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

[Draft version 1.0]

12 JAN 18
Disclaimer

These Clinical Guidelines are a general guide to appropriate practice, to be followed subject to the clinician’s judgment and the patient’s preference in each individual case. The Clinical Guidelines are designed to provide information to assist decision-making and are based on the best evidence available at the time of development.

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Citation

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

General practitioners see most patients with work-related injuries and have an important role in facilitating recovery and return to work. This guideline has been developed to ensure that people with work-related mental health conditions, who present to their general practitioner, receive the most appropriate and effective evidence-based care.

The recommendations in this guideline were informed by a systematic review of the evidence using an internationally recognized approach called GRADE (Grading of Recommendations, Assessment, Development and Evaluation). Where we found no evidence to address a key clinical question, we drew on expert opinions to form a consensus statement.

For the full list of recommendations, explanation of grades and background information, access the full guideline at www.med.monash.edu.au/general-practice or The Royal Australian College of General Practitioners racgp.org.au

Assessment and diagnosis of a work-related mental health condition

Is it a mental health condition?

- Use the PHQ-9 to assist an accurate diagnosis of depression & assess its severity.
- Use either GAD-7 or the DASS to assist a diagnosis of an anxiety disorder.
- Use the PCL-C to assist in making an accurate diagnosis of post-traumatic stress disorder (PTSD) and assessing its severity.
- May use the AUDIT, SADQ or LDQ to assist in making an accurate diagnosis of an alcohol use disorder, and assessing its severity.
- May use the LDQ to assist in making a diagnosis of substance use disorders and assessing their severity.

Is the mental health condition work-related?

Undertake a comprehensive clinical assessment.

How can I ensure that the patient understands and acknowledges the diagnosis?

Establish a therapeutic alliance and maintain this throughout treatment.

When conveying a diagnosis have regard to:

- Patient concerns (e.g. stigma or discrimination)
- A patient's socio-cultural background
- Negotiating confidentiality and information sharing

- 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.
- Promote a patient-centered recovery based approach.

Is this patient developing a comorbid mental health condition?

In patients with a work-related injury, GPs should note the following factors to assist in the early detection of a comorbid work-related mental health condition:

- job strain.
- failure to return to work following injury.
- past experience of, and response to, treatments.
- greater pain intensity, where physical injury was a precursor to the mental health condition.
- lower self-efficacy (i.e. capacity to cope with difficult demands by themselves).
- lack of social support and personal relationship status (i.e. relationship problems).
- perception of injustice of the compensation claim process.
- any comorbid medical condition.
- any comorbid substance misuse.
- a chronic physical health problem.
- past history of depression.
- pre-existing depressive disorder or other anxiety disorder.
- insomnia, low mood, anhedonia and suicidal thoughts.

PHQ-9 Patient Health Questionnaire-9
GAD-7 Generalized Anxiety Disorder 7 item
DASS Depression Anxiety Stress Scales
PCL-C PTSD Checklist (Civilian)
AUDIT Alcohol Use Disorders Identification Test
SADQ Severity of Alcohol Dependence Questionnaire
LDQ Leeds Dependence Questionnaire
Management of a work-related mental health condition (MHC)

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

Refer to existing high quality clinical guidelines for the management of MHC.
For a secondary work-related MHC, use work-directed cognitive behavioural therapy.

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

Medical factors
- persistent symptoms prior to going on sick leave.
- higher degree of severity of the condition.
- longer duration of sick leave at baseline.
- extensive physical injury.
- chronic pain.
- quality of rehabilitation services.

Employment/workplace factors
- job/work stress.
- poor communication with supervisor/employer.
- harassment and bullying as a precursor to the MHC.

Health behaviours and attitudes
- alcohol intake, smoking, drug dependence.
- overweight, underweight.
- attitude towards return to work.
- reduced expectations by patients about being able to return to work.

Personal/patient factors
- stressful life factors outside of work.
- patients aged >40 years.

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

If work-related or non-work-related stressors are evident, assist to address them.

If no work-related or non-work-related stressors are identified, and persistent depression is present, consider:
- A collaborative multidisciplinary approach.
- Cognitive behaviour therapy as an adjunct to pharmacotherapy.

What strategies are effective at managing comorbid MHCs?

Note the presence and severity of comorbidities, and consider these in treatment planning.

Use an integrated approach for people with work-related MHCs and comorbid substance use disorders.

Use individual-based trauma-focussed psychological therapy delivered along with substance use disorder therapy.

