Formulating evidence-based recommendations, consensus statements and practice points

The GDG considered formulated evidence-based recommendations, consensus statements and practice points over four face to face meetings and three teleconference meetings. At each meeting the discussion was facilitated by the Chair, who ensured that all members contributed to the discussions. Decisions were made through group discussion until the GDG reached unanimous consensus.

In some instances, queries were raised by GDG members about the quality or limited amount of evidence available for recommendations for specific questions. To address this issue, the project team revisited search strategies for questions that were queried, made adjustments where appropriate, and conducted a further review of the evidence. The implications of the updated search results on the draft recommendations were discussed with the GDG via teleconference. Members were then given the opportunity to make further edits to the draft recommendations in light of any new findings.

Table 3 Quality of evidence GRADEs

Evidence rating	Definition
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of the effect.

Following a decision from the GDG about the clinical questions in the first meeting and an initial systematic review, the GDG convened a second time to review the outcomes of this review. The project team developed a list of draft recommendations, primarily based on available evidence that arose from systematic literature reviews and/or recommendations adapted from existing high-quality guidelines. At this meeting the GDG recommended adjustments to the review questions and eligibility criteria, and extending the search criteria to identify potentially relevant clinical guidelines and systematic reviews.

A revised literature review was undertaken and presented to the GDG at a third face-to-face meeting. The GDG recommended adjustments to the recommendations, consensus statements and practice points and discussed any potential harms and benefits of each recommendation.

At the fourth face-to-face meeting all draft recommendations were presented to GDG members via round table discussion for final review. After assessing all of the evidence, the GDG members were asked to discuss and finalise the wording for each recommendation.

Phrases such as ‘recommend’ or ‘should’ were used when the evidence underpinning the recommendation was strong and where the GDG judged that the benefits of implementing the recommendation outweighed the harms. Phrases such as ‘suggest’ or ‘may’ were used when the evidence base was weaker and where the balance of benefits over harms was less clear.

The draft Implementation Plan was also ratified at this meeting, and the draft guideline was ratified by teleconference shortly thereafter and distributed for National public consultation.

A fifth GDG meeting was convened to discuss the feedback received from the public consultation process and revise the guideline in response to this feedback.

Note about the supporting discussion for each recommendation

For each recommendation, a supporting discussion is included. The purpose of this discussion is to (a) provide detail about the nature and quality of the evidence that was used to develop a recommendation, (b) outline how the evidence was used by the GDG when creating a recommendation, and (c) provide detail about factors that might influence the implementability of the recommendation in practice.

Consideration of strategies to facilitate the implementation of recommendations

An Implementation Plan has been developed to supplement the guideline and provide advice about the strategies that are likely to improve implementation of recommendations by GPs. The Implementation Plan also provides instruction on how to assess whether the guideline is being used, and the extent to which it is being used, appropriately.

Public consultation

The draft guideline document and draft Implementation Plan were released to the public, with an invitation to comment on the quality and perceived usefulness of the recommendations and supporting guideline content. Public consultation took place between 15 January 2018 and 15 March 2018. The guideline and supporting documents were sent via electronic mail to 39 individuals and 101 organisations across Australia. The initial invitation was followed with two reminders prior to 15 March 2018. An invitation to contribute to the public consultation was also made available via the Monash University Department of General Practice and National Health and the Medical Research Council webpages. In addition, Steering Group members further distributed notice of the public consultation among their networks.

We received detailed responses from 28 organisations and 4 individuals over the two months of public consultation. The GDG reviewed this feedback and made revisions to the guideline in light of these responses. All comments that were received regarding the draft guideline or Implementation Plan were collated and a response provided to each individual comment. A list of the comments and responses from the GDG is available on the Monash University Department of General Practice – Compensable Injury website: <http://www.med.monash.edu.au/general-practice/compensable-injury/index.html>.

Procedure for updating the guideline

After three years, subject to availability of funding, this guideline will be reviewed and updated as per NHMRC processes.

Supporting documentation

The following documents provide additional detail on the methods used when developing the Guideline:

1. Administrative report
2. Technical report
3. Implementation and Dissemination Plan
4. Public Consultation Submissions Summary

These documents are available via: www.monash.edu/work-related-mental-health-guideline.

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5



What tools can assist a GP in diagnosing and assessing the severity of a mental health condition?

Why is this topic important?

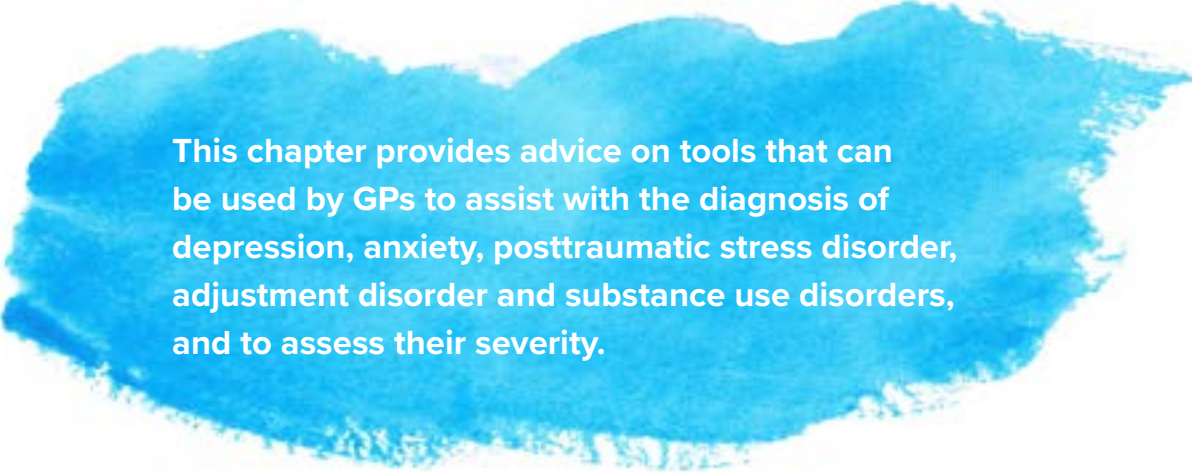
An accurate diagnosis is an essential step towards recovery for patients with a mental health condition. A diagnosis can be used to (1) alleviate patient concerns about their signs and symptoms, and provide patients with a rationale for how these symptoms emerged, and (2) consider and select optimal management strategies for the patient¹. For those patients who decide to submit a claim for compensation through a worker's compensation scheme, a clearly stated diagnosis on the certificate of capacity can also assist with an efficient assessment of the compensation claim².

The foundation of assessment and diagnosis of a mental health condition is a comprehensive clinical interview. The comprehensive clinical interview for a suspected mental health condition should be supported by DSM-5 criteria, which is designed to “identify symptoms and behaviors, cognitive functions, physical signs, syndrome combinations, and durations to assist GPs to differentiate from normal life variation and transient responses to stress.”³

In the setting of a comprehensive assessment of a patient with a potential work-related mental health condition, there are contexts where a tool can assist a GP with making a diagnosis and assessing severity of symptoms.

GPs are highly proficient at discerning patients who do not have a mental health condition (approximately 87% accuracy for depression and 92% accuracy for anxiety)^{4,5}. However, when identifying patients with anxiety or depression without using a tool (i.e. sensitivity), it is reported that depression is only accurately identified half of the time^{5,6} and anxiety disorders are accurately identified only one third of the time⁴. A validated instrument is, therefore, a highly valuable asset to GPs to use alongside a comprehensive clinical interview.

Many instruments are available to assist clinicians in making a diagnosis of the numerous mental health conditions that might present in general practice, and in determining the severity of these conditions. These tools vary in their scope of topic, mode of administration, level of expertise required to utilise them in practice, and validity and reliability for diagnosing and/or assessing mental health conditions and feasibility in the Australian general practice setting.



This chapter provides advice on tools that can be used by GPs to assist with the diagnosis of depression, anxiety, posttraumatic stress disorder, adjustment disorder and substance use disorders, and to assess their severity.

Summary of recommendations



What tools can assist a GP in diagnosing and assessing the severity of a mental health condition?

- 5.1 For workers with symptoms of mental health conditions, a GP should use:
- the [Patient Health Questionnaire-9](#) to assist in making an accurate diagnosis of depression and assess its severity
 - either the [Generalized Anxiety Disorder 7-item](#) or the [Depression Anxiety Stress Scales \(DASS\)](#) to assist in making an accurate diagnosis of an anxiety disorder
 - the [PTSD CheckList – Civilian Version](#) to assist in making an accurate diagnosis of PTSD and assessing its severity
 - the [Alcohol Use Disorders Identification Test, Severity of Alcohol Dependence Questionnaire](#), or the [Leeds Dependence Questionnaire](#), to assist in making an accurate diagnosis of an alcohol use disorder, and assessing its severity
 - the [Leeds Dependence Questionnaire](#) to assist in making a diagnosis of substance use disorders and assessing their severity.
- [Strong recommendations FOR (high quality of evidence)]*
- 5.2 Adjustment disorder implies a level of distress greater than would otherwise be expected after a certain event(s). It is sometimes diagnosed when other psychiatric illnesses such as major depression and anxiety have been excluded and is time limited. There are no recommended tools for diagnosing adjustment disorder or assessing its severity in general practice. A GP may consider use of the [DASS](#) to assess levels of patient distress and [World Health Organization Disability Assessment Schedule 2.0](#) to assess levels of functional impairment.
- [Consensus-based recommendation]*
- 5.3 Tools should be used alongside a comprehensive clinical assessment, which includes consideration of cultural issues.
- [Practice point]*
- 5.4 The advice of a specialist mental health clinician (e.g. psychiatrist or clinical psychologist) should be sought by a GP if they are experiencing difficulties in diagnosis.
- [Practice point]*



Evidence summary

Depression

A systematic review identified two tools that had been validated for use by GPs for the assessment of depression in a work-context.

Patient Health Questionnaire (PHQ-9)

- Volker et al.⁷ assessed validity of the PHQ-9 in a work context, and Cholera et al.⁸ assessed validity in a primary care setting in South Africa.
- Both studies demonstrated good sensitivity (64% to 94%) and specificity (71% to 85%) for detecting depression (above 70% in a work context and 67% in a non-work context). These studies were of a moderate to high quality.
- The PHQ-9 was also reviewed in a high-quality review conducted by the NICE in the UK⁹. This review identified 11 studies have described the diagnostic accuracy testing of the PHQ-9 and concluded that the PHQ-9 has high sensitivity (82%) and high specificity (83%).

Depression Anxiety Stress Scale (DASS)

- Nieuwenhuijsen et al.¹⁰ assessed the validity of the DASS and reported a sensitivity of 91% and specificity of 46% in depression for a cut-off score of 12. This study was of moderate to high quality.

Anxiety disorders

The evidence review identified two tools that had been validated for use by GPs for the assessment of anxiety disorders in a work context. These were the [Four-Dimensional Symptom Questionnaire \(4DSQ\)](#)¹¹ and the [DASS](#)¹⁰:

- Langerak et al. assessed the validity of the 4DSQ in a work context and found >70% sensitivity and 70% specificity for detecting anxiety.
- Nieuwenhuijsen et al.¹⁰ assessed the validity of the DASS in a work context and found high sensitivity (92%) but only 40% specificity.

Tools for the diagnosis of anxiety disorders were discussed in three guidelines: [NICE 2016 Depression](#)⁹, [NICE 2011 Generalised Anxiety Disorder](#)¹², and [Royal Australian and New Zealand College of Psychiatrists \(RANZCP\) 2018](#)¹³.

- [Hospital Anxiety and Depression Scale \(HADS\)](#): The NICE 2016 Depression guideline⁹ included a review of the HADS¹⁴. A total of 21 studies were included in the review; however, meta-analysis could not be conducted because of the very high heterogeneity ($I^2 = 90\%$) of the different patient populations groups considered.
- [Generalized Anxiety Disorder-7 \(GAD-7\)](#): The RANZCP 2018 guideline¹³ recommends using the GAD-7 for assessment of anxiety disorders. The recommendation was based on expert consensus.
- [Penn State Worry Questionnaire-3 \(PSWQ-3\)](#): The RANZCP 2018 guideline¹³ recommends using this tool to assess patients for anxiety disorders. The recommendation was based on expert consensus.

The [RANZCP 2018 guideline](#)¹³, also recommends the use of four diagnostic interview schedules that generate reliable and valid diagnosis: [Structured Clinical Interview for Axis 1 DSM-IV Disorders](#), [Anxiety Disorders Interview Schedule](#), [Composite International Diagnostic Interview](#), and [Mini-international Neuropsychiatric Interview](#).

Posttraumatic stress disorder

The systematic review identified one tool that has been validated for use by GPs for the assessment of posttraumatic stress disorder (PTSD) in a work-context. This is the [Posttraumatic Stress Disorder Checklist – Civilian version \(PCL-C\)](#), which demonstrated high sensitivity (90%) and good specificity (79%) for the detection of PTSD in a work context¹⁵.

Acute stress disorder

There is no valid screening or diagnostic tool for acute stress disorder. Diagnosis of an acute stress disorder is made using a comprehensive clinical interview and diagnostic criteria outlined in the DSM-5³.

Adjustment disorders

There is no valid screening or diagnostic tool for adjustment disorders. Diagnosis of an adjustment disorder is made using a comprehensive clinical interview and diagnostic criteria outlined in the DSM-5 (e.g. through the exclusion of other, more severe mental health conditions, such as depression or anxiety).

Substance misuse and addictive disorders

The evidence review did not identify any tools that may be considered for use by GPs for the assessment of substance misuse and addictive disorders. Tools for the diagnosis of substance misuse and addictive disorders were, however, considered in the high-quality [NICE 2011 Clinical Guideline](#)¹⁶.

- [Alcohol Use Disorders Identification Test \(AUDIT\)](#) (alcohol only): High internal consistency has been reported and high reliability was found in the context of a young adult population¹⁶.
- [Severity of Alcohol Dependence Questionnaire \(SADQ\)](#) (alcohol only): The test–retest reliability (correlation coefficient ranged from 0.55 to 0.82 across individual questions). It was found to have good content, criterion and construct validity, and correlates with physician and patient ratings of withdrawal severity and the quantity of medication to be prescribed during alcohol withdrawal^{17, 18}.
- [Leeds Dependence Questionnaire \(LDQ\)](#): It was found to have satisfactory test–retest reliability and internal consistency¹⁹.
- [Alcohol Problems Questionnaire \(APQ\)](#) (alcohol only): It was found to have high reliability and validity for assessing alcohol-related problems in people with alcohol use disorder¹⁶.

Issues considered when assessing the evidence

Assessment of depression: A change from current practice

Australian GPs commonly use the [Kessler Psychological Distress Scale \(K10\)](#)²⁰ or the [DASS](#)^{21, 22} to assist in making a diagnosis of depression. Despite the use of these tools in the Australian general practice setting, our systematic review did not identify any studies that described its validity or reliability in assessing depression by GPs in a work context. The [PHQ-9](#) and the [DASS](#) had high validity, with the [PHQ-9](#) also demonstrating high reliability for identifying depression. We therefore recommend using the [PHQ-9](#) for the assessment of depression and its severity for patients with mental health symptoms that may have arisen from work and are indicative of depression.

The Patient Health Questionnaire-9 (PHQ-9)

- The [PHQ-9](#) is a nine-item survey that asks a person about their emotional experiences over the previous two weeks.
- It is intended for use as screening tool, where depression is suspected; however, it can also be used as an assistive tool at the disposal of a GP for use as part of the diagnostic process for depression, or to measure depression severity²³. For instance, it can be used by GPs as a guide to asking the right questions during a clinical interview to assist in making a diagnosis of depression.
- The optimal cut-off score for diagnosing depression with the [PHQ-9](#) is 10⁷.
- The [PHQ-9](#) is very similar to the [K10](#), which is commonly used by Australian GPs, so we have confidence that Australian GPs will be able to use it without difficulty.

Anxiety disorders

The evidence review identified the [4DSQ](#), the [DASS](#), the [HADS](#) and the [PSWQ-3](#) as tools that may assist GPs with making a diagnosis of an anxiety disorder.

Although the [DASS](#) had lower specificity for anxiety than the [4DSQ](#), the [DASS-21](#) software is easily accessible, available in the public domain and can reasonably be completed within a GP consultation, whereas the [4DSQ](#) is a 50-item tool that may not be suitable for use in a GP consultation. Further, the [4DSQ](#) is not widely used in Australia and would, therefore, require additional training for GPs to use it.

The [HADS](#) is not recommended because there was significant heterogeneity in the studies that described its use and no conclusive analysis could therefore be undertaken on its validity and reliability.

The [PSWQ-3](#) is also not recommended because it is a three-item generalised anxiety disorder-specific questionnaire²⁴ that would not detect other anxiety disorders such as social phobia or generalised anxiety disorder, which are described in the [DSM-5](#)³.

The [DSM-5](#) describes 13 categories of anxiety disorders³. It is not practicable to expect GPs to be familiar with using the range of tools available to diagnose individual anxiety disorders, because these disorders may occur concurrently. Similarly, the additional tools recommended for use by the RANZCP, despite being well-established, would additionally not be feasible for use by most GPs, as they require administration by a trained practitioner and take at least an hour to complete.

The [DASS](#) and [GAD-7](#) are therefore recommended for the diagnosis of an anxiety disorder in the general practice setting.

The Depression and Anxiety Stress Scales (DASS)

- The [DASS-42](#) or the abbreviated [DASS-21](#) comprise 42 or 21 items respectively, and measure the negative emotional states of depression, anxiety and stress¹⁰.
- It can be self-administered by the patient and subsequently assessed by a GP.
- As the [DASS](#) has low specificity, it cannot be used to confirm a diagnosis; however, its content and structure make it suitable for use by a GP in a clinical interview to assist in making a diagnosis (i.e. as a screening tool).
- The [DASS](#) can also be used with a [GAD-7](#) to assess anxiety.

The Generalized Anxiety Disorder 7 (GAD-7)

- The [GAD-7](#) is a seven-item screening tool for symptoms of generalised anxiety disorder²⁵.
- It can be used to assist a GP when considering many aspects of anxiety and can also be used as a screening tool to assess the severity of a range of anxiety disorders.

Posttraumatic stress disorder

The only tool identified to assist GPs with making a diagnosis of PTSD and assessing its severity was the [Posttraumatic Stress Disorder Checklist – Civilian version \(PCL-C\)](#)²⁶.

- The [PCL-C](#) is a 17-item standardised self-reporting scale that corresponds to symptoms of PTSD as stated in the DSM-IV.
- It is self-administered by the patient and subsequently discussed with the clinician.
- GPs may also note that a newer version of the [PCL-C](#), known as the [Posttraumatic Stress Disorder Checklist-5 \(PCL-5\)](#) is now available²⁷.
- The [PCL-5](#) is a 20-item tool that assesses the 20 symptoms of PTSD described in the [DSM-5](#). The [PCL-5](#) has been validated in the military veteran population however it requires further validation in the general patient population. Despite its limited validation, the [PCL-5](#) is the preferred tool for use as a screen for [DSM-5](#)-based diagnosis of PTSD since the [PCL-C](#) has been validated against DSM-IV-based diagnosis of PTSD.

Acute stress disorder

The GDG provided no additional consensus statement regarding the use of tools to assist the diagnosis of an acute stress disorder. Instead, GPs may refer to the DSM-5 criteria and Australian Guidelines for the Treatment of Acute Stress Disorder & Posttraumatic Stress Disorder²⁸.

Adjustment disorder

A diagnosis of an adjustment disorder implies a level of distress is worse than would be attributed to a normal life adjustment that affects functional capacity.

In the absence of a valid tool for the assessment of adjustment disorders, the Guideline Development Group developed a consensus statement as follows:

“Adjustment disorder implies a level of distress greater than would otherwise be expected after a certain event(s). It is sometimes diagnosed when other psychiatric illnesses such as major depression and anxiety have been excluded and is time limited. There are no recommended tools for diagnosing adjustment disorder or assessing its severity in general practice. A GP may consider use of the [DASS](#) to assess levels of patient distress and [WHODAS 2.0](#) to assess levels of functional impairment.”

The Depression and Anxiety Stress Scales (DASS)

- The [DASS-42](#) or abbreviated [DASS-21](#) comprise 42 or 21 items respectively, and measure the negative emotional states of depression, anxiety and stress¹⁰.
- It can be self-administered by the patient and subsequently assessed by a GP.
- The [DASS](#) may be used as an indicator of distress that is associated with an adjustment disorder.
- Both the [DASS-21](#) and the [DASS-42](#) are acceptable for use in diagnosing an adjustment disorder.

