An integrated approach to returning to work with mental illness

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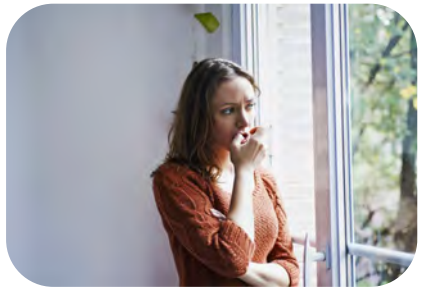
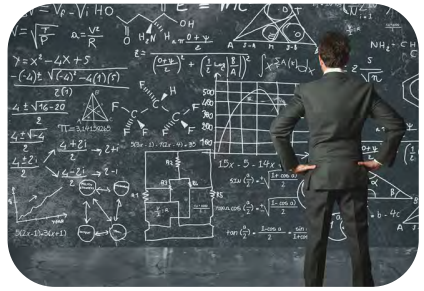
Outline

Mental illness in the workplace



Mary – case study

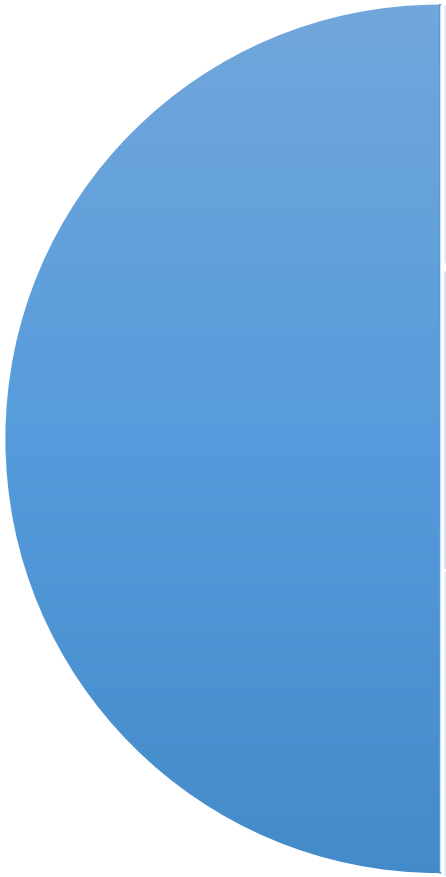


Some occupational psychiatry

Best practice treatment and return to work

Secondary psychological conditions

Mental health in Australian workplaces



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

**Source: Black Dog Institute*

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

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

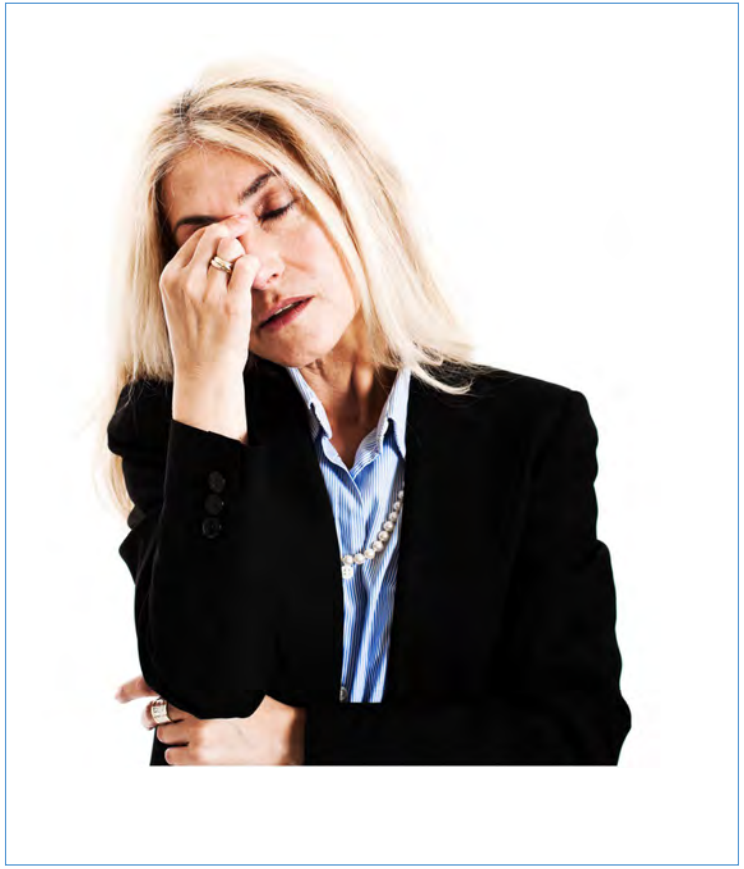
Common work-related distress triggers

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

Mental illness presentations in the workplace

Decline in performance	Excessive emotional reactions	Change in presentation	Disengagement and avoidance behaviours	Increased use of psychoactive substances
• Quality of work • Efficiency • Prioritisation	• Irritable • Upset • Tearful • Panicky	• Reduced self-care • Change in demeanor	• Unscheduled absences • Late attendance • Avoidance of tasks • Withdrawal from activities	• Caffeine • Cigarettes • Alcohol • Other drugs