In the context of PTSD and substance use disorders:
- Only commence the trauma-focussed component of PTSD treatment when the person has demonstrated a capacity to manage distress without recourse to substance misuse and to attend sessions without being drug or alcohol affected.
- Where the decision is made to treat substance use disorders first, 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.

What is appropriate communication with a patient's workplace?

Use telephone and/or face-to-face methods between a worker, supervisor, healthcare provider(s), union representatives and others.

Consider using a trained return-to-work coordinator, if available.

Ensure that communication* maintains a focus on the workplace and on the worker's needs and functional capacities.

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

Is the patient ready to return to work?

Consider physical and psychosocial capability including:
- depression severity.
- presence of comorbidities.
- presence of sleep disturbance.
- higher conscientiousness pre-injury.
- attitude towards work.
- patient motivation to work.
- work ability.
- personal circumstances.
- social deprivation (social / cultural disadvantage).
- being male.
- being older age.
- differential diagnosis.

Consider work-related factors including:
- 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.
- availability of duties that are non-stigmatizing and, where possible, commensurate with the worker's level of experience and seniority.

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1. Executive Summary

Patients with work-related mental health conditions rely on their general practitioner (GP) to direct their complex clinical journey to recovery and return to work (RTW). However, GPs face many challenges in diagnosing and managing these patients in practice and may benefit from a guideline providing evidence-based recommendations to guide patient care throughout their recovery trajectory.

The aim of this guideline is to provide GPs with the best available evidence that they can apply when managing patients with a possible or confirmed work-related mental health condition. The guideline is intended to serve as an aid to GPs and should not replace their clinical judgement. Rather, the advice provided here is anticipated to enhance clinical judgement. We would like to highlight that personal recovery and return to safe work, as described in the Health Benefits of Good Work Consensus Statement, ¹ are the key patient outcomes that we aim to affect with this guideline.

The guideline scope includes the mental health conditions of post-traumatic stress disorder, depression, anxiety, acute stress, substance use and adjustment disorder in all people who present in general practice with a possible work-related mental health condition. The key clinical questions addressed in the guideline are based upon clinical dilemmas faced by GPs in practice; particularly regarding assessing and diagnosing work-related mental health conditions, determining the work-relatedness of a condition, and managing patients to facilitate recovery and RTW.

This guideline has been developed according to the National Health and Medical Research Council’s standards for the development of clinical practice guidelines. As such, all recommendations are based on a literature review and each recommendation is given a strength based on Grading of Recommendations, Assessment, Development and Evaluation (GRADE) criteria. GRADE methodology uses four criteria to determine the strength of 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 recommendations are 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 statements – are provided where we could find no suitable evidence to answer a question. In these situations the GDG developed a consensus statement based on their clinical, consumer, policy and content expertise.

Recommendations for future research – are provided where we found no suitable evidence, and the GDG considered that such evidence would be very beneficial for clinical practice.

A summary of the recommendations and consensus statements is given below.

## Assessment and Diagnosis

**Is this a mental health condition?**

For workers with symptoms of mental health conditions a GP:

- Should use the Patient Health Questionnaire-9 (PHQ-9) to assist in making an accurate diagnosis of depression and assess its severity.
- May use either Generalized Anxiety Disorder 7 (GAD-7) item or the Depression Anxiety Stress Scales to assist in making an accurate diagnosis of an anxiety disorder.
- Should use the PTSD CheckList – Civilian Version (PCL-C) to assist in making an accurate diagnosis of post-traumatic stress disorder (PTSD) and assessing its severity.
- May use the Alcohol Use Disorders Identification Test (AUDIT), Severity Of Alcohol Dependence Questionnaire (SADQ), Leeds Dependence Questionnaire (LDQ), to assist in making an accurate diagnosis of an alcohol use disorder, and assessing its severity.
- May use the LDQ to assist in making a diagnosis of substance use disorders and assessing their severity.

*(Recommendation based on HIGH quality evidence and given a GRADE of Strong FOR)*

**Is the mental health condition work-related?**

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)*

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.

*(Consensus statement)*
How can I ensure that the patient understands and acknowledges the diagnosis?

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

a. Patient concerns such as the potential for stigma or discrimination;
b. A patient’s socio-cultural background which may affect their acknowledgement of a mental health condition;
c. Negotiating patient confidentiality and sharing of information with a person’s family or carer, if necessary.

(Consensus statement)

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 statement)

To ensure that the diagnosis of a work-related mental health condition is understood by the patient the GP should:

a. Provide information to the patient about the nature of the mental health condition, recovery expectations and the range of treatments available;
b. Provide the patient with educational material in a format that they can understand;
c. Promote a patient-centred recovery based approach.