WHODAS 2.0

- The [WHODAS 2.0](#) is a generic assessment of functional ability that is available in a 36-item version (approximately 20 minutes to complete) or a 12-item version (approximately 5 minutes to complete)²⁹.
- It can be self-administered or used by a GP in a clinical interview.

Substance misuse and addictive disorders

Several tools were identified that can assist a GP with making a diagnosis of a substance misuse disorder: the [AUDIT](#), [SADQ](#), [LDQ](#) and [APQ](#). These tools were all rated as at least satisfactory for criterion validity and reliability. Of these, the [AUDIT](#), [SADQ](#) and [LDQ](#) are recommended for use by GPs to assist in making an accurate diagnosis of an alcohol use disorder and assessing its severity. The [LDQ](#) is recommended for use by GPs to assist in making a diagnosis of a substance use disorder and assessing its severity.

Alcohol Use Disorders Identification Test (AUDIT)

- The [AUDIT](#) is a 10-item questionnaire that is designed to help in the self-assessment of alcohol use.
- It is commonly used in Australian general practice to assist in making a diagnosis of an alcohol use disorder and is available in a number of languages (<http://auditscreen.org/>).
- GPs may consider the potential value of using the abridged [AUDIT-Consumption \(AUDIT-C\)](#) tool, which is a three-item version of the AUDIT.
- The AUDIT-C has been used in male Veterans Affairs patients, but has not been validated in the civilian work context.
- A study of the [AUDIT-C](#) in female Veterans Affairs patients found sensitivity of 95% and specificity of 70%³⁰.
- Both the AUDIT and the [AUDIT-C tools](#) are easily accessible to Australian GPs and easy to complete.

The Severity of Alcohol Dependence Questionnaire (SADQ)

- The [SADQ](#) is a 20-item questionnaire that may be used to assess the presence and severity of alcohol dependence.
- The [SADQ](#) may be used to assess the nature and extent of the problems associated with alcohol misuse¹⁷.

Leeds Dependence Questionnaire (LDQ)

- The [LDQ](#) is a ten-item questionnaire designed for measuring substance dependence and severity³¹.
- It is based on a psychological understanding of dependence and can therefore be used to measure dependence for any substance, including alcohol use disorder.
- The [LDQ](#) may be used by GPs who suspect a substance use disorder in their patient.
- It is freely accessible to Australian GPs and is quick and easy to use.

Alcohol Problems Questionnaire (APQ)

Despite its high reliability and validity, the [APQ](#)¹⁶ is not recommended for assisting a GP with the diagnosis and severity of an alcohol use disorder as (1) it is skewed towards people with severe alcohol use, (2) the tool itself is very long and (3) some of the questions asked may be considered offensive to a person completing the questionnaire.



Additional points for consideration

The tools described in this chapter should be used to enhance the GP's assessment following a comprehensive clinical interview and in conjunction with criteria outlined in the DSM-5³.

Depression

Despite the Beck Depression Inventory (BDI), General Health Questionnaire (GHQ) and Center for Epidemiological Studies-Depression (CES-D) having high accuracy and sensitivity for diagnosing depression, these tools are less accessible to Australian GPs. For instance, the BDI is not available in the public domain and the GHQ and CES-D are not widely used in Australia and would thus require a significant change in GP practice.

Anxiety disorders

In practice, there is large overlap between anxiety and depression. The tools recommended for anxiety and depression can be used together to provide the GP with a better understanding of the nature of the condition in their patient and the severity of symptoms.

These tools can also be used to structure and streamline an in-depth clinical conversation and history taking, or can be used following an initial clinical consultation to highlight areas of concern, which the GP can expand upon to complete a diagnosis.

Adjustment disorder

Care needs to be taken so as not to imply that an adjustment disorder is present just because other severe mental health conditions have been excluded.

Substance misuse and addictive disorders

Patients with alcohol or substance use disorder sometimes have comorbid addictive disorders. It is therefore worthwhile for GPs to also ask patients about their opioid use or gambling habits.

Asking about opioid use is particularly important for patients with a work-related musculoskeletal injury who have been away from work and are receiving pain medication for their injury.

For these patients, clinicians should be alert to the possible development of an opioid dependency (see [chapter 6](#)).

The tools recommended here are feasible for a general practice setting, as they do not require specialist mental

health training for their administration or analysis, and can be completed in an extended consultation. These tools can be used by the GP to rule out mental health conditions and to structure the clinical conversation. When assessing a patient with symptoms of a mental health condition, be alert for suicidal ideation.

When to refer the patient

Use of the tools described here is dependent on a GPs judgement and clinical expertise. If a GP is experiencing difficulties in diagnosing a condition, they should seek the advice of a specialist mental health clinician such as a clinical psychologist, paediatric clinical psychologist or psychiatrist, and consider referring the patient to such a specialist without delay.

Patients with symptoms of a mental health condition can vary substantially, and assessing this condition may be complicated. This is particularly the case for individuals who present with complex trauma, dual diagnosis, or another complex mental health issue. In such circumstances, further consideration should be given to referral to clinicians with expertise in mental health conditions.

The time taken to obtain a good clinical history, complete one or more diagnostic or screening instruments and discuss the diagnosis with a patient is likely to require a longer consultation than the standard consultation length. Where possible, GPs should advise the patient to request a longer consultation when booking their appointment.

Patient-centred care

A person-centred approach should be used in all aspects of diagnosis and management of mental health conditions. A clinical history should complement any assessment of a mental health condition, to formulate an understanding of the condition. This can then be used as the foundation for understating the nature of the mental health condition for a patient, for setting recovery objectives and planning a management strategy to meet these objectives.

Consideration of factors through a biopsychosocial perspective is particularly valuable. For instance, a clinical history that broadens the focus of the doctor–patient interaction to include psychological and social factors as well as physical symptoms will help to develop a clearer understanding of the nature of the condition.

There is limited information about the cultural appropriateness of the recommended screening tools and the comprehensive mental health assessment for use among the Aboriginal and Torres Strait Islander population and culturally and linguistically diverse individuals who may present with work-related mental health conditions. Therefore, individuals with complex mental health needs and who are from culturally and linguistically diverse backgrounds are the most likely to be at risk of misdiagnosis.

A GP should take into account cultural and language considerations when making a diagnosis, including exploring the meaning of illness and health to each individual patient³². To this end, it is recommended that GPs use experienced interpreters where possible, including telephone interpreters, or cultural consultants as translators³³.

There is limited information about the appropriateness of the recommended screening tools and the comprehensive mental health assessment for use with young people who may present with work-related mental health conditions. Therefore, young people are at risk of misdiagnosis.

A GP should take into account personal, social and environmental factors that can impact on a young person's risk of a mental health condition. GPs should refer to the [Depression in children and young people: identification and management](#)³⁴ to assist in making a diagnosis of a mental health condition in young people. If a GP is experiencing difficulties in diagnosing a condition in a young person they should seek advice from a specialist, such as a paediatric clinical psychologist and consider referring the patient to such a specialist without delay.

Useful resources

- Patient Health Questionnaire-9 (Appendix C)²³
- Generalized Anxiety Disorder 7 item (Appendix D)²⁵
- Depression Anxiety Stress Scales (Appendix E)¹⁰
- PTSD Checklist – Civilian Version (Appendix F)²⁶
- Posttraumatic Stress Disorder Checklist-5²⁷
- Alcohol Use Disorders Identification Test (Appendix G)³⁰
- Severity of Alcohol Dependence Questionnaire (Appendix H)¹⁷
- Leeds Dependence Questionnaire (Appendix I)³¹
- WHO Disability Assessment Schedule 2.0²⁹
- Australian Mental Health Interpreting Guidelines for Interpreters 2017³⁵
- Working with interpreters: a practice guide for psychologists 2013³⁶
- Depression in children and young people: identification and management 2017 NICE³³
- Diagnostic and Statistical Manual Fifth Edition. 2013
- Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder. 2013

How will we know that the recommendations have been implemented?

Documentation of the use of the recommended tools during diagnosis.

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6



What would suggest that the patient is developing a comorbid or secondary mental health condition?

Why is this topic important?

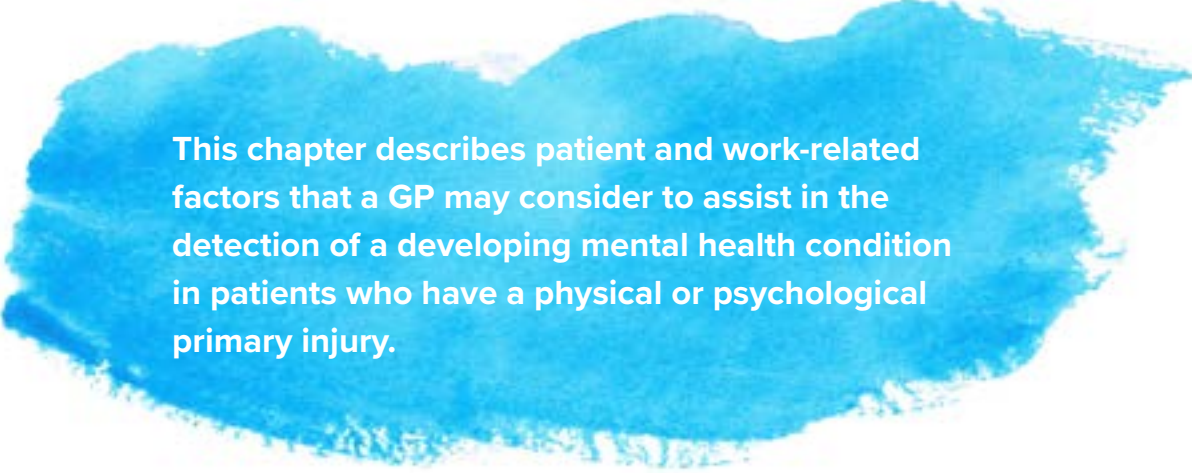
It is not uncommon for patients who sustain a physical or psychological injury to develop a comorbid or secondary mental health condition¹. Patients with a substantial or chronic physical condition are at a two- to three-times greater risk for developing depression, compared with people who have no comorbidities².

For people with depression or anxiety, the likelihood of experiencing both conditions is high³, with Australian data showing that 85% of people with depression also have symptoms of anxiety, and 90% of people with anxiety report symptoms of depression⁴. Another Australian study of people with a substance use disorder found that more than one third had also reported the existence of at least one mood disorder within the previous 12 months⁵.

As the primary care provider for people with work-related injuries, GPs are ideally placed to detect a mental health condition that is developing subsequent

to a primary work-related injury and the tools described in [chapter 5](#) may assist a GP in assessing these conditions.

There are a number of factors that can contribute to the development of a mental health condition following an initial injury or condition. If these are identified early, they can be managed to prevent the development of a secondary mental health condition, or addressed to better manage the condition. The psychological and biological pathways model⁶, sometimes referred to as the biopsychosocial approach⁷, describes these as a range of biological, environmental and psychological factors that influence a mental health condition over time. For example, for people with a work-related physical or psychological injury, a slow recovery from the condition can lead to a protracted return to everyday activities such as returning to work, thus resulting in depressive symptoms that impact on their ability to implement management plans⁸.



This chapter describes patient and work-related factors that a GP may consider to assist in the detection of a developing mental health condition in patients who have a physical or psychological primary injury.

Summary of recommendations



What would suggest that the patient is developing a comorbid or secondary mental health condition?

- 6.1 For patients with a primary physical or psychological work-related injury, a GP may consider the following factors to assist in the early detection of a comorbid or secondary mental health condition.

Patient-related factors

- Greater pain intensity, where physical injury was the precursor to the mental health condition
- Insomnia, low mood, anhedonia and suicidal thoughts
- Any existing substance misuse
- A chronic physical health problem
- Lower self-efficacy (i.e. the capacity for one to cope with difficult demands through one's own effort)
- Lack of social support and personal relationship status (i.e. relationship problems)
- Past experience of, and response to, treatments
- Past history of depression
- Perception of injustice of the compensation claim process

[Weak recommendation FOR (low quality of evidence)]

- Pre-existing depressive disorder or other anxiety disorder
- Any other existing medical condition

[Consensus-based recommendations]

Work-related factors

- Job strain
- Failure to return to work following injury

[Weak recommendation FOR (low quality of evidence)]



Evidence summary

A search of the literature identified four original observational studies^{9–12}. These studies used a case control⁹, cross-sectional^{10, 11} or cohort design¹² to identify factors that are associated with or are symptoms of mental health conditions in a work context. A low level of evidence was assigned to these studies collectively.

One Australian study aimed to identify an association between patient-perceived injustice within the compensation scheme and mental health outcomes 12 months after a moderate or severe injury¹⁰. A total of 433 participants were included in the analysis. This study found that pain severity, pain catastrophising, pain-related disability, anxiety, depression, PTSD, and perceived injustice were all positively associated with negative procedural experiences, but negatively associated with supported and positive compensation experiences ($p < 0.01$).

A second Australian study aimed to estimate the population attributable risk for depression in the 12 months following job strain exposure¹¹. A total of 1051 participants were included in the analysis. This study identified job strain-attributable depression to be 13.2% for males and 17.2% for females.

Anderson et al.⁹ undertook a case-control study to investigate prognostic factors for return to work among patients with workers' compensation claims after fusion for spondylolisthesis in the United States. A total of 686 participants were identified in this study, and 205 of these participants had either continued working for six months following fusion or returned to work within 2 years following fusion. This study found that rates of depression increased over the 12 months following fusion for spondylolisthesis. This finding, however, was significantly more pronounced in patients who did not return to work within the 12 months following fusion (22.7% higher than patients who returned to work, $p < 0.001$).

Pjanic et al.¹² conducted a cohort study of injured workers in Switzerland to investigate the role of pain, self-efficacy and social support as factors that predict

depressed mood in injured workers one year after an injury. The study found that greater pain intensity and lower social support were predictive of a depressed mood 12 months after an injury. The role of pain on depression was further moderated by lower self-efficacy. This study had a high dropout rate, with 33% of the initial participant group of 406 patients not completing the post measure. The primary difference between the 274 patients who completed the study and those who dropped out was significantly lower social support at baseline in those patients who dropped out of the study. Given that low social support at baseline was a predictor of depressed mood at 12 months, it is possible that the predictive effect on depressed mood would have been larger if fewer patients had dropped out (i.e. more patients with a lower social support at baseline had been included).

Existing clinical guidelines

A total of 16 guidelines addressed the factors assisting in early detection. Of these, seven guidelines^{13–19} offered specific recommendations for factors assisting with early detection of a comorbid mental health condition. These were, therefore, adapted for use in this guideline. The recommendations that were considered by the Guideline Development Group for adaption or adoption in this guideline are as follows:

1. Consider the diagnosis of generalised anxiety disorder in people presenting with anxiety or significant worry, and in people who attend primary care frequently who have a chronic physical health problem, or do not have a physical health problem but are seeking reassurance about somatic symptoms, or are repeatedly worrying about a wide range of different issues. [NICE, 2011 consensus]¹⁹
2. Be alert to possible depression, particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment. [UK NICE, 2016, author rating moderate level of evidence based on two observational studies]¹³

3. Consider the role of both the chronic physical health problem and any prescribed medication in the development or maintenance of the depression. Ascertain that the optimal treatment for the physical health problem is being provided and adhered to, and seek specialist advice if necessary. [NICE, 2015, author rating high level of evidence]¹⁴. It is recognised that smoking, drinking and drug-taking behaviours cluster together, and that excessive drinkers with high AUDIT scores are more likely to have used drugs in the past; therefore, the evidence suggests that co-existing substance misuse should be assessed. [NICE 2011 author rating moderate level of evidence]¹⁸
4. Other potential post-traumatic mental health conditions, such as depression, anxiety disorders or substance misuse should be considered, both as alternative primary diagnoses and as comorbid conditions. [AUS Black Dog Institute, 2015, adapted consensus]¹⁵
5. As part of the comprehensive assessment, consider how the following factors might have affected the development, course and severity of the person's generalised anxiety disorder any comorbid depressive disorder or other anxiety disorder; any comorbid substance misuse; any comorbid medical condition; a history of mental health disorders; past experience of, and response to, treatments. [NICE 2011, author rating low level of evidence]¹⁹
6. Clinicians should be alert to the possibility of depression, especially in patients with characteristics that may increase the risk of depression, and should look for it when there are clinical clues, such as insomnia, low mood, anhedonia and suicidal thoughts. [Canadian Task Force on Preventive Health Care 2013, author rating very low level of evidence]¹⁷

Issues considered when assessing the evidence

The following factors were identified through the literature review and have been incorporated into the recommendation:

- Job strain
- Failure to return to work following injury
- Greater pain intensity, where physical injury was the precursor to the mental health condition
- Lower self-efficacy
- Lack of social support and personal relationship status (i.e. relationship problems).
- Perception of injustice of the compensation claim process

The Guideline Development Group also agreed that the seven statements listed in the existing guidelines are all relevant for Australian GPs. In addition, because these statements were presented in high-quality guidelines, the Guideline Development Group agreed that all six statements should be adapted for inclusion in this guideline. It is important to note, however, that

the recommendations listed here in Chapter 6 should not be used to indicate compensable status. For advice relating to the assessment of whether a diagnosed mental health condition has arisen as a result of work please refer to Chapter 7, recommendation 7.2.

Additional points of consideration

GPs may also utilise the expertise and judgement offered by other providers involved in facilitating the patient's recovery, to assist in the assessment of a secondary mental health condition following an initial work-related injury. For instance, all patients with a previously accepted claim will have access to a workplace rehabilitation provider²⁰. Where the workplace rehabilitation provider has expertise in mental health conditions (e.g. if the workplace rehabilitation provider is a registered rehabilitation counsellor, an occupational therapist or a psychologist), they can assist the GP to identify work-related factors that can contribute, or are contributing, to the development of a secondary mental health condition.

For patients in rural and remote Australia, some of the factors described above may be exacerbated. This may be due to the markedly shorter supply of health professionals, particularly mental health professionals with expertise in work-related injury, thus leading to prolonged recovery. The reduced availability of services can result in less preventive care, less primary care, and less early intervention, which result in patients presenting at a later stage, a late diagnosis and, consequently, a more advanced stage of an illness²¹. It is therefore important for GPs practicing in rural and remote regions to be even more vigilant for factors that can lead to secondary mental health conditions.

Useful resources

- The [Australian Rehabilitation Providers Association](#) website²² describes in detail the role of workplace rehabilitation providers and provides a directory of workplace rehabilitation providers across Australia.
- The [Australian Society of Rehabilitation Counsellors Ltd](#) website²³ describes in detail the role of rehabilitation counsellors and provides a directory of rehabilitation counsellors across Australia.
- RACGP Guidelines for Preventive Activities in General Practice, ninth edition. 2018²⁴
- RANZCP Clinical Practice Guideline for the Treatment of Panic Disorder, Social Anxiety Disorder and Generalized Anxiety Disorder. 2018²⁵
- RANZCP Clinical Practice Guideline for the Treatment of Mood Disorder. 2015²⁶

How will we know that the recommendations have been implemented?

There is documented assessment of factors that can lead to the development of a mental health condition during clinical monitoring of recovery following a work-related injury.

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7



Has the mental health condition arisen as a result of work?

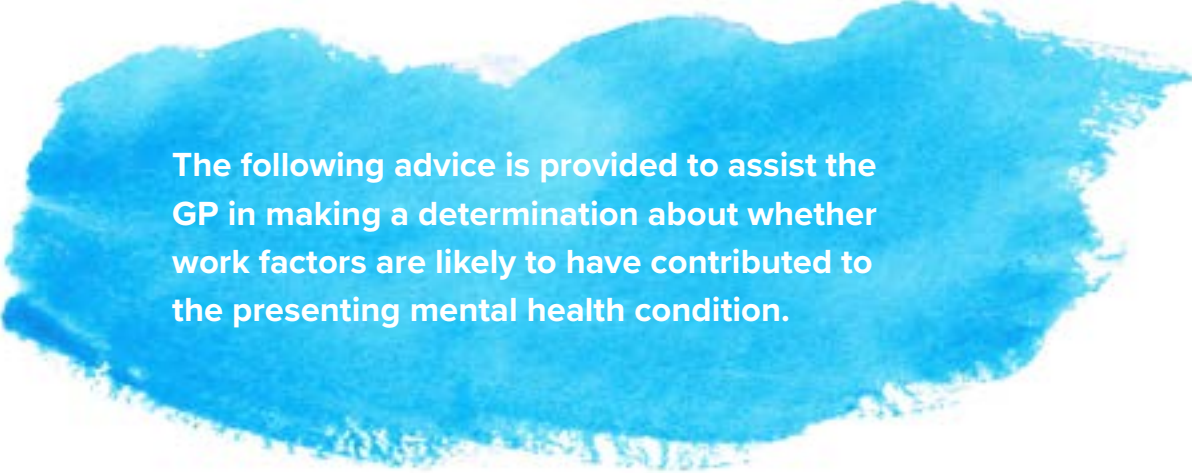
Why is this topic important?