A case study - Mary



Mary

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

14 years in the job, usually loves her role

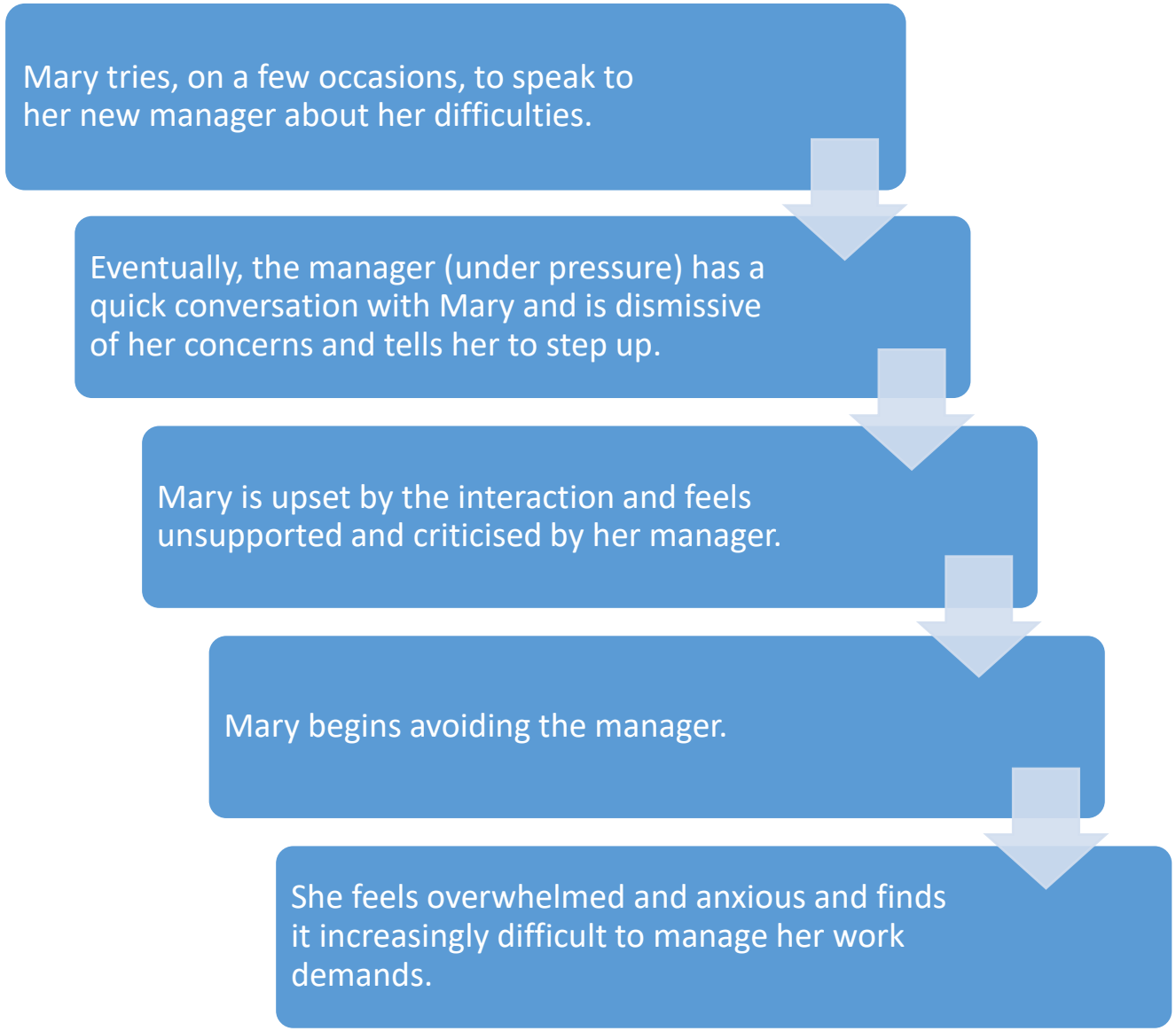
Chronically ill mother and recent relationship breakdown

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

New computer system that she is finding hard to use

New manager

Mary – the first conversation



Mary's symptoms

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

Mary’s presentation at work

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

One month later ….

The workplace perspective

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

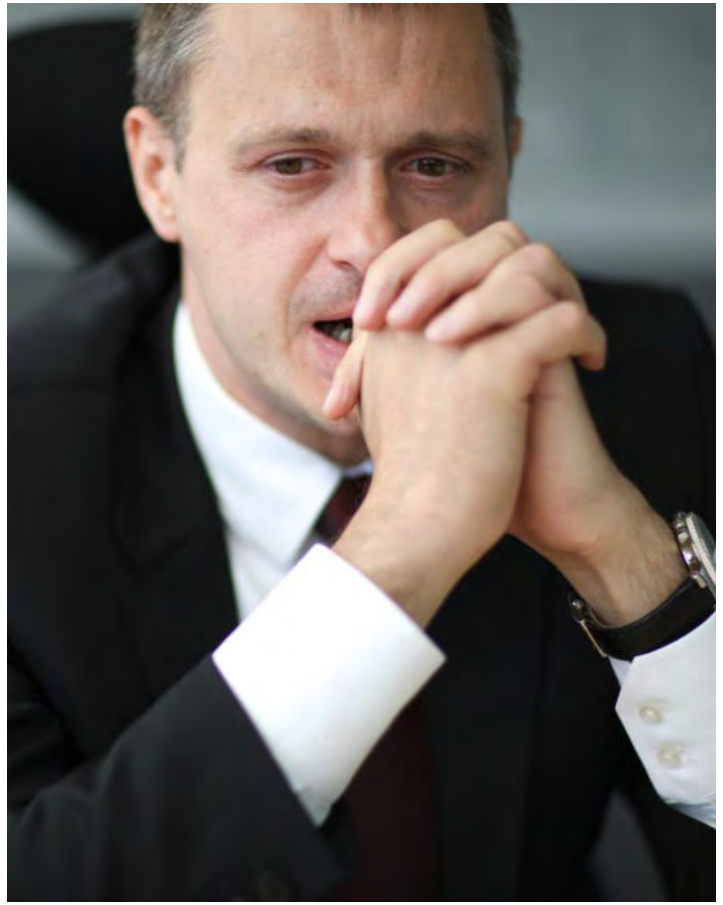
Manager notices that she is taking longer to complete tasks and she misses deadlines.

Manager expresses concern about her work performance.

The manager declines Mary's WFH request.

Mary's absences increase.

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



Mary’s perspective

Mary feels micro-managed.

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

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

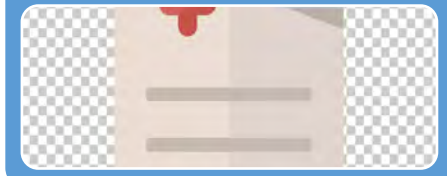
Mary starts to feel excluded from new projects.

She is resentful that her WFH is not approved.

She finds it harder to get to work.

What happens next?

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



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

C. Mary friend requests her manager on Facebook.

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

E. Mary is referred to a psychologist under a MHCP.

Mary – another month later

No contact from workplace - Mary feels discarded.