(Recommendation based on LOW quality evidence and given a GRADE of Strong FOR)

Is the patient developing a comorbid mental health condition?

GPs may consider the following factors to assist in the early detection of a comorbid work-related mental health condition:

- job strain
- failure to return to work following injury
- past experience of, and response to, treatments
- greater pain intensity, where physical injury was the precursor to the mental health condition
- 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)
- perception of injustice of the compensation claim process
- any comorbid medical condition
- any comorbid substance misuse
- a chronic physical health problem
- past history of depression
- pre-existing depressive disorder or other anxiety disorder
- insomnia, low mood, anhedonia and suicidal thoughts

(Recommendation based on LOW quality evidence and given a GRADE of Weak FOR)

Management

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

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)

GPs should refer to existing high quality guidelines for the management of mental health conditions.

(Consensus statement)

In patients with a secondary work-related mental health condition, work-directed cognitive behavioural therapy is effective at improving return to work.

(Recommendation based on MODERATE quality evidence and given a GRADE of Weak FOR)

Why isn’t the patient’s condition improving as expected?

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

a. Medical factors
   - persistent symptoms prior to going on sick leave
   - higher degree of severity of mental health conditions (distress, depression, anxiety and somatization)
   - longer duration of symptoms and longer sick leave duration at baseline
   - extensive physical injury
   - chronic pain
   - quality of rehabilitation services;

b. Health behaviours and attitudes
   - alcohol intake, smoking, drug dependence
   - overweight, underweight
   - attitude towards return to work
   - reduced expectations by patients about being able to return to work;

c. Employment/workplace factors
   - job/work stress
• poor communication with supervisor/employer
• harassment and bullying as a precursor to the mental health condition;

d. Personal/patient factors
• stressful life factors outside of work
• patients aged >40 years.

(Recommendation based on HIGH quality evidence and given a GRADE of **Strong FOR**)

**What can I do for patients who are not improving?**

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)

In patients with a persistent mental health condition that has arisen out of work, GPs 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.

(Consensus statement)

Where no work-related or non-work-related stressors can be identified, and where persistent depression is present, a GP could consider the following evidence based approaches to treat the persistent depression:

a. Collaborative care between relevant health professionals for patients with persistent depression;

b. Cognitive behavioural therapy as an adjunct to pharmacotherapy for patients with treatment-resistant depression.

(Recommendation based on HIGH quality evidence and given a GRADE of **Weak FOR**)

**What strategies are effective at managing comorbid mental health conditions?**

GPs should note the presence and severity of comorbidities in their assessments, with a view to considering their implications for treatment planning.

(Consensus statement)

GPs should use an integrated approach for people with work-related mental health conditions and comorbid substance use disorders.

(Consensus statement)
Individual-based trauma-focussed psychological therapy delivered along with substance use disorder therapy is more effective than usual treatment for PTSD.

*(Recommendation based on VERY LOW quality evidence and given a GRADE of Weak FOR)*

In the context of PTSD and substance use disorders:

a. The trauma-focussed 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.

b. 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.

*(Consensus statement)*

What is appropriate communication with the patient’s workplace?

GPs 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.

*(Recommendation based on MODERATE quality evidence and given a GRADE of Strong FOR)*

GPs should consider using a trained return-to-work coordinator to coordinate and negotiate return to work amongst stakeholders, if available.

*(Recommendation based on HIGH quality evidence and given a GRADE of Strong FOR)*

When discussing the care of a patient who has a work-related mental health condition with their workplace, ensure that communication\(^1\) maintains a focus on the workplace and on the worker’s needs and functional capacities.

*(Consensus statement)*

Is the patient ready to return to work?

GPs should consider the following patient and work-related factors when determining whether a person has the capacity to return to work:

a. Physical and psychosocial capability including:
   - depression severity
   - presence of comorbidities

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\(^1\) Communication between a GP and their patient’s workplace should only occur with a patient’s consent.
• presence of sleep disturbance
• higher conscientiousness pre-injury
• attitude towards work
• patient motivation to work
• work ability
• personal circumstances
• social deprivation (social / cultural disadvantage)
• being male
• being older age
• differential diagnosis;

b. Work-related factors including:
• 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 in the workplace)
• availability of duties that are non-stigmatizing and, where possible, commensurate with the worker’s level of experience and seniority
• size of the workplace.