The GP's opinion about whether work has contributed to a mental health condition has significant implications on a patient's recovery. This opinion, which is formed early in the patient's journey, sets the direction of recovery expectations, influences management strategies and impacts on the therapeutic relationship between the GP and the patient. For instance, the role of work in developing a mental health condition may influence whether continuing to work or returning to work can be recommended to the patient as a component of their management strategy, or considering whether the care team should be extended to include health professionals with expertise in work-related mental health conditions.

Making a determination about the role of work in a presenting mental health condition is, however, a notable challenge that has been described by Australian GPs¹. In particular, difficulties may arise because the factors that can cause or aggravate the condition can be complex in their investigation and difficult to authenticate. Furthermore, GPs have reported challenges in distinguishing between mental health conditions that developed as a result of work-related stress and those that are related to a pre-existing mental illness.

According to 2013 national claims data, the most common causes of work-related stress are work pressure (31%) and work-related harassment and/or bullying (27%)². Within the subcategory of work pressure, the most prominent root of the pressure arises from work backlogs or deadlines, organisational restructures, interpersonal conflicts, disciplinary actions, performance counselling or promotion disappointment³. Other causes for work pressure include poor relations with a boss or colleagues, role ambiguity and poor physical working conditions⁴.

For a GP who is considering a treatment approach for a patient with a possible work-related mental health condition, it is important that the GP forms an opinion about whether they believe that work has contributed or continues to contribute to the patient's mental health condition. Embedded within this judgement is an awareness of the contribution of any pre-existing illness or other non-work factors to a current mental health condition.



The following advice is provided to assist the GP in making a determination about whether work factors are likely to have contributed to the presenting mental health condition.

Summary of recommendations



Has the mental health condition arisen as a result of work?

- 7.1 On the available evidence, there is no clear support for an instrument to indicate the probability that a mental health condition has arisen out of work; therefore, there is an urgent need to promote research in this area.
- [Recommendation for future research]*
- 7.2 The assessment of whether a diagnosed mental health condition has arisen as a result of work should be made on the basis of:
- a comprehensive clinical assessment
 - consideration of factors such as pressures, events and/or changes in the workplace and the temporal relationship between these factors and symptom onset
 - consideration of whether the mental health condition is consistent with the description of how the condition arose.

[Consensus-based recommendation]



Evidence summary

A systematic review of the literature identified 13 tools described in 13 studies. Of these tools, two are available in German (FIT Questionnaire and Task Diagnosis Survey), and so were excluded. A further three tools: Consultant's Mental Health Questionnaire, the Stressor Scale for Pediatric Oncology Nurses, and the Work Environment Questionnaire—were excluded because they addressed work-related mental health conditions in medical professionals only. The Job Content Questionnaire was excluded because it is not available for commercial use and the Medical Report Checklist was excluded because it could not be accessed. The following tools were excluded because they did not report both reliability and validity data in the general practice and work context: Work Environment Impact Scale, Copenhagen Psychosocial Questionnaire II, Clinician-Administered PTSD Scale – Organisational stressors domain, Pressure Management Indicator.

Only two tools reported reliability and validity data in the general practice and work context and were therefore included in the analysis: the [Work Environment Subscales of the Work Health Check \(WHC\)](#)⁵ and the [Workplace Stressors Assessment Questionnaire \(WSAQ\)](#)⁶.

Gadinger et al.⁵ conducted a cross-sectional study to analyse the validity and reliability of the [Work Environment Subscales of the WHC](#). A total of 941 employees representing a range of work types in Germany were included in the study. Reliability of the [Work Environment Subscales \(WES\)](#) was found to be acceptable to excellent ($\alpha = 0.74–0.93$). However, the [WES](#) had low validity, and a comparison of the scales assessed against symptoms measured with the PHQ-9 showed a small to medium correlation ($r = 0.10–0.34$). The [WSAQ](#) was developed and piloted in a US government high-tech worksite⁶. The [WSAQ](#) had good reliability ($\alpha = 0.69–0.93$), but, like the [WES](#), was also rated low on validity ($r = 0.11–0.56$).

Issues considered when assessing the evidence

Given the low validity of both the [WES](#)⁵ and the [WSAQ](#)⁶ and the absence of validity and reliability data for other tools, the Guideline Development Group concluded that no tool reports sufficient reliability and validity to effectively indicate the probability that a mental health condition has arisen as a result of work.

Additional points of consideration

In the absence of a validated tool, a clinical judgement about the work-relatedness of a mental health condition should be made by undertaking a thorough history of the condition, and detailed consideration of the person's circumstances and current and past medical history. Key aspects of a GP's clinical judgement will involve:

- the GP's own knowledge of the workplace
- a consideration of the temporal relationship between the occurrence of problems and the stated pressures, events or changes at work
- ensuring that the patient's description of the injury and workplace environment corroborates with actual events, i.e. plausibility.

Despite the [WES](#)⁵ and the [WSAQ](#)⁶ not having sufficient evidence that they are reliable and valid, the content of these tools are useful and relevant for a clinical assessment. As such, a GP can use these tools to guide history taking and the clinical assessment of a patient with a mental health condition that may have arisen as a result of work factors. The [WES](#) aims to measure features of the psychosocial work-environment that are associated with employees' experiences of stress and health. It differentiates from its parent questionnaire, the [WHC](#)⁵, which assesses health behaviours, health prevention activities, medical history, personality, perceived stress and psychosomatic symptoms. The WHC is currently undergoing refinement; however, interested GPs may wish to review updates at http://storyworks.com/_gethelpnow/index.html.

The [WSAQ](#) aims to systematically monitor employees' perceptions of work-related stressors⁶. It comprises 22 items covering six major domains: demands, control, support, role, rewards and relationships. The [WSAQ](#) may be obtained from the developing institution by contacting sjcoons@c-path.org.

GPs can also consider the presence of the following psychological hazards, which are included in [Preventing Psychological Injury Under Work Health And Safety Laws](#)⁷ by Safe Work Australia, to assist them in assessing if a mental health condition has occurred due to work.

- High job [demands](#): Sustained high physical, mental and or emotional effort is required to do the job.
- Low job demands: Sustained low levels of physical, mental or emotional effort is required to do the job, or little task variety or highly monotonous work.
- Low job [control autonomy](#): Little control over aspects of the work including how or when a job is done.
- Poor support: Inadequate emotional, informational and instrumental support to do the work safely or well.

- Poor workplace [relationships](#) between workers and their managers, supervisors, co-workers and clients or other people the worker is required to interact with.
- Low role clarity: There are unclear, incompatible or constantly changing expectations about the role and responsibilities.
- Poor organisational [change](#) management: Changes in the organisation, structure or job are poorly communicated and managed.
- Low recognition and reward: There is lack of positive feedback and rewards for job and task performance.
- Poor organisational justice: There is perceived unfairness, inconsistency and bias in decisions about the work and or the way workers are treated.
- Poor environmental conditions: There is exposure to poor quality or hazardous work environments.
- Rural and remote work: Work is at locations where access to resources and communications is difficult and travel times may be lengthy. Additional factors specific to workers in rural and remote Australia include unique agricultural and mining stressors (e.g. financial impact of policy change) or the impact of natural disasters (flood, bush fires, drought).
- Isolated work: The work is where there are no or few other people around.

A person's GP is ideally equipped, due to their own knowledge of the patient and their history, to determine whether the condition is consistent with the stated cause, including an exacerbation of a pre-existing condition, or if it is likely to be consistent with symptoms of a pre-existing condition. If a GP does not feel able to manage this assessment, they should refer the patient to a health professional who has expertise in assessing work-related influences on mental health. This may include a trained rehabilitation counsellor, a psychiatrist or an occupational therapist.



Workers' compensation legislation and the role of the GP

For patients who choose to submit a compensation claim for the presenting mental health condition, it is the role of the compensation agency, not the person's GP, to attribute causation. It is probable that a GP's opinion with regards the work-relatedness of a mental health condition will be considered as part of this assessment; however, the GP's report is reviewed alongside other sources of information such as reports provided by the patient, an independent medical examiner, compliance with legislation, employment relationship and information from other sources.

Legislative requirements vary between jurisdictions across Australia. For GPs whose patients intend to submit a claim for worker's compensation, it would be valuable to be aware of the legislation that is relevant for their patients, and the implications for their patient. In particular, the GP should be cognisant of the definitions of work-relatedness that are used by the jurisdictions that apply to their patients. [The Comparison of Workers' Compensation Arrangements in Australia and New Zealand \(2017\)](#)⁸ compares some of the key features of each scheme, including coverage, benefits, return to work provisions, dispute resolution and cross-border arrangements.

Considering the complexities of this process and the likelihood for lengthy delays between submission of a claim and a resolution from a compensation agency, the GP should ensure that any written information to support the patient's claim includes sufficient detail to enable an assessment to proceed without requiring further information. For instance, a report can outline:

- the circumstances that have led to the onset of the condition
- summarise the contact between the patient and the GP, use of diagnostic assessments in diagnosis, and detail the planned treatment and return-to-work strategy.

How will we know that the recommendations have been implemented?

There is documentation of a comprehensive clinical assessment, which includes consideration of:

- factors such as pressures, events and/or changes in the workplace and the temporal relationship between these factors and symptom onset,
- whether the mental health condition is consistent with the description of how the condition arose.

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Useful resource

[Comparison of workers' compensation arrangements in Australia and New Zealand 2017](#)⁸

8



What should a GP consider when conveying a diagnosis of a mental health condition to the patient?

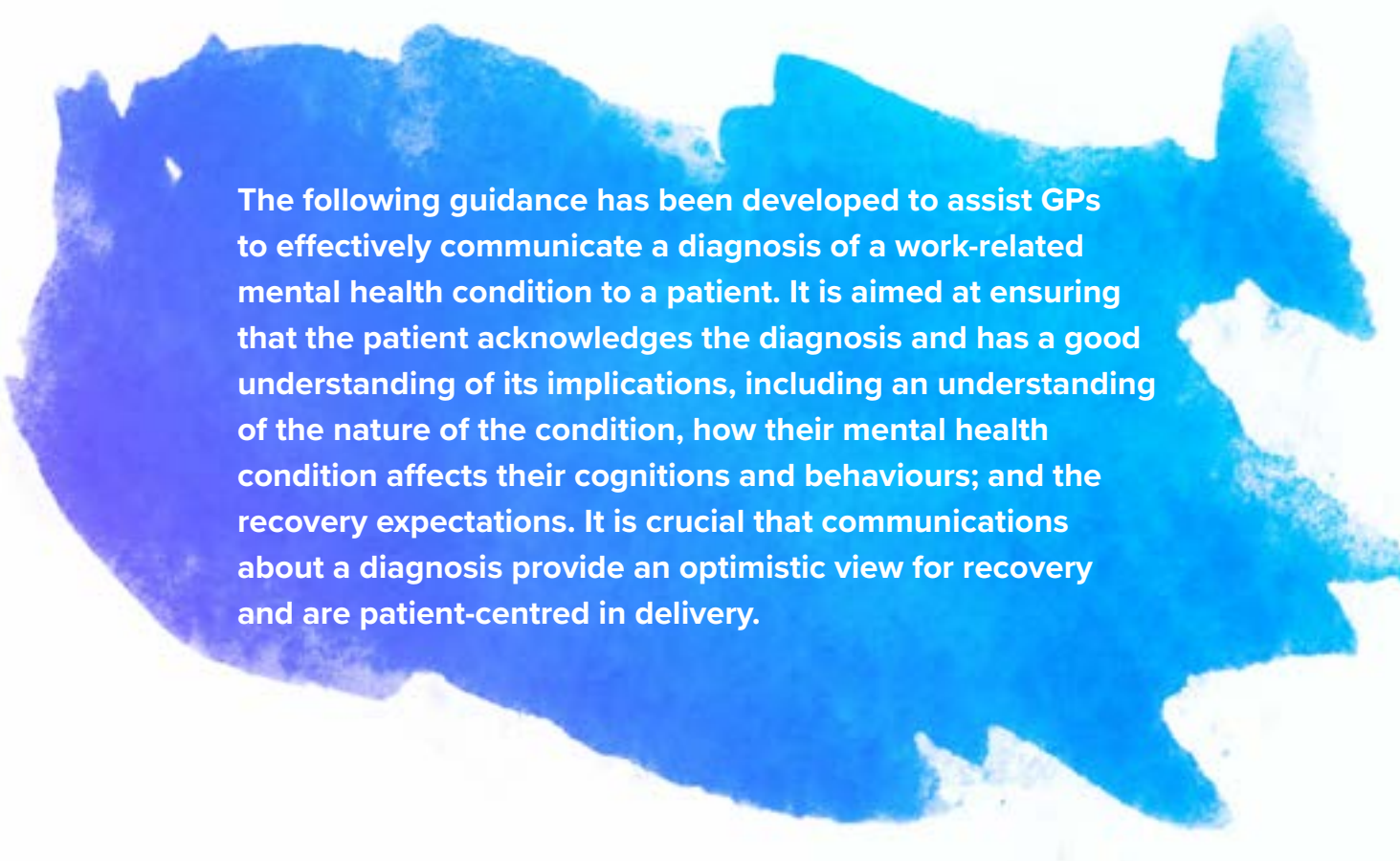
Why is this topic important?

It is of the “utmost importance that GPs ensure there is clear and effective communication between both parties in the doctor-patient relationship so that GPs can effectively manage their patients’ healthcare”.¹

For patients with mental health conditions, GPs have a key role in setting the tone for an optimistic and hopeful recovery journey. This includes conveying information about the clinical symptomology to the patient, explaining treatment options, guiding recovery expectations, and arming the patient with the support and resources they require to move through the illness to recovery. When communication between a GP and the patient is effective, this can result in a patient’s acceptance of the mental health condition, better understanding of treatment options for themselves, patient-centred treatment choices and, ultimately, the facilitation of personal recovery. Conversely, not

accepting a diagnosis or having a poor understanding of the condition, its recovery expectations and treatment options can result in non-adherence to a treatment plan, and consequent negative outcomes for the patient^{2,3}.

A patient’s ability to understand and willingness to accept a diagnosis of a work-related mental health condition is influenced by many factors as highlighted in the biopsychosocial model of mental health. A patient may be influenced by the condition itself (such as the capacity of the patient to comprehend the diagnosis at a time when they are experiencing psychological stress), social concerns (such as those associated with workplace discrimination or stigma, community discrimination or stigma, or financial security), and the complex nature of the illness itself and the potential recovery pathways.



The following guidance has been developed to assist GPs to effectively communicate a diagnosis of a work-related mental health condition to a patient. It is aimed at ensuring that the patient acknowledges the diagnosis and has a good understanding of its implications, including an understanding of the nature of the condition, how their mental health condition affects their cognitions and behaviours; and the recovery expectations. It is crucial that communications about a diagnosis provide an optimistic view for recovery and are patient-centred in delivery.

Summary of recommendations



What should a GP consider when conveying a diagnosis of a mental health condition to the patient?

- 8.1 When conveying a diagnosis of a work-related mental health condition, a GP should have regard to:
- patient concerns, such as the potential for stigma or discrimination, loss of employment, isolation and financial insecurity
 - a patient's socio-cultural background, which may affect their acknowledgement of a mental health condition, and
 - negotiating patient confidentiality and sharing of information with a patient's family or carer, if necessary.
- [Consensus-based recommendation]*
- 8.2 To ensure that the diagnosis of a work-related mental health condition is understood by the patient, a GP should:
- provide information to the patient about the nature of the mental health condition, the recovery expectations and the range of treatments available
 - provide the patient with educational material in a format that they can understand.
- [Strong recommendation FOR (low quality of evidence)]*
- 8.3 To ensure that the diagnosis of a work-related mental health condition is understood by the patient, a GP should promote a patient-centred recovery-based approach.
- [Consensus-based recommendation]*
- 8.4 Before initiating treatment, it is important to establish a therapeutic alliance with the patient regarding diagnosis and treatment. It is important to maintain the alliance so that their patient's care is a collaborative endeavour.
- [Consensus-based recommendation]*



Evidence summary

When considering the search strategy for this question, the evidence review team considered that there is little evidence that specifically answers this question. We chose to review similar, high-quality guidelines to ascertain if they were able to identify relevant studies using a specific search strategy; however, we did not find any guidelines that conducted searches for a topic similar to this. We therefore chose to not undertake a review of the literature. Instead, the evidence review team undertook a systematic search for existing clinical practice guidelines that addressed the topic, and identified nine guidelines^{4–12}. The guidelines ranged in quality, with the lowest scoring 67% and the highest scoring 97% on the [AGREE-II checklist](#)¹³. Recommendations within those guidelines that addressed the issue of communication with a patient were most often developed using consensus. Only two guidelines used critically appraised evidence to inform recommendations^{5, 12}. Four themes arose from these guidelines: (1) general principles involved in diagnosis that impact on a patient's understanding, (2) the value of establishing a therapeutic alliance, (3) what information is helpful to facilitate a patient's understanding and acknowledgement of their diagnosis, and (4) the content of this information.

General principles involved in diagnosis that impact on a patient's understanding

The [NICE 2018 guidelines](#)⁴ offer a number of consensus-based recommendations regarding principles to consider when diagnosing a patient with depression:

- Be respectful of and sensitive to diverse backgrounds.
- Build a trusting relationship and work in an open, engaging and non-judgemental manner.
- Be aware that stigma and discrimination can be associated with a diagnosis of depression.
- Negotiate between the person and their family or carer about confidentiality and the sharing of information.

What information is helpful to facilitate a patient's understanding and acknowledgement of their diagnosis?

A number of guidelines provided guidance about the type of information that should be given to patients:

- Provide information about the nature and course of depression and the range of treatments available. ([NICE 2018, consensus](#))⁴
- Advise patients to be vigilant for mood changes, negativity and hopelessness. ([NICE 2015, consensus](#))⁶
- Provide psycho-education about physical injuries that may lead to mental health symptoms. ([UNSW 2013, consensus](#))⁹
- Provide education about panic disorder and its treatment. ([American Psychiatric Association 2010, author rating of strong level of evidence](#))¹²

Factors to consider when offering information packages to a patient

A number of NICE Guidelines and the [American Psychiatric Association \(APA\) 2010 guidelines](#)¹² provided guidance about the type of information that should be given to patients:

- Use language that is readily understandable to the patient. ([American Psychiatric Association 2010 author rating of strong level of evidence](#))¹², ([NICE 2018 consensus](#))⁴
- "Healthcare professionals involved in the detection, assessment or treatment of children or young people with depression should ensure that information is provided to the patient and their parent(s) and carer(s) at an appropriate time. The information should be age appropriate and should cover the nature, course and treatment of depression, including the likely sideeffect profile of medication should this be offered." ([NICE 2015 consensus](#))⁷
- Avoid clinical language without adequate explanation. ([NICE 2018 consensus](#))⁴
- Provide and work proficiently with independent interpreters (i.e. someone who is not known to the person with depression) if needed. ([NICE 2018 consensus](#))⁴

Therapeutic alliance

Two guidelines discussed the value of establishing a therapeutic alliance^{5, 12}. Both guidelines were based on low quality evidence; however, the recommendations were rated as strong:

- “Before initiating treatment, it is important to establish a therapeutic alliance with the patient regarding diagnosis and treatment options (in which there is overlap in the patient’s and clinician’s definition of the problem and agreement on which steps are to be taken by each).” (Mitchell et al., 2016, author rating of low quality evidence)⁵
- “Psychiatrists should work to establish and maintain a therapeutic alliance so that the patient’s care is a collaborative endeavour.” (American Psychiatric Association 2010, author rating of low quality evidence, recommended with substantial clinical confidence)¹²



Issues considered when assessing the evidence

General principles involved in diagnosis that impact on a patient's understanding

The NICE 2018 guidelines⁴ offered a number of consensus-based recommendations regarding principles to consider when diagnosing a patient with depression. The Guideline Development Group (GDG) considered that these recommendations were broadly relevant for the Australian context and thus adapted these into the following consensus statement:

“When conveying a diagnosis of a work-related mental health condition, GPs should have regard to:

- patient concerns, such as the potential for stigma or discrimination, loss of employment, isolation and financial insecurity,
- a patient's socio-cultural background which may affect their acknowledgement of a mental health condition, and
- negotiating patient confidentiality and sharing of information with a person's family or carer, if necessary.”