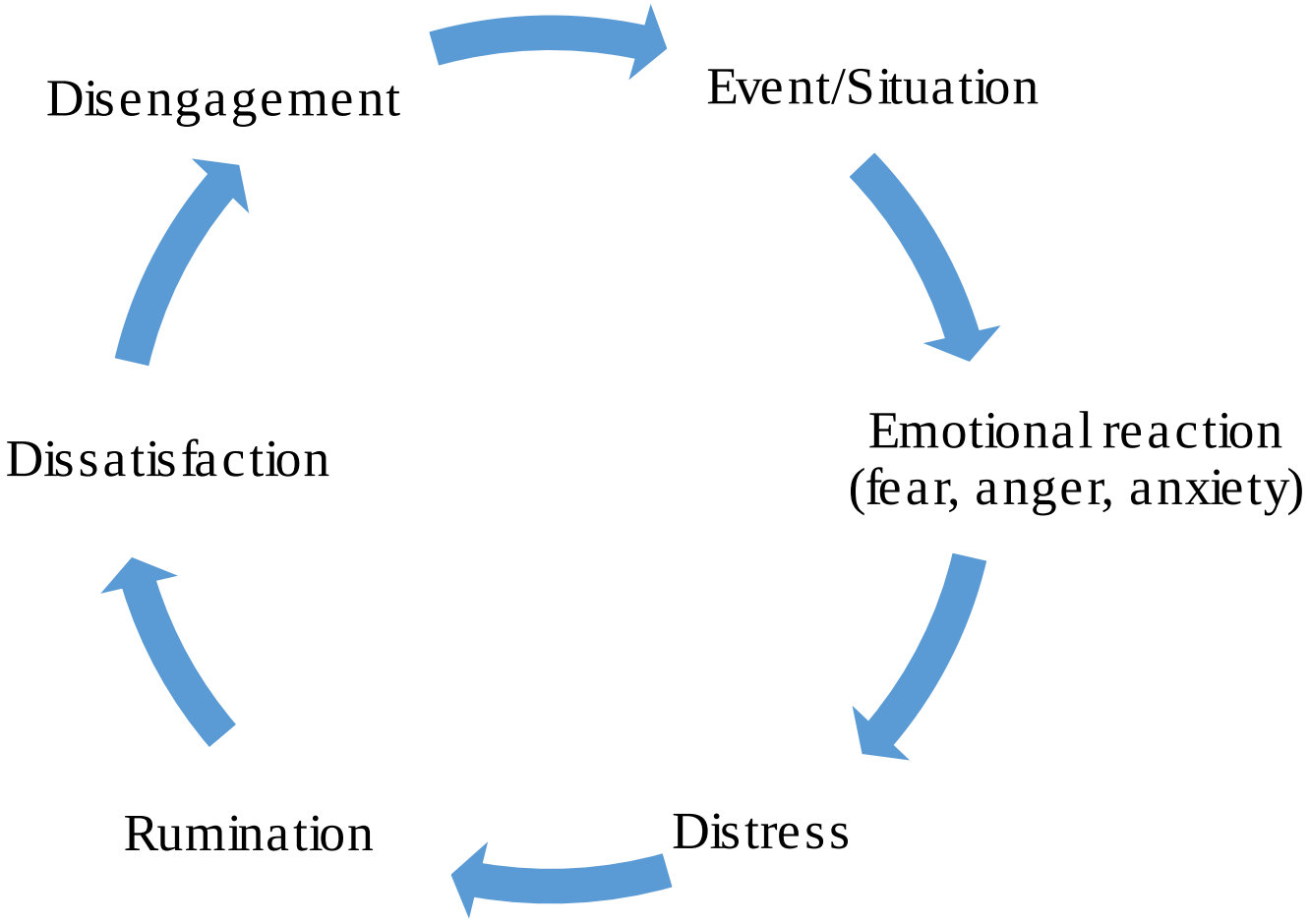
Spending time mostly at home.

Ruminating, lacking meaning and purpose.

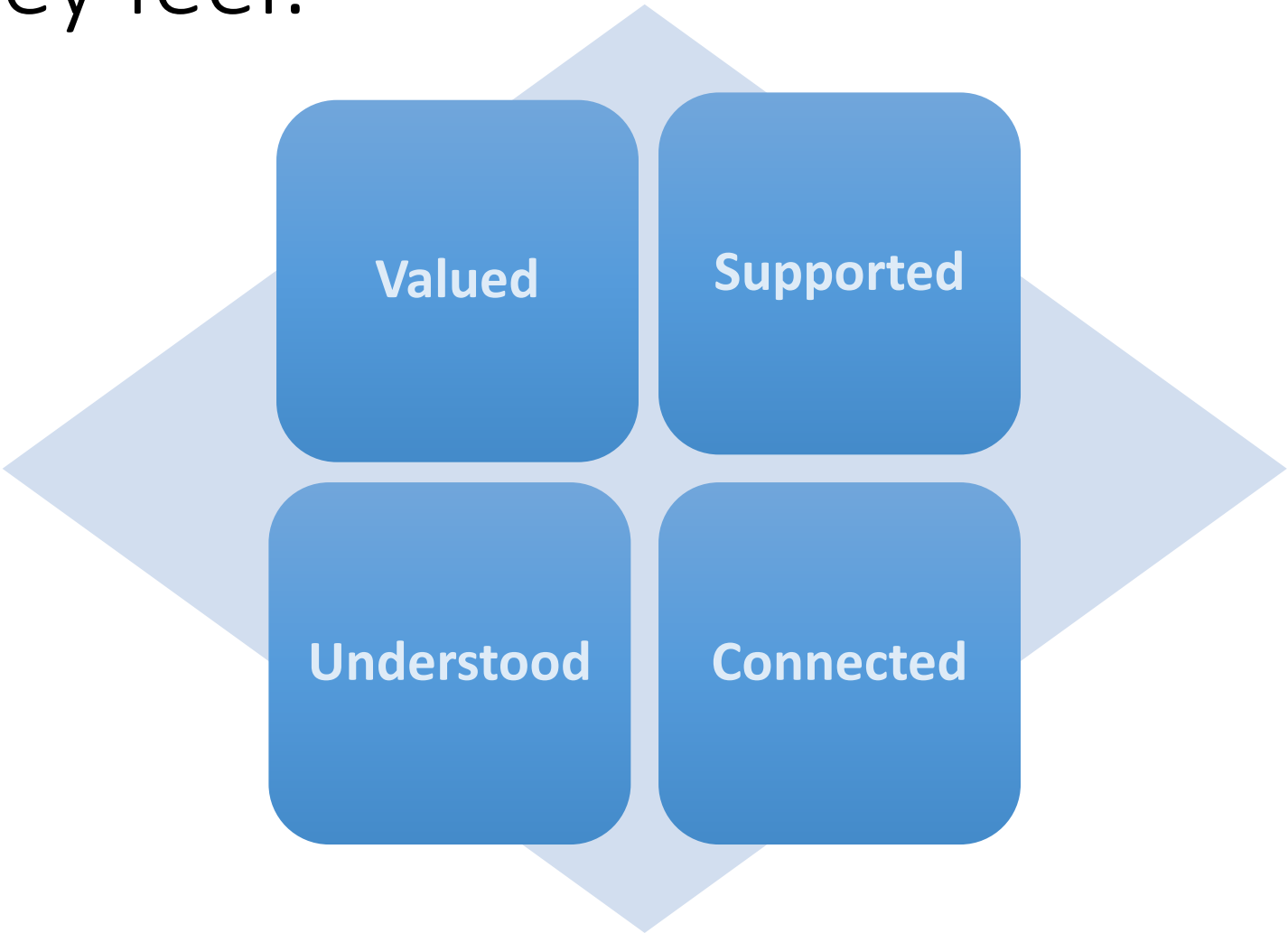
Increasing self-medication with alcohol.

Two sessions with a Psychologist.

The distress cycle



Most people can handle work stressors when they feel:



Mary – on sick leave

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

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

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

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

Mary – the claim process

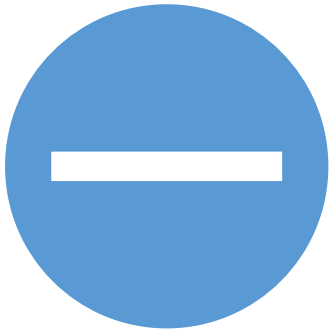
An investigation and IME are organised via the insurer.
The employer submits a reasonable management action defense.

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

Mary feels aggrieved that she was put through these processes.

Do you think Mary’s claim is accepted?

Yes



No

Mary – what happens next

Mary’s claim is accepted.

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

Mary’s Psychologist expresses concern that the relationship with the employer has broken down. “Removal” from the “toxic” workplace is recommended.
Mary is certified unfit for work by the GP for a month and recommends no contact with the employer.

Which of the following work-related factors are most likely to contribute to Mary lodging a claim?