(Consensus statement)
2. Introduction

Participation in good and safe work is good for health. However, hazards at work, such as job stress, racism, or delayed recovery following a musculoskeletal injury can lead to the development of work-related mental health conditions. Australian claims data show that the incidence of people with work-related mental health conditions increased from approximately 6800 mental health claims to 8500 mental health claims between the years 2000 to 2011. However, this number reflects only those who have had a successful claim accepted. In reality, the number of people with work-related conditions is estimated to be up to 30 times higher.

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. Whilst recognising that some mental health conditions take months to resolve, and some may continue over a lifetime, there are actions that a general practitioner (GP) can take to accelerate patient recovery and return to work.

GPs play a significant role in the lives of people with work-related injuries. In fact, 96% of injured workers see a GP for an injury claim. As the primary providers of care, GPs can positively influence the recovery trajectory of their patients. Further, as a coordinator of a patient’s clinical care, the GP can facilitate necessary access to allied or specialist care for their patients. Finally, the GP is the primary certifier of work capacity whose clinical judgement influences the length of time that a worker is absent from work, whether or not a worker returns to work, and whether that person receives compensation for their injury. Therefore, the GP plays an important and valuable role in patient recovery, return to work and access to compensation.

A. Background

i. Clinical need for this guideline

In Australia, work-related mental health disorders are the second most common cause of worker compensation claims after manual handling. At present, GPs are more likely to certify workers with a mental health condition as unfit for work than those with physical conditions.

This project is a 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 existing Australian study of GP perceptions about sickness certification, members of the guideline development project team found that numerous GPs encountered knowledge barriers with regards to facilitating return to work, as well as certifying and managing patients with work-related mental health conditions. 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.

Taking this into consideration, 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.

ii. A brief note on the Australian policy context

In Australia, there are six jurisdictions with ten federal territories. Employers have an obligation to comply with legislation through the Safe Work Australia Act. Each jurisdiction has a different compensation scheme system. There are two main types of compensation scheme systems: no fault or ‘third party’ (fault-based). A no-fault based system means that people who may have caused their injury (e.g. in a motor vehicle accident), are still eligible for compensation. These systems generally have better health outcomes. In contrast, third party systems only compensate claimants who are ‘not at fault’. Some jurisdictions, for example South Australia, do not accept mental health conditions as a secondary claim to a physical injury for instance. It is also noteworthy that not all workers can receive compensation through workers compensation schemes. For instance, people who participate in ‘Work for the Dole’ activities are not eligible to access compensation through worker’s compensation schemes.

To date, there are no clinical practice guidelines that exist to address the clinical complexities associated with diagnosing and managing potentially compensable work-related mental health conditions in the Australian general practice setting. There are however, several position statements and guidelines that are relevant for clinicians who have patients with work-related mental health conditions. Of these, the Health Benefits of Good Work (HBoGW) consensus statement and the “Taking Action – A Best Practice Framework for the Management of Psychological Claims” guideline are most relevant. The HBoGW consensus statement, to which the Royal Australian College of General Practitioners (RACGP), Royal Australian College of Physicians (RACP), ReturnToWorkSA, NSW State Insurance Regulatory Authority (SIRA), WorkCover WA and Comcare (among others) are signatories, 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”. - HBoGW
Reinforcing this message, the *Taking Action* guideline \(^{12}\), which is produced for use in the compensation setting, provides recommendations to employers and compensation agencies about facilitating recovery and return to work for people with work-related mental health conditions. GPs would benefit from reviewing these documents as they influence and affect compensation schemes, employers, clinicians and patients.

iii. Purpose

We hope that this guideline will provide GPs with the best available evidence that they can apply when managing patients with a possible or confirmed work-related mental health condition. The guideline is intended to serve as an aid to GPs and **should not** replace their clinical judgement. Rather, the advice provided here is anticipated to enhance 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 returning to work, as an additional recovery goal.

This guideline has been developed according to the National Health and Medical Research Council’s Standards for Guideline Development 2011 \(^{13}\). Development of the guideline has also been informed by learnings in implementation science to increase the usefulness and usability of the guideline. Some of the methods that we used to develop this guideline include: a) utilising interviews with GPs and key informants to identify the key clinical dilemmas faced by GPs when diagnosing and managing patients, and using these dilemmas to formulate the key clinical questions that are addressed in the guideline; b) using a clinical reasoning framework as a blueprint for the structure of the guideline document – thus replicating the nature of consultations in a clinical setting; and c) developing an evidence-based implementation and dissemination plan that can be employed following publication of the guideline.