The NICE 2018 guidelines⁴ provide useful advice to “Be respectful of and sensitive to diverse backgrounds”. However, we replaced the phrase ‘diverse background’ with ‘a patient's socio-cultural background’ to acknowledge that diverse backgrounds reflect cultural diversity, gender diversity, professional identity (e.g. soldiers) and many other forms of diversity. The phrase ‘be respectful of and sensitive to’ was also removed from this recommendation.

What information is helpful to facilitate a patient's understanding and acknowledgement of their diagnosis?

The identified guidelines offered several recommendations regarding the content of the information that should be given to patients:

- Provide information about the nature and course of depression and the range of treatments available. (NICE 2018, consensus)⁴
- Advise patients to be vigilant for mood changes, negativity and hopelessness. (NICE 2015, consensus)⁶
- Provide psycho-education around physical injuries that may lead to mental health symptoms. (UNSW 2013, consensus)⁹
- Provide education about panic disorder and its treatment. (APA 2010, low quality evidence)¹²

- Use language that is readily understandable by the patient. (APA 2010 low quality evidence)¹², (NICE 2018 consensus)⁴
- Provide information appropriate to the patient's level of understanding about the nature of depression and the range of treatments available. (NICE 2015 consensus)⁷
- Avoid clinical language without adequate explanation. (NICE 2018 consensus)⁴
- Provide and work proficiently with independent interpreters (that is, someone who is not known to the person with depression) if needed. (NICE 2018 consensus)⁴

The GDG condensed the above recommendations into the following advice:

- To ensure that the diagnosis of a work-related mental health condition is understood by the patient, the GP should:
 - provide information to the patient about the nature of the mental health condition, recovery expectations and the range of treatments available
 - provide the patient with educational material in a format that they can understand. (strong recommendation FOR)
- To ensure that the diagnosis of a work-related mental health condition is understood by the patient, the GP should promote a patient-centred recovery-based approach. (consensus-based recommendation)

Therapeutic alliance

A therapeutic alliance is a dynamic process of ongoing trust and engagement between the clinician and the patient. The GDG consider that it is imperative to build a therapeutic alliance at the start of treatment, at the time of assessment and diagnosis, and continue this alliance throughout treatment and recovery. Consequently, we adapted the American Psychiatric Association recommendation in this guideline.

For many patients, treatment for a mental health condition is likely to involve the ongoing collaboration between a number of health professionals. In order to maintain the therapeutic alliance, a GP must be willing to share in ongoing patient participation and decision making (including decisions about which medical professionals are involved in their patient's care and communication with the patient's workplace).

Additional points of consideration

Recovery expectations are often formed at the time of diagnosis. In order to establish a positive recovery expectation with patients at the time of diagnosis, GPs should be realistic as well as optimistic about recovery¹⁴.

First, the GP should ask questions about the person's understanding of their condition and how they are feeling about it, and sense out resistance to the information, offer support, provide clear information and demonstrate a willingness to share decision making. Then, the GP can foster appropriate expectations of recovery by increasing the patient's knowledge and understanding of the condition (e.g. symptoms, and how the mental health condition affects their cognition and behaviour), the treatment options, possible responses to treatments and expectations for the recovery pathway.

Patients with mental health conditions that have arisen as a result of work are frequently concerned about potential stigma they may face at work, home or in the community as a consequence of their diagnosis. It is therefore important to first ask the patient if they would like to involve a family or community member, and to inform the patient about limits of confidentiality before obtaining the patient's consent to involve support people and family in their care.

It can also be useful to link the patient with patient support groups (e.g. mental health support groups or culturally relevant support groups). When linking the patient with cultural and community groups, it is useful to give consideration to who from the community could be helpful. In some communities, this may be a religious leader or an informal community leader.

Although the recommendations here pertain to mental health conditions, it is also appropriate for GPs to adopt the same optimistic and realistic approach when promoting recovery for patients who sustain a musculoskeletal injury. This positive yet realistic approach may assist in the prevention of a secondary mental health condition following the initial physical injury.

Useful resources

- The Clinical Framework for the Delivery of Health Services 2013¹⁵
- Mental Health in Multicultural Australia Language Services¹⁶
- Multicultural People: beyondblue¹⁷
- The Fifth National Mental Health and Suicide Prevention Plan 2017¹⁸
- Guidelines for adults on how to communicate with adolescents about mental health problems and other sensitive topics 2013 Fischer et al.¹⁹
- Communicating with an Aboriginal or Torres Strait Islander Adolescent: Guidelines for being culturally appropriate when providing mental health first aid 2014 Chalmers et al.²⁰

How will we know that the recommendations have been implemented?

There is documented use of a checklist of factors (Appendix J) that GPs need to consider including:

- providing the patient with information about the nature of the mental health condition, recovery expectations and treatment choices
- providing the patient with educational material in a format that they can understand
- consideration of patient concerns, such as the potential for stigma or discrimination, loss of employment, isolation and financial insecurity
- a discussion of confidentiality with the patient.

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9



How can the condition be managed effectively to improve personal recovery or return to work?

Why is this topic important?

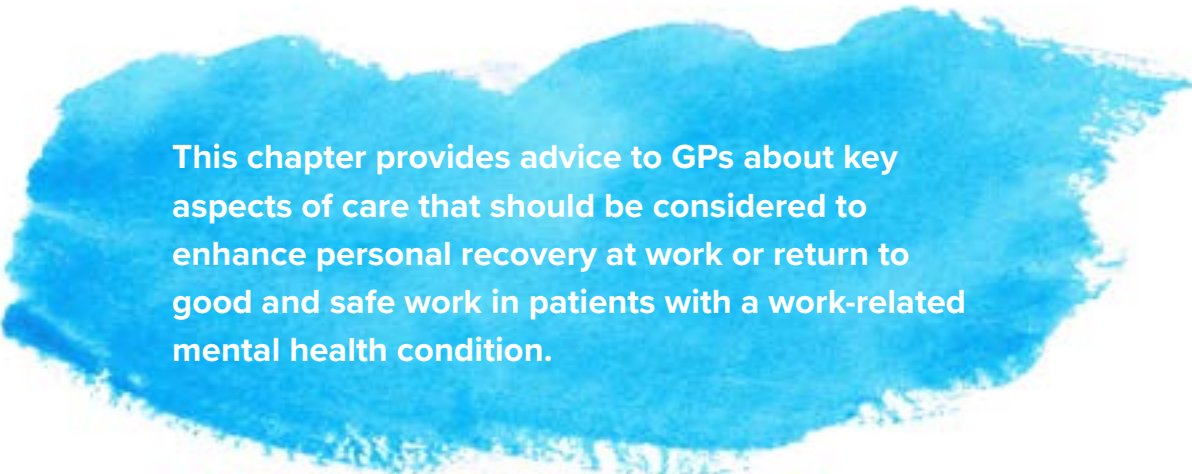
For the majority of patients with a work-related mental health condition, their GP has a significant role in the recovery journey, including setting expectations for recovery, explaining and discussing potential treatment options with the patient, and identifying other key professionals who can assist in providing the patient with the optimal care and management.

The [National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers](#)¹ and [The Fifth National Mental Health and Suicide Prevention Plan](#)² define 'personal recovery' as:

"being able to create and live a meaningful and contributing life in a community of choice, with or without the presence of mental illness. [While the journey to recovery is unique to each individual], central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing free of stigma and discrimination"².

Personal recovery from a mental health condition can ensue when the values, beliefs and practices about recovery of both the patient and the GP are considered in collaboration. This includes considering patient values, setting optimistic and realistic beliefs about recovery, demonstrating recovery-promoting attitudes, choosing patient-centred treatment strategies and acknowledging the stages of recovery, which can include both achievements and setbacks^{2, 3}.

For patients with a mental health condition, participation in good and safe work is strongly associated with good mental and physical health⁴⁻⁶ and work may help to foster recovery by enhancing feelings of connectedness, hope, optimism, identity, meaning, purpose and empowerment (CHIME)³. Participation in good and safe work can also help to prevent the negative consequences of time away from work that hinder recovery, such as reduced social connectedness, reduced feelings of purpose, economic hardship, and can lead to the development of comorbidities⁷⁻⁹.



This chapter provides advice to GPs about key aspects of care that should be considered to enhance personal recovery at work or return to good and safe work in patients with a work-related mental health condition.

Summary of recommendations



How can the condition be managed effectively to improve personal recovery or return to work?

- 9.1 On the available evidence, there is no clear support for an intervention in a general practice setting to improve personal recovery or return to work in patients with a work-related mental health condition; therefore, there is an urgent need to promote research in this area.

[Recommendation for future research]

- 9.2 Adopt a patient-centred approach. Refer to existing high-quality guidelines for the management of mental health conditions, while considering work-related factors.

[Consensus-based recommendation]

- 9.3 In recognition of the health benefits of safe work and in regards to personal recovery, consideration should be given, where appropriate, to whether a patient can remain at or return to work (this may include transition back to work or work modification).

[Consensus-based recommendation]

- 9.4 In patients with a secondary work-related mental health condition, where the primary condition was a musculoskeletal injury, a GP may consider work-directed cognitive behavioural therapy.

[Weak recommendation FOR (moderate quality of evidence)]



Evidence summary

A systematic literature review identified 16 original studies^{10–25} and eight systematic reviews^{26–33} of high quality that addressed the review question. Of the 16 original studies, eleven were randomised controlled trials (RCTs)^{11–14, 17, 18, 20–24}, the other five^{10, 15, 16, 19, 25} were non-randomised design studies. In most studies, anxiety, and depression were addressed together, with some also including adjustment disorder, PTSD or other mental health conditions. One study¹⁰ considered PTSD alone.

Nine of the eleven RCTs were undertaken in a work context^{11, 14, 17, 18, 20–24}; the other two were not^{12, 13}.

The interventions described in the nine studies that considered work were categorised as follows: (1) interventions that incorporated an aspect of multidisciplinary collaborative care^{10, 14, 19–21}, (2) enhanced primary care^{18, 22}, (3) a social worker-led approach¹¹, (4) guideline-based care by occupational physician¹⁷, and (5) other (individual or group) therapy²⁴ or minimal intervention²³. The interventions that were not undertaken within a work context compared the effects of cognitive behavioural therapy (CBT) with counselling, GP treatment as usual¹² and an internet-based self-help CBT¹³.

Interventions that incorporated an aspect of multidisciplinary collaborative care

Bender et al.¹⁰ utilised a quasi-RCT design to investigate the effect of a multidisciplinary assessment and treatment program that comprised return to work (RTW) coordination, education, and referral to specialised mental health services compared with GP usual care on personal recovery and RTW in patients with PTSD. This study found no effect on personal recovery; however, RTW rates were increased, although not significantly, six months after the intervention.

Netterstrom et al.¹⁴ used an RCT design to compare the effect of a collaborative approach comprising a specialist in occupation medicine, psychologists and a care manager with GP usual care on personal recovery and RTW rates in patients with stress or depression. The study found no significant effect

on symptom reduction; however, it did find a significant improvement in RTW three months after the intervention.

Shippee et al.¹⁹ used an observational study design to investigate the effect of a collaborative approach comprising nursing, allied health, motivational interviewing, teaching, self-management and information sharing with primary care providers and psychiatrists on remission rates of patients with depression compared with GP usual care. This study found significant symptom remission at six months in favour of the collaborative care.

Vlasveld et al.²⁰ used an RCT design to also compare the effect of a collaborative approach comprising a specialist in occupation medicine, psychologists and a care manager with GP usual care on personal recovery and RTW rates in patients with stress or depression. The study found no significant effect on symptom reduction and no significant effect on RTW 12 months after the intervention.

Volker et al.²¹ used an RCT design to compare the effect of a multifaceted approach that incorporated a web-based component aimed at teaching sick-listed employees about the benefits of resuming work while symptoms were still present, and an email decision aid with occupational physician treatment as usual on RTW outcomes. This study found a higher rate of RTW with the intervention, but this was not significant.

Due to the heterogeneity of the study types investigating the effect of a collaborative approach on work participation or personal recovery, they were given a combined grade of low quality of evidence.

Interventions that emphasised enhanced primary care

Rost et al.¹⁸ used an RCT design to compare the effect of an enhanced primary care intervention (physicians and care managers trained in guidelines-based management of depression with pharmacotherapy) with usual care on duration of antidepressant use and sick leave. This study found no evidence that an enhanced primary care management program reduced the number of months of antidepressant use.

It also found no difference in the amount of sick leave between intervention and usual care.

van der Klink et al.²² used an RCT design to compare an 'innovative activating intervention' with usual care in patients on sick leave for an adjustment disorder. The intervention had an emphasis on recovery and involved a program centred on engaging in less demanding tasks and gradually progressing to more demanding tasks. This resulted in a significant rate of either partial or full RTW rates at three months compared to usual care, but no difference at 12 months. There was no significant difference in the improvement of symptoms of the adjustment disorder.

Together, these studies were assigned a grade of high quality of evidence.

An intervention using a social worker-led approach

Brouwers et al.¹¹ used an RCT design to compare the effect of a social worker-led intervention that included activating and supporting the patient to restore coping and to adopt a problem-solving approach toward his/her problems with GP usual care on symptom improvement. This study found a non-significant trend towards symptom improvement, but no significant effect on RTW rates. The body of evidence for an intervention using a social worker-led approach was given a grade rating of moderate quality of evidence as it had a 'not serious' risk of bias and included only a single study.

Guideline-based care by occupational physicians

Rebergen et al.¹⁷ used an RCT design to compare the effect of care delivered by occupational physicians trained in guideline-based care with occupational physician usual care on RTW outcomes in police men and women. The study found a significant improvement in RTW rates at 12 months in patients who received the intervention. The body of evidence for care delivered by occupational physicians trained in guideline-based care was given a grade rating of low quality of evidence as it was based on one study which was identified a 'serious' risk of bias.

Intervention focusing on individual or group therapy

Nystuen and Hagen²⁴ undertook a subgroup analysis of patients with psychological distress and burnout in an RCT that included patients on sick leave. The intervention involved individual or group 'solution-focused practice' that encompassed coping strategies, peer support and goal setting compared with treatment as usual. The intervention resulted in significantly better mental health status at six months than treatment as usual but no difference in length of sick leave. Although the RCT design was considered to have a 'not serious' risk of bias, the outcomes reported here are a secondary analysis of the RCT. The present study was considered to have a serious risk of 'indirectness' and 'imprecision' and had low participant numbers. As a result, this study was given a grade rating of low quality of evidence.

Minimal intervention

Fleten and Johnsen²³ analysed subgroup data of patients with depression and other unspecified mental disorders, in an RCT of patients on sick leave. The intervention was described as 'minimal intervention delivered via post package' focusing on information about RTW on modified duties. The study found no difference in length of sick leave at 12 months. Although the RCT design was considered to have a 'not serious' risk of bias, the outcomes reported here are a secondary analysis of the RCT. The present study was considered to have a serious risk of 'indirectness' and a not serious risk of 'imprecision'. As a result, this study was given a grade rating of moderate quality of evidence.

Non-work-related interventions

Kivi et al.¹³ used an RCT design to compare internet-based cognitive behavioural therapy (iCBT) with usual care for depression. The intervention involved a 12-week interactive self-help program that involved acceptance and mindfulness exercise workbook, with minimal email contact with the therapist. The study found no differences in depressive and anxiety symptoms, suicide risk, or rates of deterioration between participants who received iCBT and usual care. Holst et al.²⁵ undertook a secondary analysis of patients' experiences of the intervention from the above RCT¹³. The findings revealed a mixed response on views about iCBT; that is, some patients felt the iCBT experience was empowering and improved their mood, while other is found it stressful because of the limited contact with the therapist nature of the self-help iCBT. King et al.¹² used an RCT design to compare the effect of CBT, non-directive counselling with GP usual care on personal recovery. All three treatments individually resulted in significant improvement in symptoms at 12 months and were equally as effective as each other in reducing symptoms at 12 months. This study did not consider a work context.

Together this body of evidence identified for non-work-related interventions was given a grade rating of high level of evidence.

Overall, the RCTs found that training in guideline-based care (for occupational physicians or GPs, *albeit* GP training related to medications only) resulted in significant improvements in RTW rates. The evidence also suggests that collaborative care had no significant effect on rates of RTW, although there was a trend towards improvement.

Systematic reviews

The eight additional systematic reviews that addressed the clinical topic focused on a range of mental health conditions and reported on RTW outcomes, duration of sick leave and some patient outcomes.

Nigatu et al.²⁷ reviewed 17 studies describing a variety of interventions for improving RTW in workers with common mental disorders. Six of the studies included in this review were also identified in our evidence search^{11, 14, 17, 20, 21, 23}. Interventions identified in this review included problem-solving strategies, CBT, coping strategies, exposure-based therapy, occupational therapy, psychoeducation, and diagnosis, consultation and referral. Pooled results showed that the interventions were not significantly effective at improving RTW rates in patients with a common mental disorder. There was, however, a modest effect on reducing the number of days of sick leave in participants in the intervention group compared with the control group. The authors concluded that the existing RCTs provided weak evidence about the effectiveness of psychotherapy (irrespective of collaborative or multidisciplinary, work-focused CBT or CBT alone) on RTW and sick leave.

A Cochrane Review undertaken by Nieuwenhuijsen et al.²⁸ evaluated 23 studies describing the effectiveness of interventions aimed at reducing work disability in employees with depressive disorders. Two studies in this review^{18, 20} were also identified in our evidence search. The authors concluded that the following interventions had a moderate effect on reducing the duration of sick leave: (1) adding a work-directed intervention to a clinical intervention compared to a clinical intervention alone, (2) enhancing primary or occupational care with CBT compared to usual care alone, and (3) a structured telephone outreach and care management program that included medication compared to usual care. Enhancing primary care with a quality improvement program did not have a considerable effect on sickness absence.

A second Cochrane Review undertaken by Arends et al.²⁹ included nine studies describing interventions that were aimed at facilitating RTW for workers with adjustment disorders. Two studies in this review were also identified in our evidence search. The studies included in this review described ten psychological interventions: five were based on CBT and the other five were based on problem-solving therapy. Of the CBT-focused studies, two focused on the work environment, while the other was a strict CBT protocol. An important limitation described in this review was the small number of studies included in the meta-analyses and the small number of participants, which lowered the power of the analyses. The findings from this review suggest that a more prescriptive approach (e.g. problem-solving therapy) might be more effective at assisting people to RTW than CBT. Specifically, the authors' main findings and conclusions were:

- there was moderate-quality evidence that CBT overall (work and non-work combined) did not significantly reduce time to partial RTW and low-quality evidence that it did not significantly reduce time to full RTW compared with no treatment
- there was moderate-quality evidence that problem-solving therapy significantly enhanced partial RTW at the one year follow-up compared to non-guideline-based care, but it did not significantly enhance time to full RTW at one-year follow-up.

A systematic review conducted by Jayakody et al.³¹ reported findings from eight RCTs and found that, regardless of type (aerobic or non-aerobic), exercise may reduce symptoms of anxiety but is less effective than antidepressants; thus, exercise may be effective as "an adjunctive treatment for anxiety disorders". The authors acknowledged that further well-conducted RCTs are needed.

de Souza Moura et al.³⁰ systematically reviewed ten studies which, when combined, reported high risk of bias. The authors of this review concluded that exercise cannot replace conventional treatments, such as selective serotonin reuptake inhibitors or CBT, but it, can still be recommended as an additional treatment modality.

A systematic review conducted by Druss et al.³³ was informed by six included RCTs published between 2001 and 2003 and found that rates of abstinence from alcoholism were variable across interventions in patients with alcohol use disorder. Of these, one study demonstrated a significant increase in abstinence rates (74% versus 48%) in veterans who received an integrated care that included a clinical intervention for alcohol misuse with their primary medical care. A second subgroup of those with addiction-related medical and mental health conditions also showed significantly greater abstinent rates (69% vs. 55%); however, there was no difference in the full group with addiction and other comorbidities.

Dorflinger et al.³² assessed the effect of training in CBT delivery provided to primary care physicians on mental health outcomes. Two out of the nine included studies evaluated the effect of primary care physicians trained in CBT on patients' mental health outcomes, while the other seven studies evaluated provider performance, reaction and learning outcomes. Of the two studies evaluating patient outcomes, one showed a significant improvement in global psychological distress, the other found no difference on depression and anxiety outcomes.

Cullen et al.²⁶ reviewed 36 studies describing interventions aimed at improving RTW outcomes in workers with musculoskeletal or pain-related conditions and a comorbid mental health condition. This review included a study that was identified in our evidence search²⁰. The interventions described in this review were categorised into four domains: (1) health-focused interventions, (2) service coordination interventions, (3) work modification interventions, and (4) multi-domain interventions. The authors found that multi-domain interventions that had components across at least two of the three single-domain interventions were the most effective at reducing time off work. This review also found high-level evidence (from six high-quality studies and one medium-quality study) for work-focused CBT and high-level evidence against traditional CBT.