A. Work stressors not acknowledged by management.

B. Manager's tone and style.

C. Mary's WFH request being declined.

D. Mary's work colleagues not sharing their morning tea with her.

As a treating health professional, which of the following would have been helpful for the management of Mary?

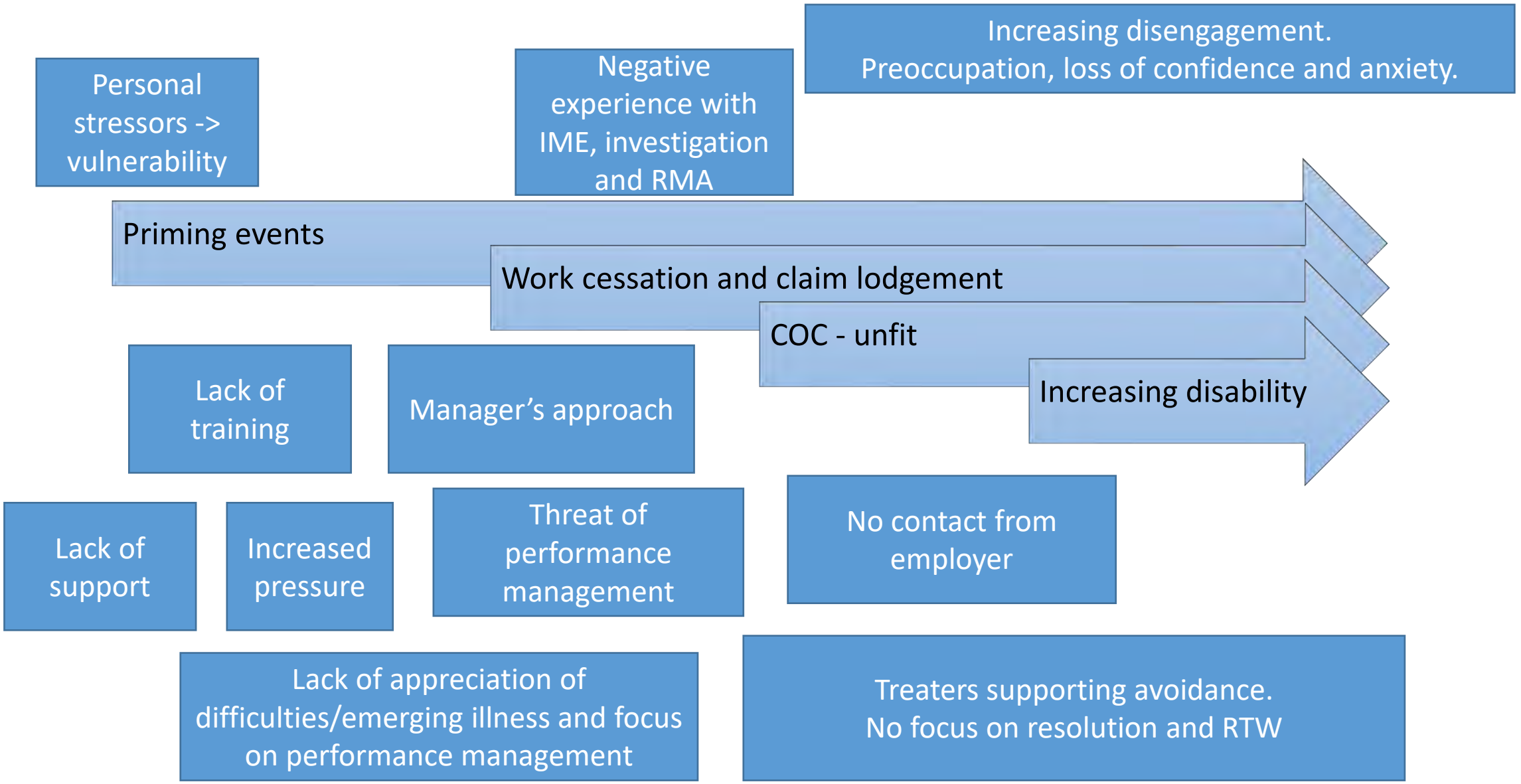
A. Write a medical certificate with two months' off work.

B. With Mary's permission, contacting her employer to discuss her situation.

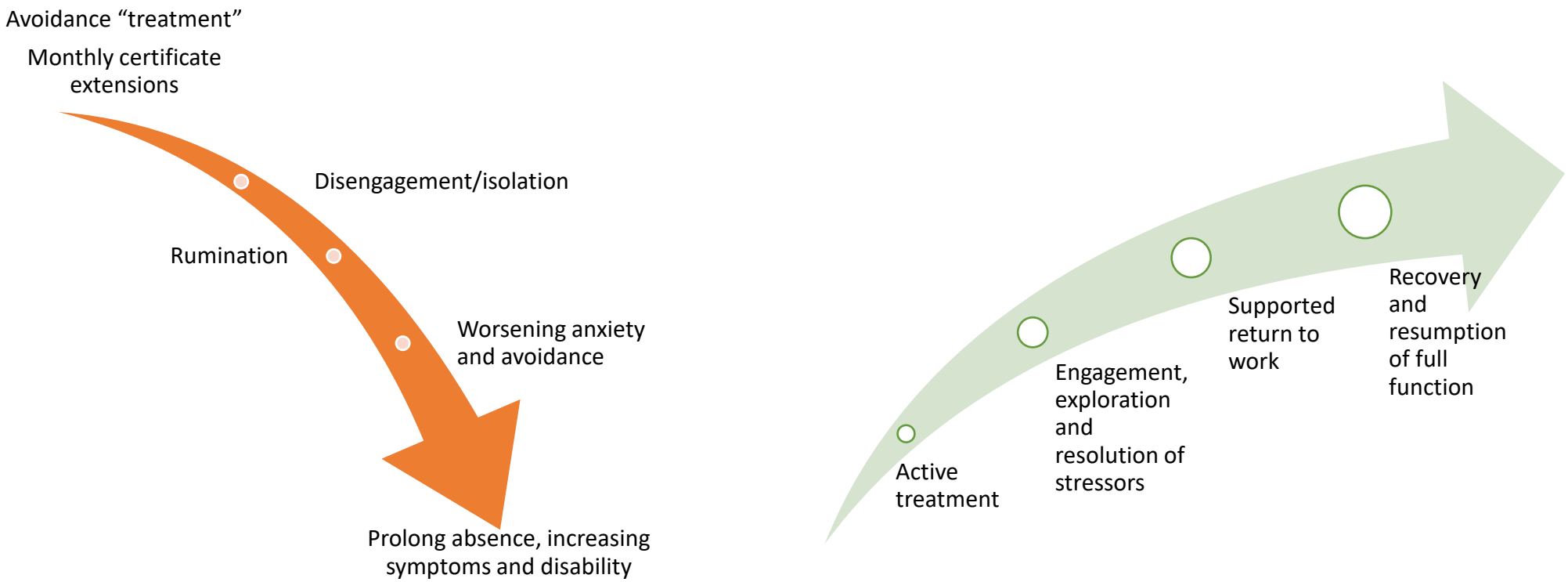
C. Advise Mary not to have coffee with a work colleague.