B. How to use the 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, and to get through the complexity that you would have to navigate. Recommendations are presented in three formats: 1) a flow chart 2) an Executive Summary and 3) detailed discussion about the recommendations. The flow chart is intended to be used as a quick reference to guide clinical decision making in practice. The Executive Summary (Chapter 1) includes an overview of the guideline aims, methods, recommendations and consensus statements. Here each recommendation is accompanied by a note about whether it is a recommendation for practice, a consensus statement or a recommendation for future research. In addition, for each 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, and are colour coded as red or yellow, respectively. Detailed discussions about the recommendations are included in Chapters 4 and 5. These chapters provide a discussion about the evidence and factors to consider when implementing the guideline in practice.

C. Scope
The guideline covers the mental health conditions of post-traumatic stress disorder, depression, anxiety, acute stress, substance use and adjustment disorder in all people who present in general practice with a possible work-related mental health condition. We used an 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 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.

The guideline addresses clinical dilemmas regarding assessing and diagnosing work-related mental health conditions, determining the work-relatedness of a condition, and managing patients to facilitate recovery and RTW.

The guideline does not consider detailed management of comorbidities that frequently exist alongside mental health conditions, for example chronic pain; however, the management of mental health conditions that coincides with the management of comorbidities is addressed in the guideline.

The guidelines define work-related mental health conditions as:

- Those mental health conditions that developed as a direct result of a work-related stressor; or
- Mental health conditions that developed as a consequence of the primary work-related injury; or
- A pre-existing mental health condition that was exacerbated by a workplace stressor.

Topics addressed in this guideline were identified through a user-centred approach to ensure that the questions that the guideline addressed were going to be relevant. This is detailed in the Methodology section.

D. Clinical questions
Review Q1: 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?

Review Q2: 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?
Review Q3: In workers, what factors assist in the early detection of a comorbid work-related mental health condition?

Review Q4: In patients with a mental health condition, what GP strategies result in the highest level of personal recovery and/or return to work?

Review Q5: In patients with a diagnosis of a work-related mental health condition what factors adversely affect progress in the patient’s condition?

Review Q6: In patients with work-related mental health conditions who are not improving, what strategies should a general practitioner undertake to improve the patient’s condition?

Review Q7: In patients with a work-related mental health condition, what GP interventions are effective at managing comorbid substance misuse and addictive disorders?

Review Q8: 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?

Review Q9: What is appropriate communication with the patient’s workplace, in order to appropriately manage a work-related mental health condition?

Review Q10: In workers with a mental health condition, what information should a GP consider to determine whether a person has capacity to return to work?
3. Methodology

A. Overview of the steps

i. 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*. 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.

B. Governance

i. Steering Group

A Steering Group comprised representatives from each of the agencies that funded or supported the development of the clinical practice guideline. The role of the Steering Group members 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 they again drew upon existing networks to tailor guideline implementation, state by state. Membership of the Steering Group is given in Table 1.

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<th>Organisation</th>
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<tr>
<td>Monash University – Department of General Practice</td>
<td>Danielle Mazza, Bianca Brijnath &amp; Samantha Chakraborty</td>
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<tr>
<td>Monash University – ISCRR</td>
<td>Andrea de Silva</td>
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<td>Department of Employment (Commonwealth)</td>
<td>Monica Sapra</td>
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<td>State Insurance Regulatory Authority NSW</td>
<td>Henry Ko, Liane Steele</td>
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<td>ReturntoWorkSA (SA)</td>
<td>Marcia Vernon (until July 2017), Julianne Flower</td>
</tr>
<tr>
<td>Department of Justice (QLD)</td>
<td>Rachel Hawkins, Allicia Bailey</td>
</tr>
<tr>
<td>WorkCover (WA)</td>
<td>Chris White</td>
</tr>
</tbody>
</table>

ii. Editorial independence

The organisations that funded the development of this guideline did not participate in its development, except when invited; a representative offering a national policy perspective was
invited from the Australian Government Department of Employment and a representative offering a state-based policy perspective was invited from the Queensland Government Office of Industrial Relations. Expertise and assistance from the funding organisations were sought 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 and to participate during the public consultation period to ensure wide dissemination of the draft guideline across Australia.

iii. Guideline Development Group

The 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). Membership of the Guideline Development Group is given in Table 2.