Issues considered when assessing the evidence

Management of a primary mental health condition

Together, the RCTs did not identify any GP-led interventions that were successful at improving patient recovery outcomes for work-related mental health conditions. In the absence of consistent evidence for the management of work-related mental health conditions, GPs should draw upon the existing high-quality guidelines listed below to identify the optimal management strategy for the underlying mental health condition.

Depression

- Clinical practice guidelines for mood disorders: major depression summary 2018, RANZCP³⁴
- Depression in adults: recognition and management 2018, NICE³⁵
- Depression in children and young people: identification and management 2017 NICE⁴⁷

Anxiety disorders

- Prescribing drugs of dependence in general practice 2015, RACGP³⁶
- RANZCP Clinical Practice Guideline for the Treatment of Panic Disorder, Social Anxiety Disorder and Generalized Anxiety Disorder. 2018³⁷

Trauma- and stressor-related disorders

- Australian Guidelines for the Treatment of acute Stress Disorder and Posttraumatic Stress Disorder 2013, Phoenix Australia³⁸
- Expert guidelines: diagnosis and treatment of post-traumatic stress disorder in emergency service workers 2015, Harvey, Bryant and Forbes³⁹

Substance misuse disorders

- Smoking, Nutrition, Alcohol and Physical activity (SNAP) guidelines 2nd edition 2015, RACGP⁴⁰
- Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence 2011, NICE⁴¹

Although not directly addressing patient recovery outcomes, the evidence demonstrated that improvements in return to work rates could be achieved by providing training in guideline-based care to occupational physicians, or training in prescribing to GPs. Collaborative care, likewise, may improve RTW rates; however, the trends towards improvement were not significant.

One systematic review that was rated as having a high risk of bias demonstrated that exercise can be recommend in combination with traditional approaches. The Guideline Development Group (GDG) supports the view that there is value in prescribing exercise as an adjunctive treatment for patients with mental health conditions. GPs may consider referring the patient to an exercise physiologist who has been accredited by Exercise and Sports Science Australia.

Management of a secondary mental health condition

For patients with a secondary work-related mental health condition, one high-quality systematic review found high-level evidence in favour of work-directed CBT at reducing sickness absence, compared with traditional CBT²⁶, where work-directed CBT was defined as “CBT that focused on identifying work relevant solutions”. Duration of sick leave may represent personal recovery, as it is an indicator of recovery if a person is able to engage in work. It is therefore recommended that GPs use work-directed CBT for patients who develop a secondary mental health condition, after a primary work-related injury. As the outcome of this trial did not specifically assess patient recovery outcomes, the Guideline Development Group (GDG) opted to give the recommendation a grade of ‘Weak FOR’ rather than a ‘Strong FOR’.

This review also found strong evidence in support of the use of multi-domain interventions on reducing sickness absence²⁶. As it is unlikely that GPs will have the capabilities to apply multi-domain interventions in practice, and because patient recovery outcomes were not examined in this study, the GDG opted not to include a recommendation for multi-domain interventions in the guideline.

Additional points of consideration

Patient-centred care

A patient-centred approach encompasses the tenets of a biopsychosocial approach (i.e. addressing the clinical aspects of the illness, the patient's perceptions, beliefs and attitudes, and environmental factors that can promote or hinder recovery) with a view to enhancing feelings of connectedness, hope, optimism, identity, meaning, purpose and empowerment.

Patients should always be involved in making decisions about their care, including who should be included. It is important that patients provide consent to contact other health professionals, workplace representatives or other individuals, such as cultural consultants or family members, who can advocate for the patient's needs and concerns.

Enhancing self-efficacy

People with higher self-efficacy are more likely than those without to return to work⁴². A GP can assist to enhance a patient's self-efficacy by:

- discussing with the patient about their own and work-related factors that might affect progress (e.g. the importance of maintaining activities of daily living including work)
- providing the patient with psychoeducation about their condition, management options and recovery pathways
- seeking independent remediation or referral (while maintaining a patient-centred and coordinated approach), to negotiate the changes that need to be done to achieve safe RTW.

Monitoring

It is important for the GP to be aware of secondary impacts of the work-related mental health condition on a patient, such as the impact of loss of work on families, and consider these impacts when planning treatment.

Culturally-suitable care

When discussing treatment approaches for Aboriginal and Torres Strait Islander people, GPs should be aware of cultural needs and dealing with current and past trauma⁴³. A range of high-quality resources that have been designed for clinical use are available at the [Australian Indigenous HealthInfoNet](#) website⁴⁴. In addition, GPs may consider engaging with cultural consultants or other patient advocates to assist in offering optimal care pathways for the patient.

Collaborative care

It is important to be cognisant of, and collaborate with, other individuals who can impact on the patient's recovery process. As well as the patient, these may include other clinicians, a patient's employer/or employment representative, a workplace rehabilitation provider or cultural consultant and/or other patient advocates. GPs should refer to the [RANZCP guidelines on communication between psychiatrists, general practitioners and psychologists](#)⁴⁵ for best practice approaches to referral, communication and shared care.

For GPs practicing in rural and remote Australia, access to psychiatrists, psychologists and mental health nurses is limited and often GPs are the only readily available health care practitioner. GPs working in rural and remote Australia may consider using electronic case conferencing methods to facilitate collaborative care for their patients.

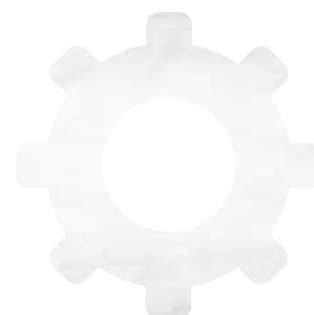
Useful resources

- Depression
 - Clinical practice guidelines for mood disorders: major depression summary 2018, RANZCP³⁴
 - Depression in adults: recognition and management 2018, NICE³⁵
 - Depression in children and young people: identification and management 2017 NICE⁴⁸
- Anxiety disorders
 - Prescribing drugs of dependence in general practice 2015, RACGP³⁶
 - RANZCP Clinical Practice Guideline for the Treatment of Panic Disorder, Social Anxiety Disorder and Generalized Anxiety Disorder. 2018³⁷
- Trauma- and stressor-related disorders
 - Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder 2013, Phoenix Australia³⁷
 - Expert guidelines: diagnosis and treatment of post-traumatic stress disorder in emergency service workers 2015, Harvey et al.³⁹
- Substance misuse disorders
 - Smoking, nutrition, alcohol and physical activity (SNAP) guidelines 2nd edition 2015, RACGP⁴⁰
 - Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence 2011, NICE⁴¹
- Other
 - Guidelines on communication between psychiatrists, general practitioners and psychologists for best practice approaches to referral, communication and shared care 2014, RANZCP⁴⁵
 - Guidelines for adults on how to communicate with adolescents about mental health problems and other sensitive topics 2013 Fischer et al.⁴⁶
 - Mental Health First Aid Training and Research Program. (2013). Communicating with an Aboriginal or Torres Strait Islander adolescent: Guidelines for being culturally appropriate when providing mental health field. Melbourne: Mental Health First Aid Australia. Chalmers et al.⁴⁷
 - Australian Indigenous Health/InfoNet⁴⁴: <http://www.healthinonet.ecu.edu.au/other-health-conditions/mental-health/resources/practice-resources/guidelines>
 - Fifth National Mental Health and Suicide Prevention Plan 2017²
 - Clinical Framework for the Delivery of Health Services 2012⁴⁹

How will we know that the recommendations have been implemented?

There is documentation of:

- the use of clinical guidelines in the management of work-related mental health conditions
- consideration for whether the patient can remain at work or transition back to work.
- consideration to using work-directed cognitive behavioural therapy for patients with a secondary mental health condition, where the primary condition was a musculoskeletal injury.



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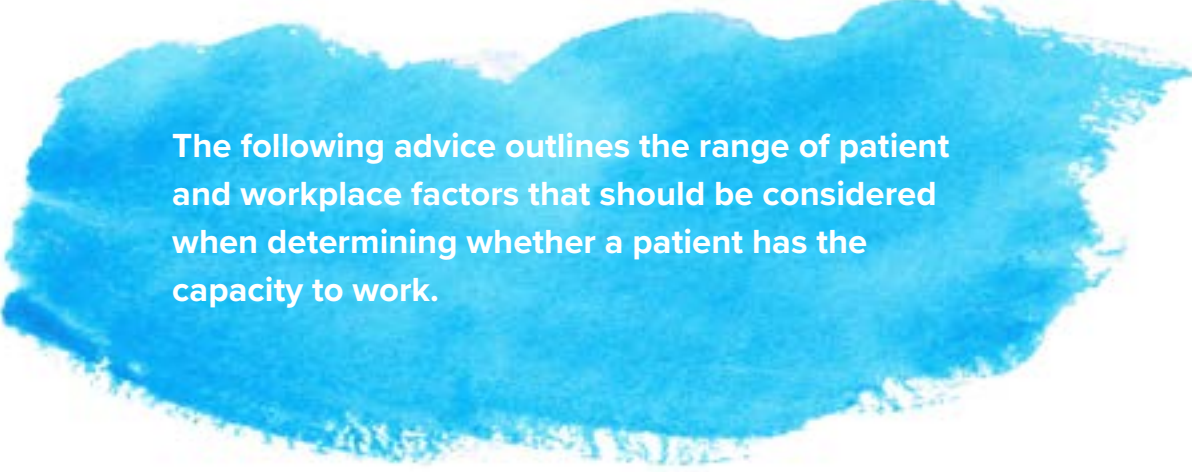
Can the patient work in
some capacity?

Why is this topic important?

Engaging in good, safe and meaningful work has many benefits on health^{1, 2}. Benefits to mental health alone include a greater sense of autonomy, improved well-being, improved recovery from mental health conditions, increased access to resources to cope with demands, enhanced social status and access to opportunities that stimulate personal development and mental health promotion². As such, it is important that engagement in work is considered early and as part of any treatment and recovery plan³. Where a patient's workplace is likely to be safe and supportive, the strategy may involve continuing to work at the workplace, with possible adjustments made to

duties, timings or other aspects of work. Where a person is on sick leave, a transition to safe work may facilitate recovery.

Determining whether a patient has the capacity to work requires an assessment of a range of factors that can impact on the patient and their capacity to participate in work. This includes factors relevant to the patient (such as the mental health condition, beliefs and attitudes about the workplace and their own capacity to work, and social aspects that influence their capacity to work) and the workplace (such as ongoing or new stressors that can aid recovery or exacerbate the mental health condition).



The following advice outlines the range of patient and workplace factors that should be considered when determining whether a patient has the capacity to work.

Summary of recommendations



Can the patient work in some capacity?

- 10.1 A GP should consider the following patient and work factors when determining whether a patient has the capacity to work.

Patient factors

- Severity of the mental health condition
- Presence of comorbidities
- Presence of sleep disturbance
- Higher conscientiousness pre-injury
- Attitude towards work
- Patient motivation to work
- Work ability
- Personal circumstances (personal relationships, finances, housing arrangements, level of physical activity)
- Social deprivation (social/cultural disadvantage)

Work-related factors

- Work environment
- GP's knowledge about the patient's workplace and its limitations
- Suitability of work
- Size of the workplace
- Conflicts with the person's supervisor
- Ongoing work-related stressors (e.g. conflict with colleagues in the workplace)
- Availability of duties that are non-stigmatising and, where possible, commensurate with the worker's level of experience and seniority

[Consensus-based recommendation]

- 10.2 A GP should consider consulting with a workplace rehabilitation provider in order to make an assessment of the workplace environment.

[Practice point]



Evidence summary

The evidence review produced 12 studies that described factors for consideration by GPs when formulating a decision to recommend return to work; two records described the same study. Of the 11 original papers included, two were RCTs^{4, 5}, eight were cross-sectional or cohort studies^{6–13}, and one clinical guideline was identified by the Guideline Development Group (GDG)¹⁴.

Both RCTs had been conducted in the Netherlands^{4, 5}. The first study, investigated the effect of treatment as usual and occupational therapy on rates of long-term patient recovery and long-term return to full-time work, and predictors of these rates⁴. Long-term symptom remission was predicted only by baseline depression severity; however, long-term return to work was predicted by lower depression severity, absence of a comorbid anxiety disorder, higher work motivation, or higher conscientiousness at baseline. The second RCT was a prospective cluster-RCT in which predictors of recurrent sickness were compared between participants who achieved partial or full return to work at six and 12 months⁵. This study found that comorbidities, large-sized companies (>100 workers) and conflicts with the person's supervisor increased the odds of a recurrent sickness absence. The RCTs had a low risk of bias and were both rated as Moderate quality.

Cross-sectional or cohort studies from the UK, Europe and Canada revealed a range of factors that are associated with longer-term incapacity, some of which can be addressed by the patient's GP^{6–12}. These factors include physical and psychosocial capability; access to, and receipt of, appropriate medical treatment; social deprivation; patient motivation; work ability; work environment; a GP's knowledge about the patient's workplace and its limitations; suitability of work; presence of sleep disturbance; being male; being older; differential diagnosis (e.g. possible malingering). Together these observational studies were rated as having a low risk of bias and were rated as Moderate quality.

The GDG added one high-quality, consensus-based Australian clinical guideline focusing on emergency workers with PTSD¹⁴, which listed the following recommendations that were considered to be relevant to this question:

- “Positions should be provided that allow alternative duties that are non-stigmatizing and, where possible, commensurate with the worker's level of experience and seniority.”
- “Clinicians should consider the possibility of adjusted duties and partial return to work as ways of promoting recovery and reducing the risk of long-term sickness absence.”
- “The risk of self-harm, aggression and violence needs to be regularly assessed throughout each stage of treatment in any emergency worker with PTSD. The risk of these behaviours recurring requires reassessment when returning a worker to frontline duties.”¹⁴

Issues considered when assessing the evidence

The studies identified in the evidence review elicited a variety of factors that a GP can consider when determining if a person has the capacity to work. Given the moderate quality of these studies, we chose to incorporate the following factors that may either impede or promote recovery.

Patient factors

- Severity of depression: Consider the nature of the mental health condition and how symptoms of depression can be managed in order for the patient to participate in work, and the likely effects of work participation on the patient's recovery.
- Presence of comorbidities: Consider how comorbidities can be managed in order for the patient to participate in work and whether participation in work will impact on the comorbidities.
- Presence of sleep disturbance: This may indicate an underlying medical or behavioural reason that impacts on the patient's capacity to work.
- Higher conscientiousness at baseline: Consider whether work adjustments need to be made to facilitate a safe return to work.
- Patient motivation to work: Consider whether work adjustments need to be made to facilitate a safe return to work.
- Ability to work: Consider the patient's physical and psychosocial capability to participate in work.
- Social deprivation: Consider social and cultural disadvantages, such as having access to and receiving appropriate care.

Work factors

- Work environment: Consider whether aspects of the work environment are likely to improve or exacerbate the condition.
- The GP's knowledge about the patient's workplace and its limitations: Consider whether the GP feels

confident that they have or can obtain sufficient knowledge about the workplace and its limitations, or if the patient would benefit from a collaborative care approach that includes the GP and a workplace rehabilitation provider who has expertise in assessing workplace requirements and liaising with employers.

- Suitability of work: Consider whether work duties upon return to work are commensurate with the person's current capabilities and expectations.
- Size of the workplace: Patients from larger-sized companies (with over 100 employees) are more likely to take sick leave. This may be due to the existence of continued or new stressors or, inversely, due to increased availability of compensation for sick leave. For workers in large organisations GPs should consider whether the patient's immediate and broader workplace environment can be conducive to their recovery.
- Conflicts with the person's supervisor: Consider whether conflicts with the person's supervisor are likely to be alleviated upon returning to work and, if not, how this is likely to influence the patient's recovery.
- Availability of duties that are non-stigmatising and where possible commensurate with the worker's level of experience and seniority: This statement was adapted from the [Australian Black Dog Institute guidelines](#)¹⁴ and refers to the suitability of the work activities that a person would undertake.

The Guideline Development Group chose to exclude the factors 'being male' and 'being older' because these factors should not specifically influence a GP's decision about determining whether a person has the capacity to return to work. The factor 'considering a differential diagnosis' was also excluded because a GP who has created a therapeutic alliance with a patient should not, at this stage, need to consider a differential diagnosis.

Additional points of consideration

Additional factors can impact on a person's recovery and should therefore be considered by a GP when determining if a person can participate in work.

- The patient's attitude towards work: Consider the patient's perspective towards engaging with work and the workplace, including the patient's expectations about their own capacity to engage in work.
- Personal circumstances: This includes other circumstances such as personal relationships, finances, housing arrangements and level of physical activity that together can impact on whether a person has the capacity to participate in work.
- Ongoing work-related stressors: Consider the presence of ongoing work-related stressors to ensure safety and a patient's ability to return to work, including how to reduce the risk of exacerbating the patient's mental health condition.

The decision to recommend staying at work or returning to work is a balance of symptom management, consideration of the patient's beliefs and attitudes, and appropriateness of the workplace and work duties.

Where the GP identifies factors that are inhibiting the patient's return to work, the GP should aim to address these. For instance, if returning to work is likely to benefit the patient, but the patient is fearful of re-injury¹⁵, the GP should work with the patient and the employer to alleviate these concerns. Conversely, if the patient has the capacity to work but returning to work with the pre-injury employer cannot be achieved, consider a work-conditioning program with a similar organisation (if appropriate).

Where a patient has had a workers' compensation claim accepted, the GP should request access to information or reports on the risks and possible return to work duties from the insurer or employer and use this information to determine if the patient can transition back to work.

Patient-centred, collaborative care

The GP may wish to collaborate with allied health professionals such as an occupational physician or a workplace rehabilitation provider who may be a qualified rehabilitation counsellor, to assist in making an educated assessment of the workplace environment and the appropriateness of duties for the patient to ensure safety and continued recovery. Collaborative care should always involve the patient and, where appropriate, their advocates such as cultural consultants, community members or family members¹⁶, and should focus on the patient's needs.

With regard to collaborative care with a workplace rehabilitation provider, such care can assist the patient and the GP to identify:

- suitable duties, preferably with the pre-injury employer¹⁷
- a work placement, if a return to work is not possible initially
- graded exposure to work relationships/situations
- opportunities to practice management techniques.

Workplace rehabilitation providers are available across Australia to patients who have had a workers' compensation claim reviewed and accepted.

How will we know that the recommendations have been implemented?

There is documentation demonstrating that:

- the GP has considered consulting with or referred the patient to a workplace rehabilitation provider
- the assessment of a patient's work capacity includes consideration of patient and work-related factors.

Useful resources

- The [Health Benefits of Good Work Consensus Statement](#)¹⁸ can be used to facilitate a discussion about engagement in good work with the patient.
- The [Australian Rehabilitation Providers Association](#) website¹⁹ describes in detail the role of workplace rehabilitation providers and provides a directory of workplace rehabilitation providers across Australia.
- The [Australian Society of Rehabilitation Counsellors](#) website²⁰ describes in detail the role of rehabilitation counsellors and provides a directory of rehabilitation counsellors across Australia.
- The [Clinical Framework for the Delivery of Health Services 2012](#)²¹ outlines five key principles for the delivery of health care for people with compensable injuries.
- The [Fifth National Mental Health and Suicide Prevention Plan 2017](#)¹⁶ outlines key government priorities to improve the provision of better integrated mental health care in Australia.



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11



What is appropriate communication with the patient's workplace?

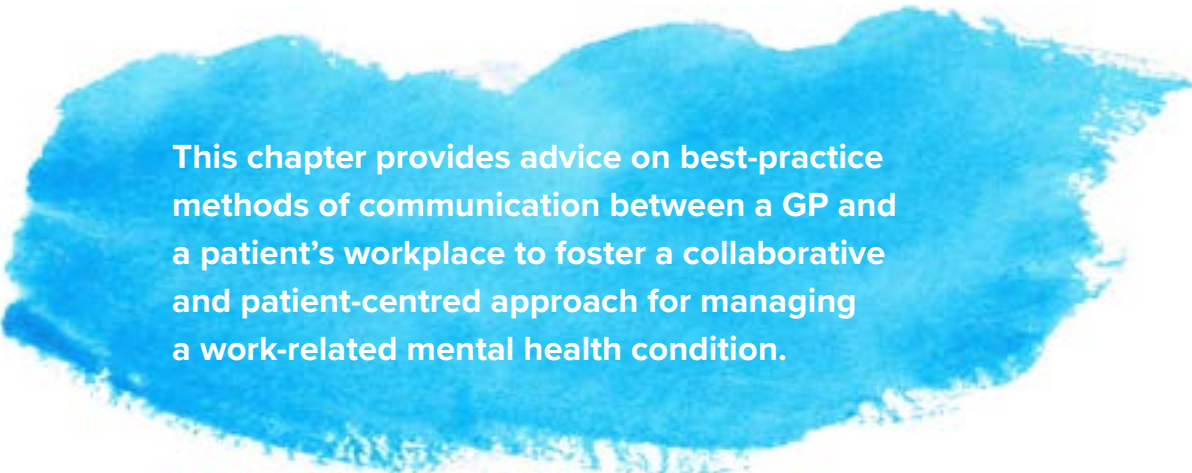
Why is this topic important?