D. Advise Mary not to return the insurance agent or employer's calls because she finds contact distressing.

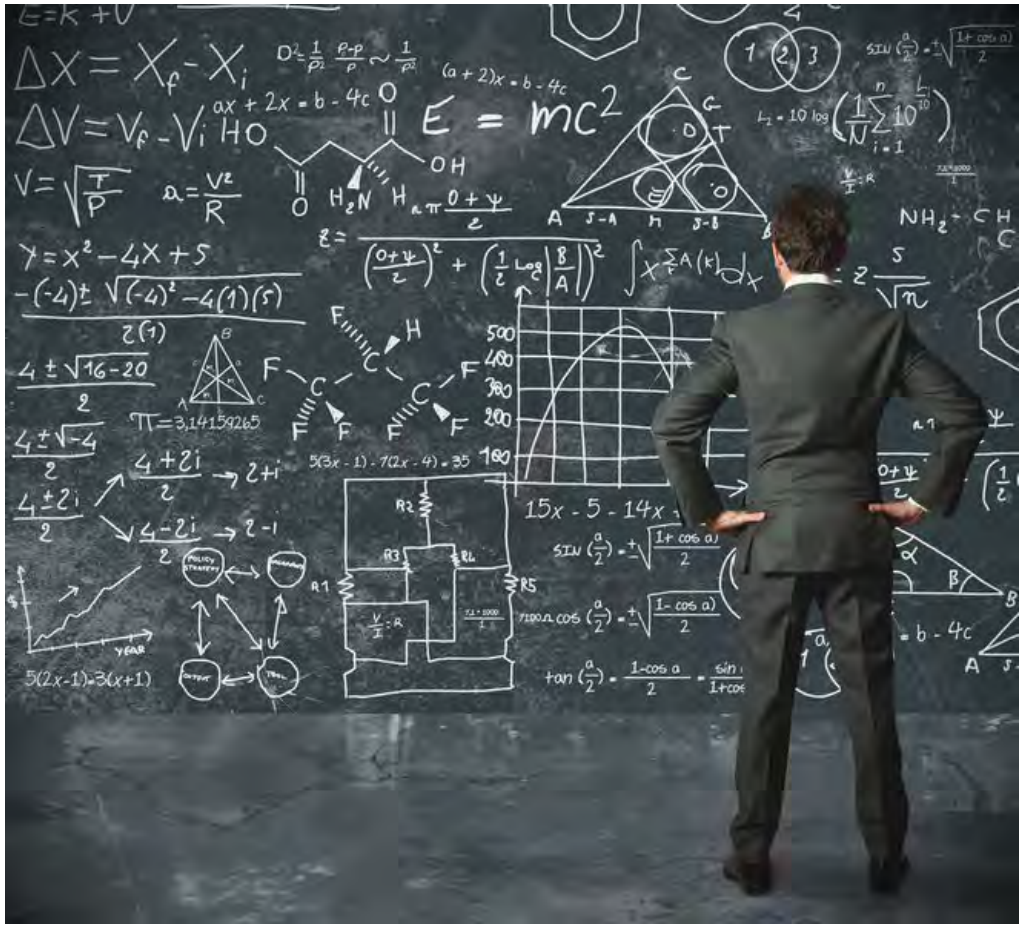
Mary – points of inflection



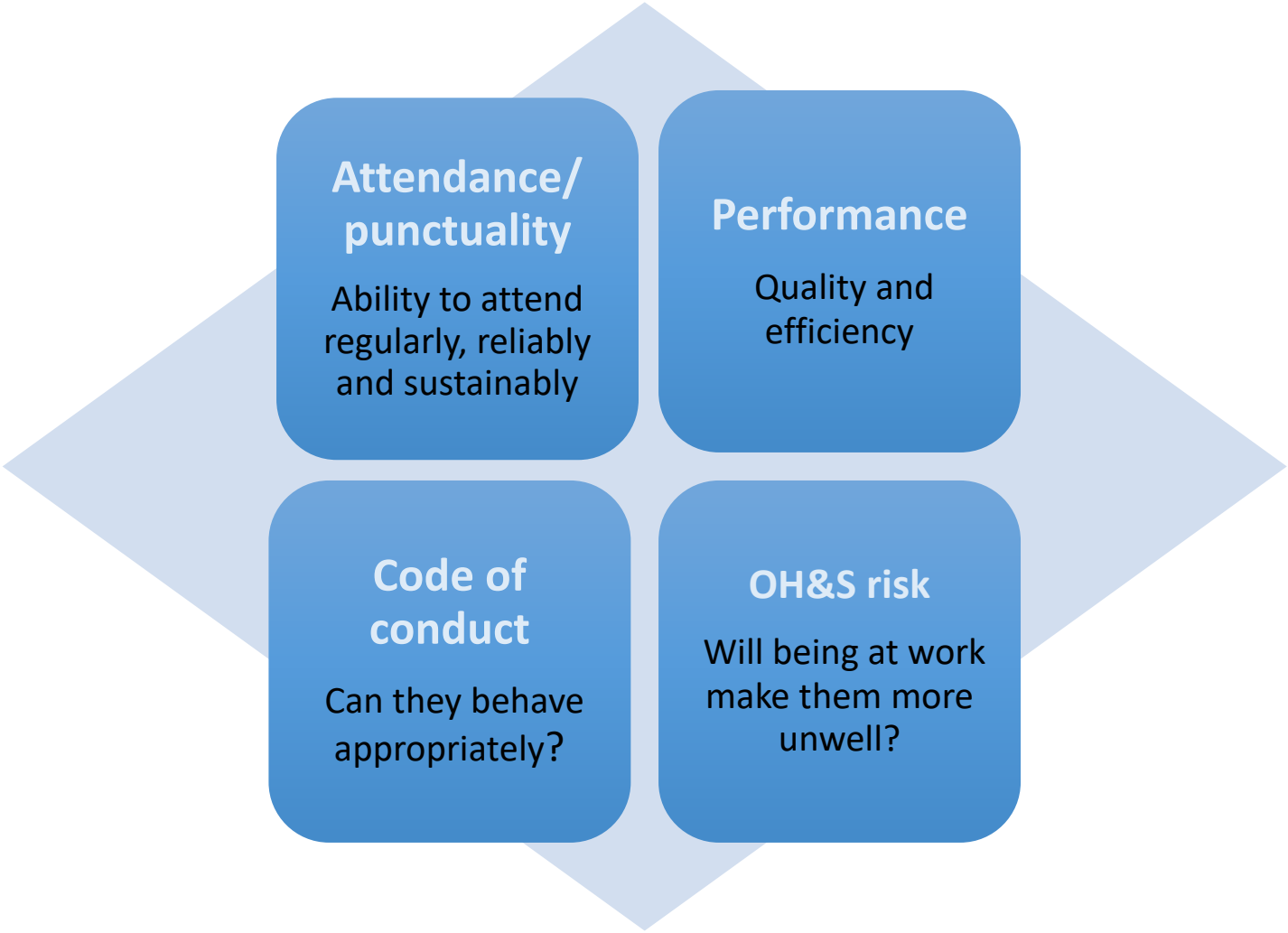
Mary – where to from here?