*Table 2 Membership of the project Guideline Development Group*

<table>
<thead>
<tr>
<th>Affiliation, role</th>
<th>Member</th>
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</thead>
<tbody>
<tr>
<td>General practitioner, content expert (Chair)</td>
<td>Prof Danielle Mazza</td>
</tr>
<tr>
<td>Monash University / National Aging Research Institute, content expert</td>
<td>Dr Bianca Brijnath</td>
</tr>
<tr>
<td>Mental Health Australia, consumer representative</td>
<td>Ms Heather Nowak</td>
</tr>
<tr>
<td>RACGP representative, general practitioner</td>
<td>Dr Cate Howell</td>
</tr>
<tr>
<td>General practitioner</td>
<td>Dr Trevor Brott</td>
</tr>
<tr>
<td>RACP (AFOEM), occupational physician</td>
<td>Dr David Gras</td>
</tr>
<tr>
<td>RANZCP representative, psychiatrist</td>
<td>Dr Michelle Atchison</td>
</tr>
<tr>
<td>Australian Psychological Society, content expert</td>
<td>Prof Justin Kenardy</td>
</tr>
<tr>
<td>Office of Industrial Relations QLD, state-based policy maker</td>
<td>Ms Fiona Emery (meetings 1 and 2), Mr Richard Buchanan (meetings 3 and 4)</td>
</tr>
<tr>
<td>Comcare, national workers compensation scheme representative</td>
<td>Mr Seyram Tawia</td>
</tr>
</tbody>
</table>

iv. Conflicts of interest

All members completed 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 emerged since the previous meeting.

The majority of GDG meetings were held face to face with discussion directed by the Chair. The Chair ensured that all members contributed to the discussions.
C. Development of clinical questions

i. Methods for developing key clinical questions that are 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 national and international guideline development groups in Australia, the US, Canada, and Europe to identify best practice approaches for how to prioritise key questions for clinical practice guidelines. This process identified 12 guideline development protocols. The two most comprehensive protocols were then selected and used as a framework for generating questions in the clinical guideline development process.

In Phase two the framework was augmented to incorporate views from end users (GPs) and other stakeholders (compensation scheme workers and psychiatrists) using a qualitative research approach. The Clinical Reasoning Framework 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 our results from the qualitative study, an initial list of questions was generated. The full methodology for developing key clinical guideline questions is in the process of publication [unpublished manuscript].

![Clinical Reasoning Framework](image)

**Figure 1:** Clinical Reasoning Framework.

D. Review of existing evidence

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

A systematic review of the literature was performed to build the evidence base for the development of this guideline. 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 31st January 2017. Preliminary evidence findings from this round were reviewed by the GDG at the meeting of 30th 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 performed, and where applicable the search either only updated the results for the period 1st February to 30th April 2017 or involved a new search with a modified search strategy from database inception to 30th 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 literature was performed by two independent reviewers to develop the evidence base for the Guideline recommendations.

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

ii. Inclusion criteria

Given that each review question addressed a different aspect of clinical practice in the Guideline, hence different outcomes, 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 adjustment disorders, depression, post-traumatic stress disorders, stress or anxiety
- Types of studies – studies of all types of design published in the English language
- Outcomes – Diagnosis, risk factors and management of patients with adjustment disorders, depression, post-traumatic stress disorders, stress or anxiety in the working population.

iii. Exclusion criteria

The exclusion criteria were:

- Any mental health condition other than adjustment disorders, depression, post-traumatic stress disorders, stress or anxiety (e.g. schizoaffective disorders).
- Substance use or addictive disorders occurring in isolation of adjustment disorders, depression, post-traumatic stress disorders, stress or anxiety.
• 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 groups).

• Non-English language publications or full text articles that could not be located/sourced.

iv. 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 two independent reviewers 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.

v. Search for existing evidence-based guidelines and systematic literature reviews

Where the evidence base was small, the team conducted an internet search of guideline clearinghouses and systematic review databases to identify relevant and high quality evidence-based guidelines and systematic literature reviews that could be considered for adaptation in the Guideline.

vi. Appraising and summarising the evidence

Included studies were assessed for methodological quality using the Downs and Black checklist 17 for interventional and prognostic studies. The Quality Assessment of Diagnostic Accuracy Studies version (QUADAS) tool 18 was used for studies of diagnostic accuracy, and A Measurement Tool to Assess Systematic Reviews (AMSTAR) 19 for systematic reviews. The 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 into Grading of Recommendations Assessment, Development and Evaluation (GRADE) evidence tables 20. Where the evidence was supplemented with existing clinical practice guidelines, the Appraisal of Guidelines for Research and Evaluation II (AGREE-II) tool 21 was used for quality assessment.

E. Development of guidance

i. Development of recommendations

The evidence was assessed by the project team and given a preliminary certainty of evidence (HIGH, MODERATE, LOW or VERY LOW) rating following GRADE criteria (Table 3) 20. For each question, the GDG was presented with an evidence profile 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 22.