Patients, employers and compensation schemes all consider the GP to have a predominant role as a patient's advocate and coordinator in recovery¹. For a patient with a mental health condition, recovery includes personal recovery and meaningful and safe participation in work². As the coordinator of the recovery pathway for people with a mental health condition, it is the GP's responsibility to ensure that:

- care strategies are coordinated in a way that is holistic and meet the needs and outcomes that are important to the patient

- treatment, care and support is personalised and provided by the right service at the right place and at the right time
- the journey through services will be smoother³.

Constructive communications between a GP and the patient's workplace can enhance the patient's recovery by enabling the patient to stay at or return to safe and meaningful work, or by identifying work factors that may hinder the patient's recovery, and using a collaborative approach with the workplace to address these.



This chapter provides advice on best-practice methods of communication between a GP and a patient's workplace to foster a collaborative and patient-centred approach for managing a work-related mental health condition.

Summary of recommendations



What is appropriate communication with the patient's workplace?

- 11.1 A GP 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.
[Strong recommendation FOR (moderate quality of evidence)]
- 11.2 A GP should consider using a trained workplace rehabilitation provider, if available, to coordinate and negotiate return to work among stakeholders.
[Strong recommendation FOR (high quality of evidence)]
- 11.3 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-based recommendation]

**Communication between a GP and their patient's workplace should only occur with a patient's consent.*

Evidence summary

A review of the evidence identified two cross-sectional studies^{4, 5} that addressed this review question. Together this body of evidence was given an evidence rating of low. In addition, one high-quality clinical practice guideline that had been developed in Canada⁶ was identified.

The first cross-sectional study was conducted by Sylvain et al.⁴ and highlighted the importance of preserving patient confidentiality. This study described Canadian GPs' practices with people experiencing work disability due to depressive disorders, and explored how the GP's work context may impact on clinical practice. As a secondary outcome, GPs were also asked to describe barriers to collaborative care with other health providers and a patient's workplace. The GPs in this study described grappling with their own intention to preserve their patients' confidentiality as a key barrier to collaboration with their patients' workplaces.

The second study was undertaken by Kinnunen-Amoroso and Liira⁵, who explored the experiences faced by occupational physicians when dealing with workplaces in Finland. Through interviews with occupational physicians, this study concluded that occupational physicians who had stronger relationships with a workplace were more likely to work together with their patient's workplace.

The Canadian guideline⁶ additionally offered advice about the content of communication that would facilitate return to work. Specifically, it stated the following recommendations that were considered for inclusion in the present guideline:

- “Return-to-work coordination and negotiation amongst stakeholders are required to accomplish individualized return-to-work strategies. To be successful, these activities may need to be coordinated by a trained return-to-work coordinator.” This recommendation was built on high-level evidence that used coordination and negotiation among stakeholders. The second part of the recommendation, pertained to the use of a trained return to work coordinator was an adaptation of [Managing long-term sickness and incapacity for work overview](#) developed by NICE in the UK, which was consensus based.
- The statement that “Structured and planned close communication between the worker, supervisor, healthcare provider(s), union representatives and other disability management stakeholders is essential to improve return-to-work/stay-at-work outcomes—this includes in-person/telephone contacts and written information for workers with mental health conditions on current policies and benefits” was based on moderate-level evidence.
- “Ensure that communications with stakeholders maintain a focus on the workplace and on worker's needs and functional capacities” was based on consensus, acknowledging that optimal return to work outcomes are met when a person's functional capacity is considered, rather than considering only symptom improvements.

Issues considered when assessing the evidence

The three recommendations described in the Canadian guideline⁶ are feasible for Australian GPs and have been adopted in the present guideline, with minor amendments to the wording of the recommendations. The two original studies^{4–5} highlighted two key factors that the Guideline Development Group also considered when formulating the recommendations. These key factors were a potential concern from GPs regarding preserving patient confidentiality, and the value of a strong relationships between clinicians and employers on the likelihood of working collaboratively. These issues have been incorporated into the recommendations as follows:



“Return-to-work coordination and negotiation among stakeholders are required to accomplish individualised return-to-work strategies. To be successful, these activities may need to be coordinated by a trained return-to-work coordinator” (*original statement extracted from clinical guideline*)⁶. The reference to a ‘trained return-to-work coordinator’ was replaced with a ‘workplace rehabilitation provider’, as the role of the workplace rehabilitation provider is appropriate for the Australian context. In Australia, as in Finland, occupational physicians commonly [within a workplace] assist a patient’s return to work. However, because there was no specific evidence that stipulated the referral to occupational physicians, we reference only a workplace rehabilitation provider in this evidence-based recommendation.

“Structured and planned close communication between the worker, supervisor, healthcare provider(s), union representatives and other disability management stakeholders is essential to improve return-to-work/stay-at-work outcomes—this includes in-person/telephone contacts and written information for workers with mental health conditions on current policies and benefits” (*original statement extracted from clinical guideline*)⁶. The wording of this evidence-based recommendation was summarised.

“Ensure that communications with stakeholders maintain a focus on the workplace and on worker’s needs and functional capacities.” This consensus-based recommendation was expanded and a footnote added to consider patient concerns for confidentiality.

Given the high quality of the evidence pertaining to the first two recommendations, along with the significant impact of these recommendations on patient outcomes, we gave these recommendations a rating of Strong FOR. The third recommendation was adapted as a consensus statement.

Additional points of consideration

In Australia, a trained [workplace rehabilitation provider](#), who may be a qualified [rehabilitation counsellor](#), is assigned to individuals who submit a claim. This claim may be for a work-related injury or even income insurance. In addition, some large employers have access to rehabilitation services that may offer similar services. Outside of these two arenas, however, access to a trained workplace rehabilitation provider is restricted. We, therefore, suggest using a workplace rehabilitation provider only if one is available. If access to a workplace rehabilitation provider is not possible, GPs may consider engaging with an occupational physician.

Patients who are experiencing symptoms of a work-related mental health condition are in a vulnerable position and rely on their GP to ensure that communications with the workplace are safe and appropriate. GPs are cognisant of patient confidentiality; however, we wished to reinforce the notion about appropriate communication with those GPs who are less experienced and to build confidence in these clinicians. The Guideline Development Group, therefore, added a footnote to state that “communication with a patient’s workplace should only occur with a patient’s consent”.

Patients located in rural and remote settings, especially school staff, police officers and health care services staff, face additional challenges such as lack of anonymity, which can make them more susceptible to new or ongoing workplace stressors, including stigma or workplace violence. GPs working in rural and remote Australia should consider these factors when communicating with a patient’s workplace.

When a patient submits a claim for workers’ compensation, they simultaneously consent to

communication between their clinician and their workplace. However, for consent to be meaningful and to ensure that the therapeutic alliance is maintained with a patient, it is important to involve the patient in decision-making throughout the communications, to ensure the individual is comfortable with the stakeholders involved in their care, and the content of the information communicated.

A GP can ensure that communications are safe and productive for the patient by:

- discussing their content with the patient before engaging with an employer, with a focus on the workplace and the patient’s needs and functional capacities
- deciding with the patient who should be involved in the communications, including patient advocates (such as cultural representatives or family members)³, if suitable
- carefully recording all communications, including phone conversations with employers, and providing written recommendations, post communication, to the patient and others that outlines work adjustments or considerations that need to be made
- engaging with other health professionals such as workplace rehabilitation providers or occupational physicians to aid the conversation.

For those patients who have a workers’ compensation claim accepted, case conferencing arrangements are now available and funded in most jurisdictions across Australia. GPs may consider using these services to support a timely and coordinated approach to return to work for the patient.

Useful resources

- The Australian Rehabilitation Providers Association website⁸ describes in detail the role of workplace rehabilitation providers and provides a directory of workplace rehabilitation providers across Australia.
- The Australian Society of Rehabilitation Counsellors Ltd website⁹ describes in detail the role of rehabilitation counsellors and provides a directory of rehabilitation counsellors across Australia.
- The Clinical Framework for the Delivery of Health Services 2012²
- The Fifth National Mental Health and Suicide Prevention Plan 2017³
- Australian Indigenous Health/InfoNet¹⁰: <http://www.healthinfonet.ecu.edu.au/other-health-conditions/mental-health/resources/practice-resources/guidelines>

How will we know that the recommendations have been implemented?

There is documentation of:

- communications with a workplace and other key people involved in the patient's recovery that focus on the patient's needs and the workplace
- consideration of engaging with a workplace rehabilitation provider to coordinate and negotiate return to work.

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12



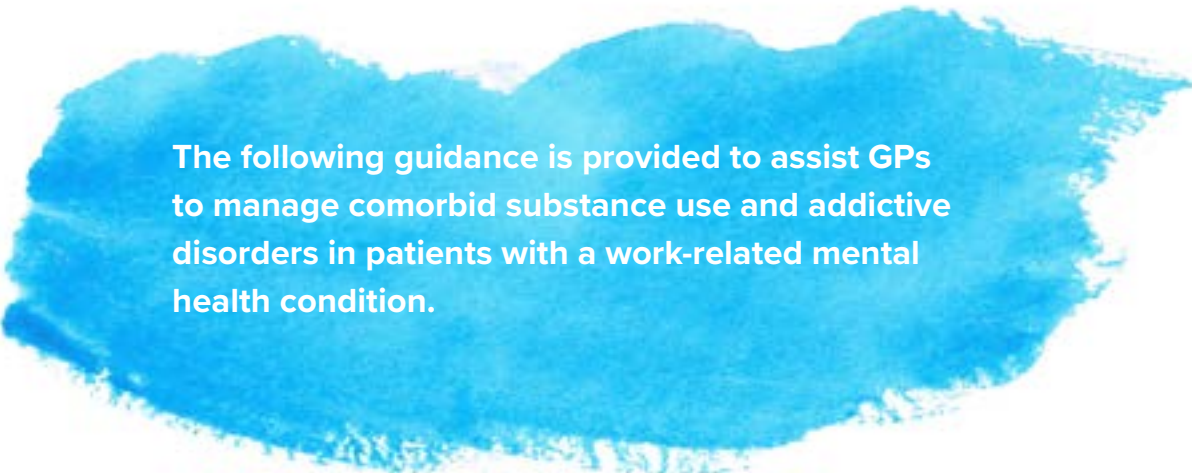
What strategies are effective at managing comorbid mental health conditions and substance misuse and addictive disorders?

Why is this topic important?

It is not uncommon for substance use and other addictive disorders to co-exist with mental health conditions such as anxiety, depression or posttraumatic stress disorder¹. For example, major depression and anxiety have between a two to four times greater association with alcohol misuse or illicit drug use².

General practice is an appropriate and established setting for addressing health-related behaviours, and GPs can offer valuable support and management for

conditions such as substance misuse or addictive disorders³. Moreover, as the most frequent coordinator of care for people with work-related mental health conditions, a person's GP is able to devise a management plan that encompasses a biopsychosocial approach (i.e. one that considers the medical nature of the mental health conditions, the patient's responses and beliefs about these conditions and recovery, and environmental factors, such as work, that together influence recovery).



The following guidance is provided to assist GPs to manage comorbid substance use and addictive disorders in patients with a work-related mental health condition.

Summary of recommendations



What strategies are effective at managing comorbid mental health conditions and substance misuse and addictive disorders?

- 12.1 On the available evidence, there is no clear support for an intervention in a general practice setting to manage comorbid substance misuse and addictive disorders; therefore, there is an urgent need to promote research in this area.
[Recommendation for future research]
- 12.2 A GP should note the presence and severity of comorbidities in their assessments, with a view to considering their implications for treatment planning.
[Consensus-based recommendation]
- 12.3 A GP should utilise existing high-quality guidelines for the management of substance misuse and addictive disorders.
[Consensus-based recommendation]
- 12.4 A GP should consider using an integrated approach that addresses both work-related mental health conditions and comorbid substance use disorders.
[Consensus-based recommendation]
- 12.5 For work-related PTSD, a GP may consider individual-based trauma-focused psychological therapy delivered with substance use disorder therapy.
[Weak recommendation FOR (very low quality of evidence)]



Evidence summary

A review of the literature produced one high-quality RCT⁴. This study investigated brief interventions to reduce problematic drinking, including a stepped-care model using alcohol-related telephone counselling. The intervention found no significant effect on alcohol consumption in patients with comorbid anxiety or depression.

As we could not draw upon the results of the RCT to form a recommendation that addresses the question, the evidence review was supplemented with recommendations from relevant high-quality clinical guidelines^{5–11} and two high-quality systematic reviews^{12, 13}, which resulted from a search for relevant clinical guidelines and systematic reviews. Of the seven guidelines, three were produced in Australia^{9–11}, three were produced in the UK^{6–8}, and one was produced by the US Department of Veteran's Affairs⁵. Two key themes emerged from the clinical guidelines and systematic reviews: (1) assessment and monitoring and (2) treatment approaches.

Importance of assessment and monitoring

Three guidelines specifically addressed the issue of assessment and monitoring: [NICE 2011 Alcohol guidelines](#)⁷, [Department of Veteran's Affairs 2015](#)⁵, and the Australian [Phoenix guidelines 2013](#)¹¹. The [NICE 2011 Alcohol guidelines](#)⁷ state that when assessing comorbid alcohol misuse and mental health conditions, there is no reliable way to determine which of these conditions developed first and which is the secondary condition. Therefore, NICE advises that clinicians should monitor for comorbid mental health conditions throughout treatment. This recommendation is supported by the US [Department of Veteran's Affairs 2015](#)⁵ guidelines for the monitoring of substance use disorders, which was created using evidence that was graded as Weak FOR. Further consensus-based advice about the nature and content of assessments was added by the [Phoenix guidelines](#)¹¹.

- “A thorough assessment is required, covering relevant history (including trauma history), PTSD and related diagnoses, general psychiatric status (noting extent of comorbidity), physical health, substance use, marital and family situation, social and occupational functional capacity, and quality of life.”
- “Assessment should cover the broad range of potential posttraumatic mental health problems beyond PTSD, including other anxiety disorders, depression and substance abuse.”
- “It is recommended that practitioners be guided in their assessment of PTSD, comorbidity and quality of life, by the available validated self-report and structured clinical interview measures.”
- “Mental health practitioners are advised to note the presence and severity of comorbidities in their assessments, with a view to considering their implications for treatment planning.”

Treatment approaches

Five of the guidelines and the two systematic reviews addressed treatment approaches for patients with alcohol and/or substance misuse and a comorbid mental health condition: [NICE 2011 GAD](#)⁶, [Black Dog Institute 2015](#)⁹, [Department of Veteran's Affairs 2015](#)⁵, [NICE 2011 Alcohol](#)⁷, [NICE Drug Misuse 2007](#)⁸.

Four guidelines^{8–11} recommended using an integrated approach for people with comorbid mental health conditions and a substance use disorder. The [Black Dog Institute 2015](#)⁹ added the caveat that “*for patients with PTSD, the trauma-focussed psychological component of treatment should not commence until the patient demonstrates improvement in their substance use condition*” and the [Phoenix guidelines](#)¹¹ added a more detailed caveat that “*In the context of PTSD and substance use disorders, the trauma-focused component of PTSD treatment should not commence until the person has demonstrated a capacity to manage distress without recourse to substance misuse and to attend sessions without being drug or alcohol affected*”. These recommendations were all based on expert consensus.

The [Phoenix guidelines](#)¹¹ added further advice that:

- “In the context of PTSD and substance use, where the decision is made to treat substance use disorders first, clinicians should be aware that PTSD symptoms may worsen due to acute substance withdrawal or loss of substance use as a coping mechanism. Treatment should include information on PTSD and strategies to deal with PTSD symptoms as the person controls their substance abuse.”
- In the context of comorbid PTSD and mild to moderate depression: (1) “health practitioners may consider treating the PTSD first, as the depression will often improve with treatment of the PTSD”, and (2) “Where the severity of comorbid depression precludes effective engagement in therapy and/or is associated with high risk suicidality, health practitioners are advised to manage the suicide risk and treat the depression prior to treating the PTSD.”

Three guidelines^{5, 7, 8} recommend that tailored, evidence-based treatment approaches be used for individual patients. These recommendations were all based on expert consensus.

One recent review by Roberts et al.¹² concluded that individual trauma-focused psychological therapy delivered alongside substance use disorder therapy was better than treatment as usual/minimal intervention in reducing PTSD severity post-treatment and at long-term follow-up, but only reduced substance use disorder at long-term follow-up. In this review Roberts et al.¹² assessed 13 studies that described four treatment approaches: (1) psychological therapies with a trauma-focused component, (2) psychological therapies with a non-trauma-focused intervention, (3) treatment as usual and (4) other active psychological therapies on PTSD and substance use disorder. These authors found that:

- “Individual-based trauma-focused psychological therapy that was delivered along with substance use disorder therapy was:
 - more effective than treatment as usual for treating PTSD at follow-up and long term (four studies; author rating: very low-quality evidence)
 - more effective than treatment as usual for treating substance use disorder at long term, but not effective at follow-up (four studies; author rating: very low-quality evidence).
- When provided alone, neither trauma-focused psychological therapy nor psychological therapy for substance use disorder improved PTSD or substance use disorder (one small study; author rating low-quality evidence).
- When provided for substance use disorder alone, neither non-trauma-focused psychological therapy nor psychological therapy for substance use disorder improved PTSD or substance use disorder outcomes.
- Non-trauma-focused psychological therapy compared with treatment as usual showed no improvement in PTSD and there were no relevant studies assessing outcomes for substance use disorder.”

A second review conducted by Ipser et al.¹³ assessed the effects of pharmacotherapy for treating anxiety in people with comorbid alcohol use disorders. The authors concluded that the evidence-base for the effectiveness of medication in treating anxiety disorders and comorbid alcohol use disorders is currently inconclusive. There was a small amount of evidence for the efficacy of medication, but this was limited and of very low quality. The majority of the data for the efficacy and tolerability of medication were for selective serotonin reuptake inhibitors; there were insufficient data to establish differences in treatment efficacy between medication classes or patient subgroups.

Issues considered when assessing the evidence

The evidence review did not reveal clear support for any intervention in a general practice setting to manage a mental health condition with comorbid substance misuse or addictive disorders.

Assessment and monitoring

The Guideline Development Group considered the consensus statements provided in existing high-quality guidelines and agreed to adopt the following statement from [Phoenix Australia guidelines](#)¹¹ into the present guideline: *“Mental health practitioners are advised to note the presence and severity of comorbidities in their assessments, with a view to considering their implications for treatment planning”.*

Treatment approaches

The following list of existing clinical guidelines can be used by GPs to develop a management approach for substance misuse and addictive disorders in the presence of comorbid mental health conditions such as posttraumatic stress disorder, depression and anxiety.

Substance misuse disorders:

- [Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence 2011, NICE](#)⁷
- [Smoking, Nutrition, Alcohol and Physical activity guidelines 2nd edition 2015, RACGP](#)¹⁴

Posttraumatic stress disorder and acute stress disorder:

- [Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder 2013, Phoenix Australia](#)¹¹
- [Expert guidelines: diagnosis and treatment of post-traumatic stress disorder in emergency service workers 2015, Harvey et al.](#)⁹

Depression:

- [Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders: major depression summary 2018](#)¹⁵
- [Depression in adults: recognition and management 2018, NICE](#)¹⁶

Anxiety disorders:

- [Prescribing drugs of dependence in general practice 2015, RACGP](#)¹⁷

Given the high quality of the Roberts et al.¹² review, and despite the low quality of the evidence, we are confident in recommending that individual-based trauma-focused psychological therapy, when delivered along with substance use disorder therapy, is more effective than usual treatment for work-related PTSD.

We considered two recommendations given by the [Phoenix Australia guidelines](#)¹¹ as follows:

- Recommendation 1: “in the context of PTSD and substance use, where the decision is made to treat substance use disorders first, clinicians should be aware that PTSD symptoms may worsen due to acute substance withdrawal or loss of substance use as a coping mechanism. Treatment should include information on PTSD and strategies to deal with PTSD symptoms as the person controls their substance abuse.” The Guideline Development Group (GDG) considered it important to also adopt this recommendation for the present guideline.
- Recommendation 2: “a person should demonstrate a capacity to manage distress without recourse to substance misuse and to attend sessions without being drug or alcohol affected”. The GDG considers that the advice to withhold drug or alcohol consumption before PTSD treatment “is unlikely to be achievable in practice, and may inadvertently cause harm to these patients” due to delayed treatment. This recommendation was not adopted into the present guideline.