Occupational psychiatry - some theory



Assessing capacity for work

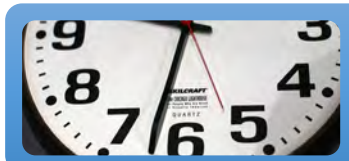


Functional assessment

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

Reasonable adjustments

Duties, eg: modified duties



Hours, eg: reduced hours, GRTWP, later start time

Expectations, eg: longer timeframes, lower KPIs

Environment, eg: alternate line of management, non-customer facing

Support, eg: support meetings, written feedback, more training, time to attend appointments

Practical examples

Poor sleep, fatigue, low energy

- Vary hours, eg reduced hours, later start time

Poor concentration and focus

- Longer timeframes to complete tasks, less multitasking

Irritability, anger, sensitivity

- Consider working more autonomously for a period of time

Traumatisation

- Period of removal from triggering situations/environment, eg back office work, with plan to gradually return

Phobic avoidance

- Gradual reintroduction

Performance management

- Increased training and support, lower KPIs for a defined period

Interpersonal conflict

- Facilitated discussion, support person, different line of reporting

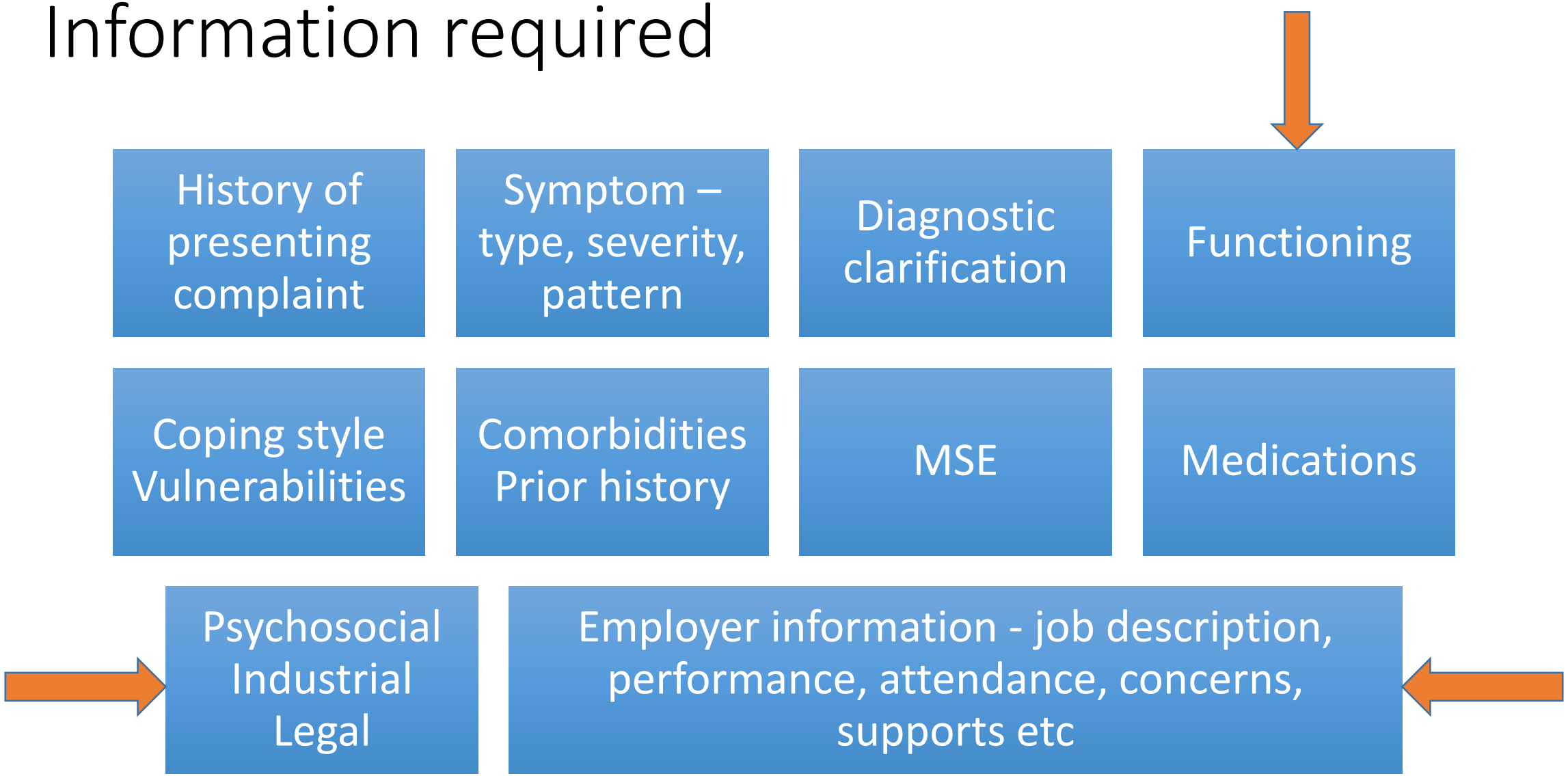
Covid / RTO anxiety:

- Ensure WP safety measures, graduated return, off peak hours

Management framework

Make time	Provide support and education	Engage and collaborate Avoid blind advocacy	Careful documentation
Expectations for recovery / Goal setting / Timeframes	Encourage activity Functional restoration	Obtain collateral information	Communication – employers, rehabilitation providers
Address issues	Avoc/ voc rehab/ GRTWP	Regular review	Close follow up during return to work