Table 3 Quality of Evidence GRADEs

<table>
<thead>
<tr>
<th>Evidence rating</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>We are very confident that the true effect lies close to that of the estimate of the effect.</td>
</tr>
<tr>
<td>Moderate</td>
<td>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</td>
</tr>
<tr>
<td>Low</td>
<td>Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.</td>
</tr>
<tr>
<td>Very Low</td>
<td>We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect</td>
</tr>
</tbody>
</table>

ii. Development of consensus statements

Where no high quality evidence was identified, the GDG devised a consensus statement 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 the Guideline.

iii. Steps for reviewing and finalising recommendations

Following the second GDG meeting, the project team developed a list of draft recommendations pertaining to each of the ten key clinical questions primarily based on available evidence that arose from systematic literature reviews and/or existing high quality guidelines.

The draft recommendations were reviewed across three GDG meetings, with the initial presentation occurring at the third GDG meeting, before being finalised by discussion.

At GDG meeting 3, members were asked to use GRADE 23 to rate each recommendation based on its strength of evidence. Where the evidence for a recommendation was absent or where low level evidence was supplemented with clinical expertise, GDG members generally opted to develop a consensus statement in place of an evidence-based recommendation.

To facilitate the process of developing useful and usable recommendations, the Chair ensured that each member contributed to the discussion and was given the opportunity to provide feedback on the grading and language used for each recommendation. When reviewing the recommendations, consensus was reached via open discussion between members.
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 further review of the evidence. The implications of the updated search results on the draft recommendations were discussed with the GDG via teleconference. Similarly, members were given the opportunity to make further edits to the draft recommendations in light of new findings. Of note, the updated searches ultimately had little impact on the draft recommendations hence minimal changes were made.

At GDG meeting 4, all draft recommendations were presented to GDG members via round table discussion for final review. After assessing all of the evidence, the GDG were asked to discuss and finalise the wording for each recommendation. Phrases such as ‘recommend’ ‘must’ or ‘should’ were used when the evidence underpinning the recommendation was strong, and phrases such as “suggest”, ‘might’ or ‘could’ were used when the evidence base was weaker.

The draft Implementation Plan was also ratified at this meeting, and the draft Guideline was ratified by teleconference shortly thereafter.

iv. Note about 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) 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.

F. 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.

G. Public consultation

The draft Guideline document and draft Implementation Plan will be released to the public along with an invitation to comment about the quality and perceived usefulness of the recommendations and supporting guideline content. Public consultation will be for a period of 60 days. Notification that the Guideline is available for public comment will be sent to Chief Executive or Secretary of
state, territory and Commonwealth departments of health, and key professional organisations, compensation schemes, employment councils and other relevant peak bodies and key stakeholders.

All comments that are received regarding the draft Guideline or Implementation Plan will be recorded and the GDG will respond to each comment individually. A list of the comments and responses from the GDG will be publicly available on the compensable injury website: [http://www.med.monash.edu.au/general-practice/compensable-injury/index.html](http://www.med.monash.edu.au/general-practice/compensable-injury/index.html) along with the Guideline at the time of publication.

The GDG will review all feedback from the public and make revisions to the Guideline in light of the responses to the public consultation process.
4. Assessment and Diagnosis

A. Is this a mental health condition?

Between 2006 and 2015, depression was ranked second amongst the most frequently managed chronic problems in Australian general practice and anxiety was among the top 25 most frequently managed chronic problems. Of all the psychological conditions, depression, anxiety, sleep disturbance and acute stress reaction were the most frequent reasons for attending a GP. This list of conditions correlates well with the national claims database records of mental health conditions that were attributable to work, which include “reaction to stressors – other, multiple or not specified” (41%), anxiety/stress disorder (28%), post-traumatic stress disorder (11%), anxiety/depression combined (10%), depression (4%), and other mental health conditions (5%).

While many GPs are confident in their ability to diagnose a mental health condition, there is considerable variation in the methods used to make a diagnosis of a mental health condition (MHC) for specific conditions. This may be, in part, because current training in Mental Health Skills for GPs does not encourage GPs to make a diagnosis, because of concerns about unforeseen legal consequences for the patient (e.g. life insurance and family law). However, for patients who submit a claim for compensation, it is imperative that a clear and substantiated diagnosis is made – otherwise the patient may have their claim denied. Furthermore, a diagnosis and an assessment of severity is necessary to guide optimal treatment, which might change over time.