We considered and adopted the recommendation given in existing guidelines that “an integrated approach should be used for people with comorbid mental health conditions and a substance use disorder”. An integrated approach refers to the consideration of mental health conditions and the contexts that are likely to influence their recovery. For instance, where PTSD and substance use are present, GPs can treat both conditions concurrently⁸. Where return to work programs are being utilised as part of the recovery plan, the GP should consider if this can occur concurrently with clinical treatment for the conditions⁸.

Additional points of consideration

When to refer?

- Where a GP feels unable to provide optimal care for the patient, they should refer the patient to a clinician with expertise in mental health.
- Where it is out of a GP's scope to provide the specified treatment approach, they can continue to provide direction over the treatment plan.
- Recovery at work should be considered as part of the patient's recovery, where a patient is able to work and it is safe to do so. GPs can gain support from a workplace rehabilitation provider or rehabilitation counsellor to assess the likely influence of work on facilitating recovery.

How will we know that the recommendations have been implemented?

There is documentation of:

- assessments that seek to note the presence and severity of comorbidities
- the use of clinical guidelines for substance misuse and addictive disorders;
- consideration given to using an integrated approach that addresses both work-related mental health conditions and comorbid substance use disorders
- consideration given to individual-based trauma-focussed psychological therapy delivered along with substance use disorder therapy for work-related PTSD.

Useful resources

Substance misuse disorders:

- Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence 2011, NICE⁷
- Smoking, Nutrition, Alcohol and Physical activity guidelines 2nd edition 2015, RACGP¹⁴

Posttraumatic stress disorder and acute stress disorder:

- Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder 2013, Phoenix Australia¹¹
- Expert guidelines: diagnosis and treatment of post-traumatic stress disorder in emergency service workers 2015, Harvey et al.⁹

Depression:

- Clinical practice guidelines for mood disorders: major depression summary 2018, RANZCP¹⁵
- Depression in adults: recognition and management 2018, NICE¹⁶

Anxiety disorders:

- Prescribing drugs of dependence in general practice 2015, RACGP¹⁷



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13

❯❯ Why isn't the patient's mental health condition improving as expected?

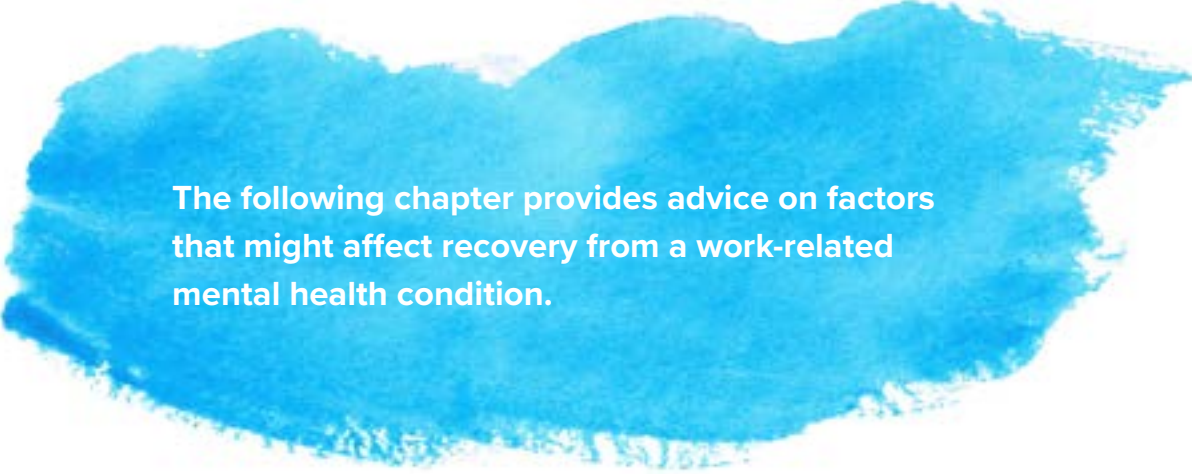
Why is this topic important?

As defined by the Australian Department of Health, patients with a mental health condition perceive recovery as “gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self”¹.

In patients with a work-related mental health condition, a number of factors can promote or delay patient recovery. These include medical factors, factors relating to health behaviour and attitudes, and employment and/or workplace factors. For example, there is strong evidence that a patient’s recovery expectation is a predictor of return to work, with positive recovery expectations associated with positive health outcomes. In turn, fear and pain avoidance can contribute to patients avoiding situations or environments (such as work) where they believe pain may be induced². Avoidance of the workplace where the injury occurred may further act as a barrier to recovery³.

It is evident that GPs play a central role in the management of work-related mental health conditions, monitoring a patient’s progress and recommending tailored strategies to combat delays in recovery⁴. As the primary certifier of sickness certificates, GPs are actively and regularly involved in a patient’s recovery journey: they might see a patient to provide updated sickness certificates, or manage other clinical conditions. These consultations with the patient should be used opportunistically by GPs to not only monitor the progress in the recovery process and provide advice regarding appropriate medical treatments needed for recovery⁴, but also to facilitate a coordinated return to work effort with the patient and other essential stakeholders.

In light of this, a literature search was undertaken to identify factors that GPs should consider when monitoring a patient’s progress and recovery, particularly when recovery is not progressing as expected.



The following chapter provides advice on factors that might affect recovery from a work-related mental health condition.

Summary of recommendations



Why isn't the patient's mental health condition improving as expected?

- 13.1 A GP should consider the following factors that might affect progress in a patient's condition.

Personal/patient factors

- Stressful life factors outside of work
- Patients aged > 40 years
[Strong recommendation FOR (high quality of evidence)]
- perceived injustice
[Consensus-based recommendation]
- poor adherence to recommended treatment.
[Consensus-based recommendation]

Health behaviours and attitudes

- Attitude towards return to work
- Reduced expectations by patients about being able to return to work

Employment/workplace factors

- Job/work stress
- Poor communication with supervisor/employer
- Harassment and bullying as a precursor to the mental health condition.

Medical factors

- Alcohol intake, smoking, drug dependence
- Persistent symptoms prior to going on sick leave
- Higher degree of severity of mental health conditions (distress, depression, anxiety and somatisation)
- Longer duration of symptoms and longer sick leave duration at baseline
- Extensive physical injury
- Chronic pain
- Overweight, underweight
- Quality of rehabilitation services

[Strong recommendation FOR (high quality of evidence)]



Evidence summary

One systematic review⁵ and 11 original studies^{6–16} were identified in the literature search. Of the eleven original studies, one was a prediction study that used the results from an RCT; the remaining ten were cross-sectional, case control or cohort studies.

The systematic literature review⁵ was conducted to identify factors that predict or restrict return to work for people suffering episodes of poor mental health, with a focus on long-term mental illness. This review concluded that there was little robust evidence about what factors carry the greatest risk for sickness absence. Since the time that this review was published, more studies have added to the literature regarding what factors influence delayed recovery. The body of currently available literature is described below.

Brouwers et al.⁹ utilised the data from an RCT that compared the effectiveness of an intervention by social workers with usual care by GPs in patients who were on sick leave due to a mental health condition. The intervention showed no effect, so the authors were able to combine treatment groups for the purpose

of this study. This study aimed to identify factors that predict return to work after three and six months for workers who were on sick leave due to mental health conditions. This study was conducted in the Netherlands. Data from 194 patients were used to identify factors associated with lower odds of returning to work.

In addition, patients' expectations about being able to return to work within six weeks of their sick leave predicted indeed a higher return to work rate three months later. Moreover, patients who had been in recent contact with the occupational physician had significantly lower chances of return to work three months after baseline.

The ten remaining studies^{6–8, 10–16} were conducted in a number of countries, including Norway, the Netherlands, Sweden and the USA; four studies were carried out in Australia^{8, 10, 13, 14}. These studies addressed factors that affect return to work outcomes in patients with anxiety, depression, PTSD, adjustment disorder and other unspecified mental health conditions.

Issues considered when assessing the evidence

The studies identified in the evidence review used a range of methods including two that involved the analyses of large databases^{6, 13}. Together, the body of evidence was assessed as having a high overall risk of bias due to the nature of the study designs. However, due to the large number of patients included in the studies (300,000 patients) and the consistency of findings, we rated this evidence as HIGH.

Several factors that are associated with adverse progress in a patient's condition were identified across these studies and have been included in the guideline:

- Employment/workplace: supervisor employer communication, harassment and bullying as precursors to mental health conditions; job/work stress
- Medical factors: higher degree of severity of mental health conditions (distress, depression, anxiety and somatisation), extensive physical injury, chronic

pain, quality of rehabilitation services, persistent symptoms prior to going on sick leave, prolonged or longer duration of sick leave (particularly where the period of leave is greater than three weeks)⁹

- Health behaviours: alcohol intake, smoking, drug dependence, overweight, underweight, attitude towards recovery
- Personal/patient factors: stressful life factors outside of work; older age (>40)

While the majority of the factors described in the literature are considered to be relevant to the Australian context, the Guideline Development Group did not feel confident in including the factor 'increased likelihood in certain employment sectors' as a factor for consideration by GPs when determining reasons for delayed recovery. This decision was based primarily on the notable absence of 'medical professionals' in the list of employment sectors with an increased likelihood

of work-related mental health conditions. This may be because the study that identified employment sectors investigated the health sector as a whole, rather than considering subsets of the health sector such as nurses, first responders and doctors individually⁶. Also, this study was undertaken in an international context, which may not reflect the Australian context. Indeed, high-risk employment sectors are likely to vary depending on the region, state of the economy and other factors.

Additional points of consideration

Perceived injustice and non-adherence to recommended treatment were not explicitly identified in the literature search but are important factors to consider in a patients' recovery and were therefore added as a consensus statement.

As a consistent and robust predictor of disability that perpetuates a wide range of mental health conditions, patient-perceived injustice is currently receiving high attention in clinical practice^{17–19}. Perceived injustice is understood in the context of the compensation claim process, as the injustice a patient may feel when:

- a claim is denied
- blaming occurs
- allegations are not vindicated
- they feel they have to prove that they are psychologically unwell
- they feel people do not believe them
- the source of the stress (i.e. supervisor, colleagues or nature of work) remains either unaddressed or unresolved^{20, 21}

When assessing ongoing job/work stress factors, the following workplace variables that have been identified by the Office of Industrial Relations, Workplace Health and Safety Queensland²² could be considered:

- unrealistic recovery expectation of the employer/supervisor
- excessive work demands
- role conflict

- low levels of decision making
- inadequate support from supervisors
- lack of role clarity
- poor organisational change management
- low recognition and reward
- poor organisational justice
- extreme environmental conditions
- remote and isolated work
- inappropriate and unreasonable behaviours
- traumatic events.

When to refer?

Collaboration with a workplace rehabilitation provider or rehabilitation counsellor can assist GPs in determining what work-related factors may be contributing to delayed recovery.

How will we know that the recommendations have been implemented?

There is documentation of utilisation of a checklist ([Appendix K](#)) that describes factors affecting progress.

Useful resources

- [Overview of work-related stress: Office of Industrial Relations – Workplace Health and Safety Queensland](#)²²
- [Implementation Guidelines for Non-Government Community Services: Principles of recovery oriented mental health practice. The Department of Health, 2010](#)¹

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14



What can a GP do for a patient whose mental health condition is not improving?

Why is this topic important?

Mental health conditions can take months or years to resolve, due to the complex biopsychosocial nature of these conditions. For instance, underlying biomedical factors can impact on the mental health condition itself. This can be further compounded by a patient's psychological response to the condition, including

knowledge about the condition and expectations for the recovery journey, or social factors such as cultural diversity, which can influence acceptability of treatment approaches and thus adherence to optimal treatment. In addition, continuing or new stressors may impede recovery.



These recommendations provide advice that can be utilised by GPs to improve personal recovery in patients with mental health conditions that are not improving.

Summary of recommendations



What can a GP do for a patient whose mental health condition is not improving?

- 14.1 On the available evidence, there is no clear support for an intervention in a general practice setting to improve personal recovery or return to work in patients with a work-related mental health condition who are not improving; therefore, there is an urgent need to promote research in this area.

[Recommendation for future research]

- 14.2 In patients with a persistent mental health condition that has arisen out of work, a GP should:
- investigate the existence of continuing work-related and non-work-related stressors that may contribute to delayed patient recovery and assist to address them
 - review the diagnosis and treatment plan to ensure that the patient is receiving optimal treatment, and
 - adopt a patient-centred collaborative care approach with relevant health professionals.

[Consensus-based recommendation]

- 14.3 Where no work-related or non-work-related stressors can be identified, and where persistent depression is present, a GP may consider the following evidence-based approaches to treat the persistent depression:
- collaborative care between relevant health professionals for patients with persistent depression
 - cognitive behavioural therapy as an adjunct to pharmacotherapy for patients with treatment-resistant depression.

[Weak recommendation FOR (high quality of evidence)]



Evidence summary

Management of persistent depression

The evidence review identified six original articles¹⁻⁶, which all addressed strategies that can improve symptoms of depression; however, only one addressed non-improvement in a work-related context³.

This study by Franche et al.³ used a prospective cohort design to estimate the association between depressive symptoms and return to work outcomes in workers with a work-related musculoskeletal injury. The authors concluded that persistent depression (more than six months) was related to under diagnosis and under treatment and the length of time off work due to injury. The authors concluded that resolution of depressive symptoms in workers with a musculoskeletal injury may be a reaction to the physical injury. They suggest that these patients may not require specialty mental health services and that supportive counselling by a health professional may be adequate.

The remaining five (non-work-related) studies included three RCTs^{1, 2, 6} and two cohort studies^{4, 5}. The RCTs identified a number of interventional strategies that were associated with increased prospects of patient recovery and satisfaction for treatment-resistant depression only.

Fortney et al.¹ investigated the effect of telemedicine-based collaborative care versus practice-based collaborative care on patient recovery and satisfaction in people with depression. The telemedicine-based approach included an on-site primary care provider and off-site depression care manager, pharmacist, psychologist and psychiatrist. The practice-based approach included only an on-site primary care provider and on-site depression care manager.

This trial found a significant improvement in patient recovery and remission with the telemedicine-based approach in the acute and follow up phase (up to 18 months). Patient satisfaction was also significantly higher with the telemedicine-based approach at six months; however no difference was found at 12 months. The Guideline Development Group considers that the telemedicine approach described in Fortney et al.¹ was used as a method for multidisciplinary teams to communicate and work collaboratively.

Wiles et al.⁶ investigated the effect of 12–18 sessions of CBT as an adjunct to pharmacotherapy versus treatment as usual alone (that comprises pharmacotherapy) for patients with treatment-resistant depression. This study found a significant improvement in patient recovery and remission with the CBT and pharmacotherapy approach. The study also reported a greater quality of life for patients in the intervention arm after 12 months.

Thompson et al.² investigated treatment compliance between two antidepressant medications in primary care. Compliance was assessed by using pill count, patient questionnaires, and the Medication Event Monitoring System. This study found a higher, but non-significant, rate of compliance with fluoxetine compared with dothiepin.

The two cohort studies^{4, 5} provided limited evidence that medication non-compliance and medico-psychological factors contribute to poorer recovery, and may be considered when formulating a treatment approach for non-recovery.

Issues considered when assessing the evidence

The quality of studies that investigated either collaborative care or CBT as an adjunct to pharmacotherapy were both of high quality. The Guideline Development Group therefore felt that it was important to develop a recommendation based on this evidence.

Wiles et al.⁶ investigated CBT as an adjunct to pharmacotherapy for treatment-resistant depression, where pharmacotherapy was usual treatment, and CBT was an adjunct to pharmacotherapy. To ensure consistency with the evidence, we advise GP to consider 'cognitive behavioural therapy as an adjunct to pharmacotherapy for patients with treatment-resistant depression'.

It should be noted, also, that the search strategy was restricted to compensable work only. Had the search been more generalised, we would expect significantly more evidence for strategies to manage treatment-resistant mental health conditions in general. Given the restricted search criteria, this recommendation is given a GRADE of Weak FOR, despite the two high-quality studies upon which it is based.



Additional points of consideration

Patient-centred, collaborative care

- For patients who are not recovering as expected, review the diagnosis and treatment plans to ensure that the patient is receiving optimal treatment that is in line with their own beliefs, values and attitudes, as well as the condition and their environment.
- Where a GP is not achieving success in managing a non-work-related stressor, they should refer the patient to a psychologist. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) further recommends that if symptoms do not improve within six months of a referral to a psychologist, the patient should be referred to a psychiatrist.⁷
- GPs should refer to the [RANZCP guideline, GPs and psychiatrists: best practice guidelines for referral and communication](#)⁷ for best practice approaches to clinical collaboration between GPs and psychiatrists.
- It is important to ensure that the patient's concerns, needs and desires are kept at the centre of any treatment plans. It is the GP's imperative, as the coordinator of the patient's care, to ensure that care is patient-centred.

Address ongoing and new stressors

- Consider the existence of factors described in [chapter 13](#) to identify any continuing stressors that may prevent recovery. These stressors may be work-related or non-work related (e.g. a physical condition that is not improving, grief or loss from not being able to return to work, or marital discord).
- Where a work-related stressor is identified, the GP should advocate to the workplace on behalf of the patient to help to manage the stressor.
- Case conferences are a useful method for discussing and addressing work-related stressors. We suggest that implementation of this consensus statement could be facilitated by providing training to GPs about advocating with a workplace on behalf of a patient.
- If a GP is not in a position to manage a work-related stressor (e.g. ongoing bullying), or if the patient does not consent for the GP to communicate with the workplace, the GP should, with the patient's consent, seek independent remediation to negotiate the changes that need to be made to ensure a safe return to work.

How will we know that the recommendations have been implemented?

There is documentation of:

- continuing work-related and non-work-related stressors
- a review of the diagnosis and treatment plan
- collaboration with other health professionals
- consideration of cognitive behavioural therapy as an adjunct to pharmacotherapy for patients with treatment-resistant depression.

Useful resource

Best practice referral, communication and shared care arrangements between psychiatrists, general practitioners and psychologists 2014, RANZCP⁷

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An abstract, layered landscape illustration in various shades of blue. The background features a range of mountains with a textured, almost crystalline appearance. In the foreground, there are rolling hills and what appears to be a body of water, all rendered with soft, blended edges. The overall effect is a sense of depth and tranquility.

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Future research

We have endeavoured to provide evidence-based advice to address the key clinical questions in the guideline; however, this was not possible for some questions where no reliable evidence was identified. Recommendations for the following key topics were built on consensus, and we strongly recommend that research efforts are directed towards addressing these.

Has the mental health condition arisen as a result of work?

Of the numerous tools identified in the literature only two had been assessed in the general practice setting, and these are not freely accessible. There is an urgent need to promote research towards creating or identifying a valid and reliable instrument that can be utilised by GPs to indicate the probability that a mental health condition has arisen out of work.

How can the condition be managed effectively to improve personal recovery or return to work?

There are few studies that have been undertaken in the general practice setting to address strategies for managing work-related mental health conditions. Two shortcomings of the evidence are (1) focus on return to work or duration of sick leave in the short to mid-term as a proxy outcome for recovery, rather than focusing on long-term patient recovery outcomes, and (2) existing systematic reviews analyse outcomes for mental health conditions together, without giving sufficient regard to the specific requirements of individual diagnoses (e.g. the management of a substance use disorder and depression are notably distinct).

Given that effective treatment approaches are necessary to improve patient outcomes following a work-related mental health condition, we strongly recommend that research that focuses on interventions to improve personal recovery and return to work are given a high priority. In particular, this research should identify management strategies for work-related mental health conditions that are feasible and acceptable for GPs to utilise, including special considerations for culturally relevant approaches, and practicability for GPs practicing in rural and remote Australia.

What strategies are effective at managing comorbid mental health conditions?

It is not uncommon for patients with mental health conditions such as depression, anxiety or posttraumatic stress disorder to exhibit symptoms of comorbid substance misuse or addictive disorders. At present no clear support exists for an intervention in a general practice setting to manage comorbid substance misuse and addictive disorders. As such, this area should be considered a priority for future research funding.

What can I do for a patient who is not improving?

There is no clear support for an intervention in a general practice setting to improve personal recovery or return to work for a patient with a work-related mental health condition who is not improving. Given that there is good evidence for collaborative approaches for mental health conditions, in general, future research should aim to optimise patient-centred collaborative care that involves key individuals who are able to influence recovery in patients with work-related mental health conditions.