Information required



To certify or not – the considerations

TYPE OF CERTIFICATE

DURATION

PURPOSE

BENEFITS

DISADVANTAGES

Management approaches

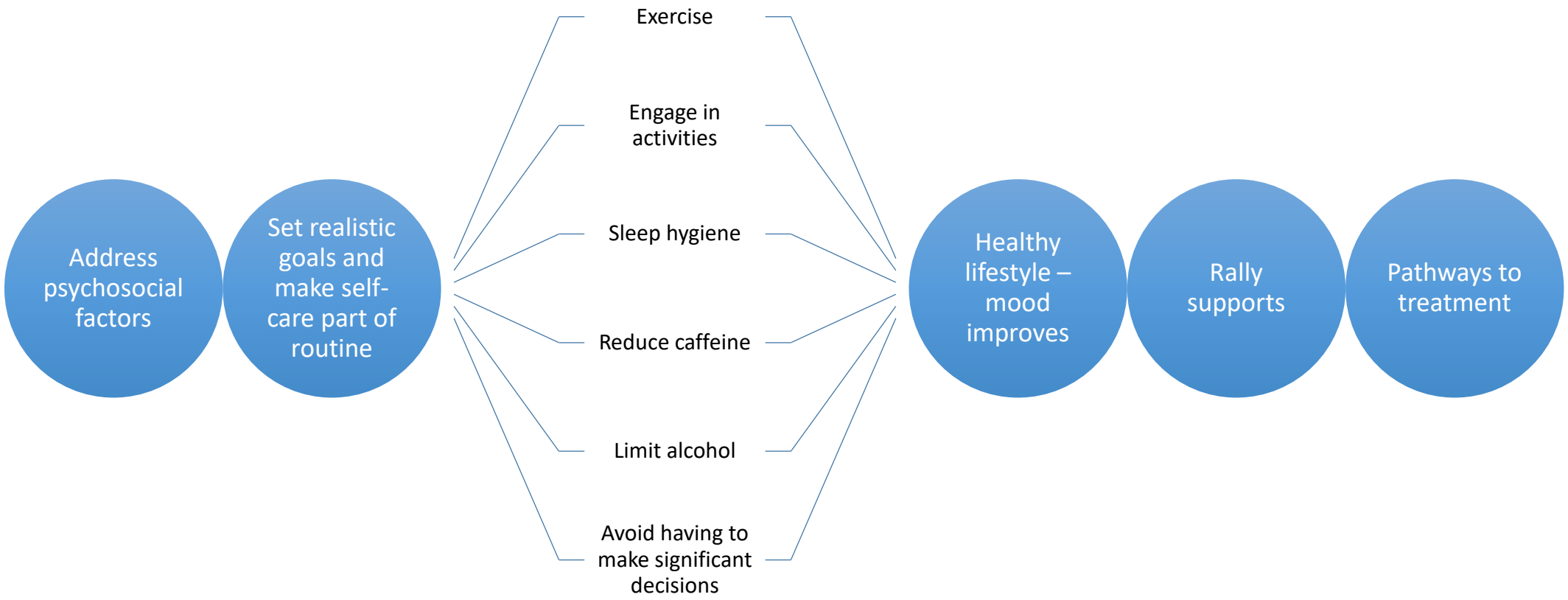
Self-care

Psychological therapy

Medication

Return to work as a treatment!

Self-care


Address psychosocial factors
Set realistic goals and make self-care part of routine
Exercise
Engage in activities
Sleep hygiene
Reduce caffeine
Limit alcohol
Avoid having to make significant decisions
Healthy lifestyle – mood improves
Rally supports
Pathways to treatment

Psychological treatment

All psychological therapies are not the same

Therapy needs to be targeted and regular

Evidenced-based:

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

Medication - overview

- Choice depends on preference and side effect profile
- Therapeutic alliance
  - Patient input
- Address barriers
  - This is my employer's fault.
    Why should I have to take medication?
  - A pill won't take my problems away
  - Stigma / Weakness
- Start low, go slow
- Education is key
  - Side effects
  - Time for effect
    "Not like taking a Panadol"
  - Impact of intermittent compliance

Setting expectations for recovery

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

Recovery trajectory – not a straight line

Setbacks ≠ catastrophisation

Facilitating a safe and sustainable return to work

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

Facilitating a safe and sustainable return to work – for the employee

Ensure adequate training.

Task lists – for cognitive symptoms, sense of accomplishment.

Longer timeframes to complete tasks, limit multitasking (to manage residual symptoms including cognitive)

Written communication – for cognitive symptoms

Ability to move around, retreat, time out

Support meetings / check-ins

Flexibility to attend appointments

Collaboration with treatment team / feedback loop

Setting expectations for return to work - employer

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

Time to re-familiarise

Performance should improve (often exponentially)

Sensitivity

Privacy considerations

Mary – path to recovery

Weekly sessions with Psychologist to build trust, rapport, validation, challenging unhelpful thoughts, psychoeducation. Activity encouraged – socialising and exercise.
Fortnightly appointments with GP to review symptoms, functioning and treatment needs.
Educated by THP re the need to keep engaged in exercise, social, recreational pursuits and have communication with work. Supported to cut down her alcohol use.
Week Four – antidepressant encouraged to assist with sleep disturbance, high anxiety, tearfulness and poor concentration. Lexapro commenced after discussion.
Week Six – some improvement in symptoms. Increased activity. Anxiety about work ongoing. Uncertainty. Encouraged to engage in return-to-work meeting.

Mary – returning to work

Return-to-work meeting goes well. Supports offered.
Facilitated discussion goes better than expected.
Certified fit for GRWTP.
Three six-hour shifts, gradually increasing.
Further training on computer system and review of workload.
Longer timeframes to complete tasks.
Information to workplace regarding expectations/prognosis/timeframes.
Increased treatment provider input at time of returning.

Secondary Psychological Conditions in Worker's Compensation

- Why is it important
- Factors contributing to distress
- Worker response and impact on recovery
- Recommendations for prevention and early intervention

Why is it important?

Commonly occurring.

Often not recognised early.

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

Early intervention and prevention is possible.

Costly for workers compensation schemes.

Stigmatised.

Research

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

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

29.4% of Victorian workers met case definition for serious mental illness within ~2 years post injury (Orchard et al, 2020)

Factors contributing to distress/psychological ill health in MSC - the injury

Pain

Loss of function

Trauma

Treatment

Factors contributing to distress/psychological ill health in MSC - the individual

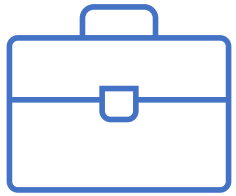
Vulnerability including genetic, prior history, comorbidities, past experience etc

Resources - internal and external

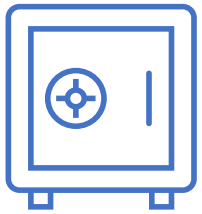
Comorbid stressors

Pain catastrophising and avoidance

Factors contributing to distress/psychological ill health in MSC - the system



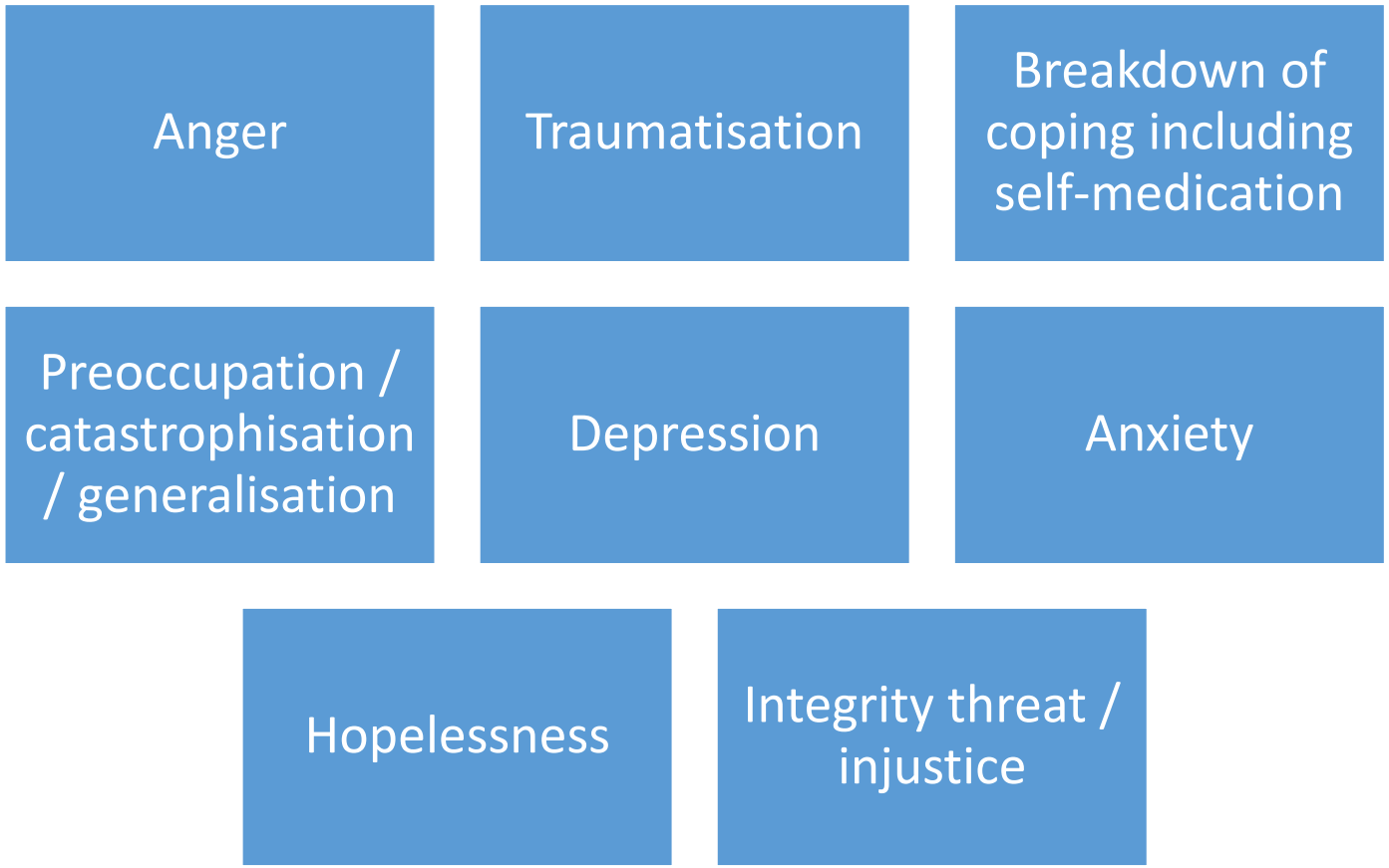
Employer factors eg RMA/investigation/contact/proving disability, RTW focus



Insurer eg investigation, proving disability, contact

Treater behaviours

Possible worker responses to work-related MSC injury



Barriers to accessing support/treatment

Stigma

Somatisation

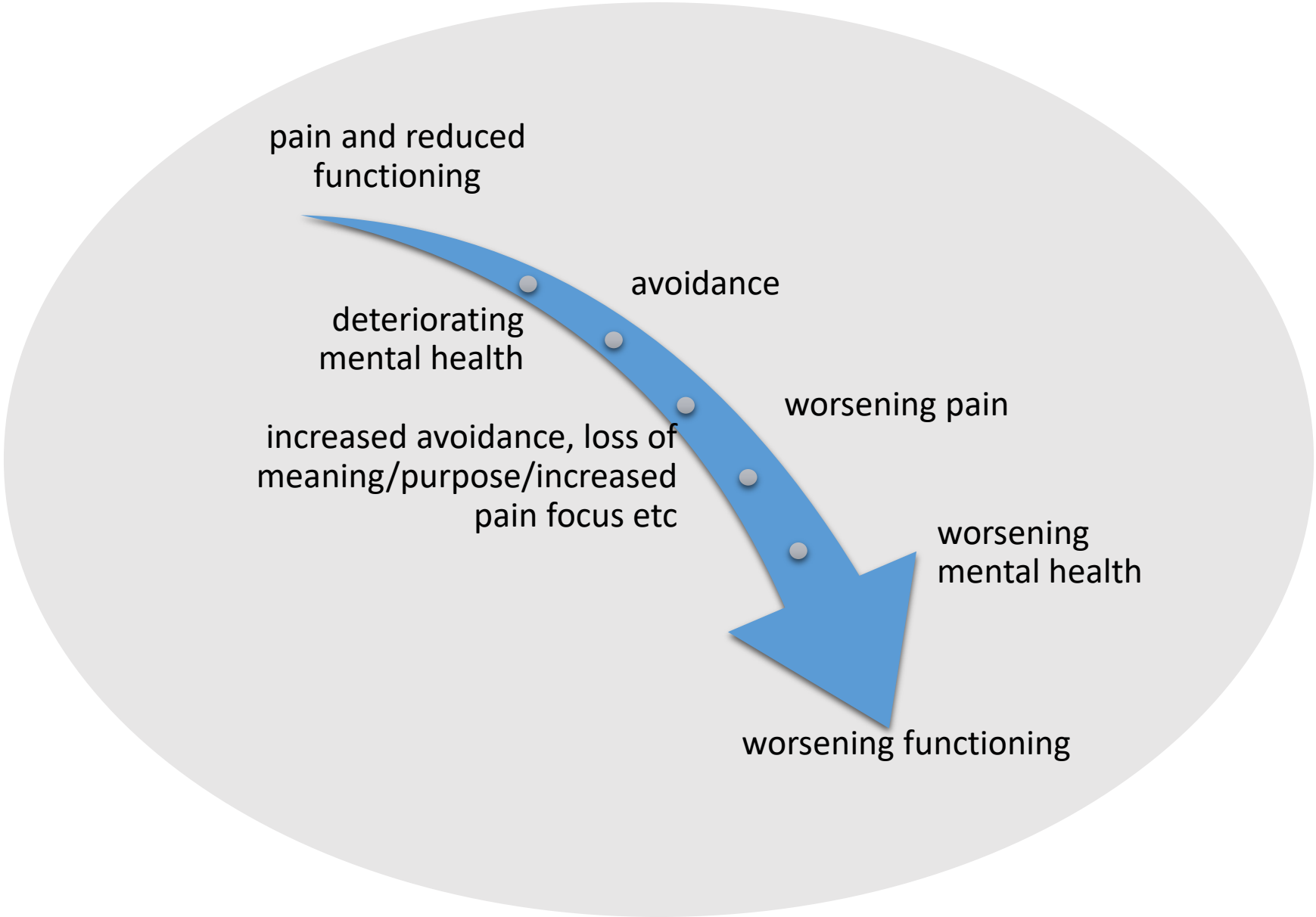
Denial coping

Negative judgements/past experience

Focus on physical condition/time limitations

Lack of available resources

Impact on recovery and return to work trajectory



What does the injured worker need?

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

Right treatment at the right time, to feel useful and able to focus on a way forward

What can you do?

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

Some take home messages for registrars

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

Acknowledgements

- Our thanks goes to Dr Peter Cotton and Mr Mark Belanti who have contributed to elements of this presentation.
- As clinical psychologists with significant experience in managing mental health conditions in the workplace they have had positive impacts on workplace management of mental ill health and the wellbeing of their individual patients.