Young people, culturally and linguistically diverse populations, and people living in rural and remote Australia

Of great importance, we note that there is an absence of high-quality research that focuses on outcomes for young people and culturally and geographically diverse populations who seek care for work-related mental health conditions in general practice. In particular, although our evidence review search strategies were broad, we did not identify any studies that focused on mental health conditions and work in the general practice setting for young people, Aboriginal and Torres Strait Islander populations, other culturally and linguistically diverse populations, or people living in rural and remote Australia. These groups should be given high priority for research within the aforementioned topic areas.

To support the research areas outlined here, funding bodies might consider specific calls for research that address these issues.



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Appendices

Appendix A Tasks involved in the development of the guideline

Timeline	Tasks of the Research team	Tasks of the GDG
Feb–Oct 2016	Formulate a plan for a scoping study. Draft the scope and the clinical questions. Undertake interviews and analyse data.	
Nov 2016	Constitute the Guideline Development Group (GDG).	
Dec 2016 to Feb 2017	<i>Cls, project manager and evidence reviewers:</i> Formulate search strategy and undertake round#1 searching of the evidence.	Meeting 1: Refine the guideline scope and key questions; agree to provisional timeline.
Feb–May 2017	<i>Cls, project manager and evidence reviewers:</i> Undertake round#2 searching of the evidence, review evidence and develop first draft of the guidelines.	Meeting 2: Review evidence and determine need for further searching.
Aug 2017		Meeting 3: Review evidence and first draft of the guideline and implementation plan.
Aug–Sep 2017	Amend the guidelines following the recommendations of the GDG.	
Nov–Dec 2017		Meeting 4: Ratify the draft guideline and implementation plan.
Jan 2018	Release draft guidelines for public consultation to key stakeholders. Distribute draft implementation plan for feedback.	
Feb–Mar 2018	Consolidate feedback from public consultation. Amend the guideline. Amend implementation plan to align with the amended guidelines.	
Apr 2018		Meeting 5: Review and amend the guideline following feedback from the public consultation.
Aug 2018	Submit draft guideline, implementation plan and other documentation to the NHMRC. Prepare dissemination material. NHMRC external scientific review. Independent AGREE II Assessment.	Meeting 6: Finalise the draft guideline and implementation plan for NHMRC approval.
Sep 2018	<i>Cls, project manager and Implementation subcommittee:</i> Prepare written responses to address issues by reviewers and NHMRC council members as requested by the NHMRC.	
Sep 2018	Prepare guideline for publication. Prepare dissemination material.	Provisional Meeting 7: Ratify responses prepared for NHMRC reviewers and/or NHMRC council members.
Oct 2018	Submit guideline for NHMRC approval.	
Nov–Feb 2019	Disseminate guideline and relevant material.	Disseminate guideline and relevant material.
Feb 2019	Obtain RACGP and ACRRM endorsement	

Appendix B Declarations of Interest Form

Clinical guideline for the diagnosis and management of work-related mental health conditions

Disclosure of interests for Guideline Development Group members

The assistance of distinguished authorities knowledgeable in a variety of medical and scientific professions is essential to the solution of international health issues. **It is expected that persons qualified to serve as an expert for the committee may have private interests related to the subject of their expertise. At the same time, it is imperative that situations be avoided in which such interests may unduly affect, or may be perceived to affect, an expert's impartiality or the outcome of work in which he/she was involved.**

To assure the highest integrity, and hence public confidence, in this guideline, all experts serving in an advisory role must disclose any circumstances which could give rise to a potential conflict of interest (i.e., any interest which may affect, or may reasonably be perceived to affect, the expert's objectivity and independence). Accordingly, in this Disclosure of Interest (DOI) form, you are requested to disclose any financial, professional or other interest relevant to the subject of the work or meeting in which you will be involved **and** any interest that could be significantly affected by the outcome of the meeting or work. You are also asked to declare relevant interests of others who may, or may be perceived to, unduly influence your judgment, such as immediate family members, employers, close professional associates or any others with whom you have a substantial common personal, financial or professional interest.

Kindly complete this form and submit it to the Project Manager, in advance of the meeting or work. You are also asked to inform the Project Manager of any change as to this information that occurs during the course of the meeting or work. If the Project team considers that a potential conflict of interest exists, one of several outcomes can occur, depending on the circumstances involved: (i) you may be invited to continue to participate in the meeting or work, provided that your interest would be publicly disclosed; (ii) you may be asked not to take part in the portion of the meeting, discussion or work related to your interest, or not participate in related decisions; or (iii) you may be asked not to take part in the meeting or work altogether. Non-completion of the DOI form would preclude further consideration of an expert's participation.

Experts are requested to agree that any relevant conflicts may be **publicly disclosed** to other meeting participants and in the resulting report or other work product. The Project Manager will assume that you consent to such a disclosure, unless you check "no" in the space provided on the last page of this form. The information disclosed by you **may later be made available** if the objectivity of the work or meeting in which you are involved is questioned.

Name:

Institution:

Email:

Please answer each of the questions below. If the answer to any of the questions is "yes", briefly describe the circumstances on the last page of the form.

The term **"you"** refers to yourself, your employer and your immediate family members (i.e., spouse (or partner with whom you have a similar close personal relationship) and your minor children). **"Commercial entity"** includes – aside from any commercial business – an industry association, research institution or other enterprise whose funding is significantly derived from commercial sources having an interest related to the subject of the meeting or work. **"Organisation"** includes a governmental, international or non-profit organisation. **"Meeting"** includes a series or cycle of meetings.

Employment and consulting

Within the past 3 years, have you received remuneration from a commercial entity or other organisation with an interest related to the subject of the meeting or work?

Please also report any application or negotiation for future work.

- | | | |
|--|------------------------------|-----------------------------|
| 1a. Employment | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 1b. Consulting, including service as a technical or other advisor | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Research support

Within the past 3 years, have you or your department or research unit received support or funding from a commercial entity or other organisation with an interest related to the subject of the meeting or work?

Please also report any application or award for future research support.

- | | | |
|---|------------------------------|-----------------------------|
| 2a. Research support, including grants, collaborations, sponsorships, and other funding | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2b. Non-monetary support (include equipment, facilities, research assistants, paid travel to meetings, etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Investment interests

Do you have current involvement in a commercial entity with an interest related to the subject of the meeting or work? Please also include indirect investments such as a trust or holding company. You may exclude mutual funds, pension funds or similar investments that are broadly diversified.

- | | | |
|--|------------------------------|-----------------------------|
| 3a. Stocks, bonds, stock options, other securities (e.g., short sales) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3b. Commercial business interests (e.g., proprietorships, partnerships, joint ventures) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Intellectual property

Do you have any current intellectual property rights that might be enhanced or diminished by the outcome of the meeting or work?

- | | | |
|---|------------------------------|-----------------------------|
| 4a. Patents, trademarks, or copyrights (also include pending applications) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4b. Proprietary know-how in a substance, technology or process | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Public statements and positions

(during the past 3 years)

- | | | |
|--|------------------------------|-----------------------------|
| 5a. As part of a regulatory, legislative or judicial process, have you provided an expert opinion or testimony, related to the subject of the meeting or work, for a commercial entity or other organisation? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5b. Have you held an office or other position, paid or unpaid, where you may be expected to represent interests or defend a position related to the subject of the meeting or work? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Additional information

- 6a.

If not already disclosed above, have you worked for the competitor of a product which is the subject of the meeting or work, or will your participation in the meeting or work enable you to obtain access to a competitor’s confidential proprietary information, or create for you a financial or commercial competitive advantage?

Yes☐

No☐
- 6b.

To your knowledge, would the outcome of the meeting or work benefit or adversely affect interests of others with whom you have substantial common personal, financial or professional interests (such as your adult children or siblings, close professional colleagues, administrative unit or department)?

Yes☐

No☐
- 6c.

Is there any other aspect of your background or present circumstances not addressed above that might be perceived as affecting your objectivity or independence?

Yes☐

No☐

Tobacco or tobacco products

(answer without regard to relevancy to the subject of the meeting or work)

7.

Within the past 3 years, have you had employment or received research support or other funding from the tobacco industry or had any other professional relationship with an entity, directly involved in the production, manufacture, distribution or sale of tobacco or tobacco products or representing the interests of any such entity?

Yes☐

No☐

Explanation of “yes” responses

If the answer to any of the above questions is “yes”, check above and briefly describe the circumstances on this page. If you do not provide the amount or value of the interest where requested, it will be assumed to be significant.

Nos. 1–4: 7

Type of interest, question number and category (e.g. Intellectual Property 4a copyrights) and basic descriptive details	Name of company, organisation, or institution	Belongs to you, a family member, employer, research unit or other?	Amount of income or value of interest (if not disclosed, is assumed to be significant)	Current interest (or year ceased)

Nos. 5–6

Describe the subject, specific circumstances, parties involved, time frame and other relevant details.

Consent to disclosure

The Project team will assume that you consent to the disclosure of any relevant conflicts to other meeting participants and in the resulting report or work product, unless you check 'no' in the space provided here. If you check 'no', the Project team will not disclose the information without your prior approval, although this may result in your not being able to participate in the meeting or conference.

Yes ☐ No ☐

Declaration

I hereby declare on my honour that the disclosed information is true and complete to the best of my knowledge.

Should there be any change to the above information due to the fact that I acquire additional interests, I will notify the Chair of the Guideline Development Group and complete a new declaration of interests detailing the changes. This includes any change which occurs before or during the meeting or work itself and through the period up to the publication of the final results.

Signature:	Date:
-------------------	--------------

Appendix C Patient Health Questionnaire-9 (PHQ-9)

Over the previous 2 weeks, how often have you been bothered by any of the following problems?

(Use “✓” to indicate your answer)

	Not at all	Several days	More than half of the two week period	Nearly every day
1. Little pleasure or little interest in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Having little energy or feeling tired	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling negative about yourself or that you are a failure or have let your self or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or talking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding _____ + _____ + _____ + _____

= Total Score: _____

If you ticked off any of the problems above, how difficult has it been for you to do your work, take care of things at home or get along with other people because of these problems?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Source: http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ9_English%20for%20Australia_0.pdf

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Appendix D Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last two weeks, how often have you been bothered by the following problems?

(Use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Having trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

For office coding _____ + _____ + _____ + _____

= Total Score: _____

Developed by Drs. Robert L. Spitzer, Jane B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.

Source: http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/GAD7_English%20for%20Australia.pdf

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Appendix E Depression Anxiety Stress Scales (DASS)

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all**
- 1 Applied to me to some degree, or some of the time**
- 2 Applied to me to a considerable degree, or a good part of time**
- 3 Applied to me very much, or most of the time**

1. I found myself getting upset by quite trivial things	0	1	2	3
2. I was aware of dryness of my mouth	0	1	2	3
3. I couldn't seem to experience any positive feeling at all	0	1	2	3
4. I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5. I just couldn't seem to get going	0	1	2	3
6. I tended to over-react to situations	0	1	2	3
7. I had a feeling of shakiness (e.g. legs going to give way)	0	1	2	3
8. I found it difficult to relax	0	1	2	3
9. I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10. I felt that I had nothing to look forward to	0	1	2	3
11. I found myself getting upset rather easily	0	1	2	3
12. I felt that I was using a lot of nervous energy	0	1	2	3
13. I felt sad and depressed	0	1	2	3
14. I found myself getting impatient when I was delayed in any way (e.g. lifts, traffic lights, being kept waiting)	0	1	2	3
15. I had a feeling of faintness	0	1	2	3
16. I felt that I had lost interest in just about everything	0	1	2	3
17. I felt I wasn't worth much as a person	0	1	2	3
18. I felt that I was rather touchy	0	1	2	3
19. I perspired noticeably (e.g. hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20. I felt scared without any good reason	0	1	2	3
21. I felt that life wasn't worthwhile	0	1	2	3

Source: <http://www2.psy.unsw.edu.au/dass/download.htm>

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Appendix F Posttraumatic Stress Disorder CheckList – Civilian version (PCL-C)

Instruction to patient: Below is a list of problems and complaints that civilians sometimes have in response to stressful life experiences. Please read each one carefully, put an 'X' in the box to indicate how much you have been bothered by that problem in the last month.

Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Repeated, disturbing dreams of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling very upset when something reminded you of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Avoid activities or situations because they remind you of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Trouble remembering important parts of a stressful experience from the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Loss of interest in things that you used to enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Feeling distant or cut off from other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling as if your future will somehow be cut short?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Trouble falling or staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Feeling irritable or having angry outbursts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Having difficulty concentrating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Being "super alert" or watchful on guard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Feeling jumpy or easily startled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD – Behavioral Science Division.

Source: https://www.mirecc.va.gov/docs/vsn6/3_PTSD_CheckList_and_Scoring.pdf

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Appendix G Alcohol Use Disorders Identification Test (AUDIT) Questionnaire

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?	<input type="radio"/> Never	<input type="radio"/> Monthly or less	<input type="radio"/> 2–4 times a month
	<input type="radio"/> 2–3 times a week	<input type="radio"/> 4 or more times a week	
2. How many standard drinks containing alcohol do you have on a typical day when drinking?	<input type="radio"/> 1 or 2	<input type="radio"/> 3 or 4	<input type="radio"/> 5 or 6
	<input type="radio"/> 7 to 9	<input type="radio"/> 10 or more	
3. How often do you have six or more drinks on one occasion?	<input type="radio"/> Never	<input type="radio"/> Less than monthly	<input type="radio"/> Monthly
	<input type="radio"/> Weekly	<input type="radio"/> Daily or almost daily	
4. During the past year, how often have you found that you were not able to stop drinking once you had started?	<input type="radio"/> Never	<input type="radio"/> Less than monthly	<input type="radio"/> Monthly
	<input type="radio"/> Weekly	<input type="radio"/> Daily or almost daily	
5. During the past year, how often have you failed to do what was normally expected of you because of drinking?	<input type="radio"/> Never	<input type="radio"/> Less than monthly	<input type="radio"/> Monthly
	<input type="radio"/> Weekly	<input type="radio"/> Daily or almost daily	
6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?	<input type="radio"/> Never	<input type="radio"/> Less than monthly	<input type="radio"/> Monthly
	<input type="radio"/> Weekly	<input type="radio"/> Daily or almost daily	
7. During the past year, how often have you had a feeling of guilt or remorse after drinking?	<input type="radio"/> Never	<input type="radio"/> Less than monthly	<input type="radio"/> Monthly
	<input type="radio"/> Weekly	<input type="radio"/> Daily or almost daily	
8. During the past year, how often have you been unable to remember what happened the night before because you had been drinking?	<input type="radio"/> Never	<input type="radio"/> Less than monthly	<input type="radio"/> Monthly
	<input type="radio"/> Weekly	<input type="radio"/> Daily or almost daily	
9. Have you or someone else been injured as a result of your drinking?	<input type="radio"/> No	<input type="radio"/> Yes, but not in the past year	<input type="radio"/> Yes, during the past year
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	<input type="radio"/> No	<input type="radio"/> Yes, but not in the past year	<input type="radio"/> Yes, during the past year

Scoring the AUDIT:

Scores for each question range from 0 to 4, with the first response for each question (e.g. never) scoring 0, the second (e.g. less than monthly) scoring 1, the third (e.g. monthly) scoring 2, the fourth (e.g. weekly) scoring 3, and the last response (e.g. Daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from top to bottom).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

Saunders JB, Aasland OG, Babor TF, de la Fuente JR, Grant M. Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption – II. *Addiction*. 1993 88(6):791-804.

Source: http://auditscreen.org/~auditscreen/cmsb/uploads/audit-english-version-new_001.pdf

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Appendix H Severity of Alcohol Dependence Questionnaire (SADQ)

Please recall a typical period of heavy drinking in the past 6 months.

When was this? Month:	Year:
-----------------------	-------

Please answer all the following questions about your drinking by circling your most appropriate response.

During that period of heavy drinking:

1. The day after drinking alcohol, I woke up feeling sweaty.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
2. The day after drinking alcohol, my hands shook first thing in the morning.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
4. The day after drinking alcohol, I woke up absolutely drenched in sweat.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
5. The day after drinking alcohol, I dread waking up in the morning.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
7. The day after drinking alcohol, I felt at the edge of despair when I awoke.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
8. The day after drinking alcohol, I felt very frightened when I awoke.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
13. I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 8 units of beer).	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
14. I drank more than half a bottle of spirits per day (OR 1.5 bottles of wine OR 15 units of beer).	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
15. I drank more than one bottle of spirits per day (OR 3 bottles of wine OR 30 units of beer).	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always
16. I drank more than two bottles of spirits per day (OR 6 bottles of wine OR 60 units of beer)	<input type="radio"/> Almost never	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Nearly always

Imagine the following situation:

You have been completely off drink for a few weeks.

You then drink very heavily for two days.

How would you feel the morning after those two days of drinking?

17. I would start to sweat.	<input type="radio"/> Not at all	<input type="radio"/> Slightly	<input type="radio"/> Moderately	<input type="radio"/> Quite a lot
18. My hands would shake.	<input type="radio"/> Not at all	<input type="radio"/> Slightly	<input type="radio"/> Moderately	<input type="radio"/> Quite a lot
19. My body would shake.	<input type="radio"/> Not at all	<input type="radio"/> Slightly	<input type="radio"/> Moderately	<input type="radio"/> Quite a lot
20. I would be craving for a drink.	<input type="radio"/> Not at all	<input type="radio"/> Slightly	<input type="radio"/> Moderately	<input type="radio"/> Quite a lot

Score: _____

Checked by: _____

Alcohol detox prescribed: Yes / No

Scoring

Answers to each question are rated on a four-point scale:

- Almost never – 0**
- Sometimes – 1**
- Often – 2**
- Nearly always – 3**

Stockwell T, Murphy, D, Hodgson R. The severity of alcohol dependence questionnaire: Its use, reliability and validity. Br J Addict. 1983;78(2):145-55.
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Appendix I Leeds Dependence Questionnaire (LDQ)

Here are some questions about the importance of alcohol or other drugs in your life. Think about the main substance you have been using over the **past 4 weeks** and tick the closest answer to how you see yourself.

	Never 0	Sometimes 1	Often 2	Nearly always 3
Do you find yourself thinking about when you will next be able to have another drink or take more drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is drinking or taking drugs more important than anything else you might do during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that your need for drink or drugs is too strong to control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you plan your days around getting and taking drink or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink or take drugs in a particular way in order to increase the effect it gives you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink or take drugs morning, afternoon and evening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you have to carry on drinking or taking drugs once you have started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is getting an effect more important than the particular drink or drug you use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you want to take more drink or drugs when the effects start to wear off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it difficult to cope with life without drink or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Raistrick D, Bradshaw J, Tober G, Weiner J, Allison J, Healey C. Development of the Leeds Dependence Questionnaire (LDQ): a questionnaire to measure alcohol and opiate dependence in the context of a treatment evaluation package. *Addiction*. 1994;89(5):563-72.

Source: <http://www.emcdda.europa.eu/html.cfm/index3528EN.html>

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Appendix J What should a GP consider when conveying a diagnosis of a mental health condition to the patient? Checklist of factors for consideration by a GP

Patient name:		Date:
---------------	--	-------

Item	Check if completed	Comments
Provide the patient with information about the nature of the mental health condition, recovery expectations and treatment choices		
Provide the patient with educational material in a format that they can understand		
Consider patient concerns such as the potential for stigma or discrimination, loss of employment, isolation and financial insecurity		
Discuss confidentiality with the patient		

Additional notes:

Completed by: _____

Appendix K Why isn't the patient's mental health condition improving as expected? Checklist of factors for consideration by a GP

Patient name:	Date:
---------------	-------

GPs should consider the following factors that might affect progress in a patient's condition

Item	Check if completed	Comments
Medical factors		
• Alcohol intake, smoking, drug dependence		
• Persistent symptoms prior to going on sick leave		
• Higher degree of severity of mental health conditions (distress, depression, anxiety and somatisation)		
• Longer duration of symptoms and longer sick leave duration at baseline		
• Extensive physical injury		
• Chronic pain		
• Overweight, underweight		
• Quality of rehabilitation services		
Personal/patient factors		
• Stressful life factors outside of work		
• Patients aged >40 years		
• Perceived injustice		
• Poor adherence to recommended treatment		

Item	Check if completed	Comments
Health behaviours and attitudes		
• Attitude towards return to work		
• Reduced expectations by patients about being able to return to work;		
Employment/workplace factors		
• Job/work stress		
• Poor communication with supervisor/ employer		
• Harassment and bullying as a precursor to the mental health condition		

Additional notes:

Completed by: _____