A myriad of standardised tools for diagnosis, assessment of severity and/or monitoring symptoms exist. These include, for example, the Diagnostic and Statistical Manual of Mental Disorders, the Hospital Anxiety and Depression Scale (HADS), the Centre for Epidemiologic Studies Depression Scale (CES-D), the Beck Depression Inventory-II (BDI-II) and the PTSD Checklist-civilian version (PCL-C). Whilst many of these tools were validated in the general population with a mental health condition, these initial studies of validity and reliability do consider the specific influences of work on the symptoms and thus the diagnosis.

The GDG also consider it prudent to assess which tools are feasible to use in the Australian general practice context. For instance, tools must be applied in a single or double consultation, they must be freely available to GPs across Australia, and their use must not be restricted to those GPs who have been extensively trained in their use.

In light of the above, the GDG sought to identify tools that can assist a GP to make an accurate (sensitive and specific) diagnosis of a mental health condition and its severity.
Review Q1: 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?

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.
- May use either Generalized Anxiety Disorder 7 item or the Depression Anxiety Stress Scales to assist in making an accurate diagnosis of an anxiety disorder.
- Should use the PTSD CheckList – Civilian Version to assist in making an accurate diagnosis of PTSD and assessing its severity.
- May use the Alcohol Use Disorders Identification Test, Severity Of Alcohol Dependence Questionnaire, or Leeds Dependence Questionnaire, to assist in making an accurate diagnosis of an alcohol use disorder, and assessing its severity.
- May use the Leeds Dependence Questionnaire to assist in making a diagnosis of substance use disorders and assessing their severity.

Recommendation

HIGH quality evidence
GRADE: Strong FOR

The literature was searched to first identify standardised tools that can be used to aid diagnosis and/or monitoring of symptoms or severity of anxiety, depression, adjustment disorder, trauma related disorders, substance use disorder and acute stress in a work context. We did not include any tools that were used to assess burnout as burnout is not recognised as an individual diagnosis within the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)\textsuperscript{31}. To identify tools that had been validated, we considered only those studies that described evaluating the sensitivity and specificity of a tool.

Following an initial search, a total of 42 studies included tools that could be used to diagnose a work-related mental health condition. Of these, five studies described sensitivity and specificity testing of tools.
A number of current, high quality clinical guidelines also make recommendations for tools that can be used to make a diagnosis of a mental health condition and to determine its severity. We identified a total of 32 guidelines that addressed the topic of diagnosis of a mental health condition. Of these, three high quality guidelines produced by the National Institute of Clinical Excellence were selected for inclusion in developing a recommendation.

Depressive disorders

The systematic review identified two original papers which described the Patient Health Questionnaire-9 (PHQ-9), and a third paper which described the Depression Anxiety Stress Scale (DASS). These three papers had accompanying diagnostic accuracy testing for its use in diagnosing and assessing severity of depression in a work and/or primary care context. Volker et al., assessed validity of the PHQ-9 in a work context while Cholera et al., 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). The DASS had a sensitivity of 91% and specificity of 46% in depression for a cut off score of 12. These studies were of moderate to high quality.

A complementary search for clinical practice guidelines identified two high quality guidelines, produced by the National Institute of Clinical Excellence (NICE), that reported on the use of tools for the identification of depression, however these were not limited to the work or general practice context. Both the NICE 2016 and NICE 2015 guidelines were based on a single systematic review that was undertaken to identify tools for assessing symptoms of depression. This systematic review was limited to tools that were likely to be used in UK clinical practice - that is, the Beck Depression Inventory (BDI), Patient Health Questionnaire (PHQ), General Health Questionnaire (GHQ), Centre of Epidemiology Studies-Depression (CES-D) and the Geriatric Depression Scale (GDS). Of these tools, the PHQ and the BDI are potentially relevant for use in the Australian context, however the BDI is not available in the public domain. With regard to the PHQ-9, the NICE review analysed 11 studies that described diagnostic accuracy testing of the PHQ-9 and concluded that the PHQ-9 has high sensitivity (82%) and high specificity (83%).

The GDG considered the feasibility and applicability of the PHQ-9 to the Australian general practice setting, including a consideration of current practice. First and foremost, the GDG advises that assessment tools cannot replace clinical judgement. Tools that are commonly used by Australian general practitioners to assist in making a diagnosis of depression are the DASS or the Kessler Psychological Distress Scale (K10). The DASS was designed to measure the negative emotional states of depression, anxiety and stress, and can be self-administered by a patient or can be used by
a GP to conduct a clinical interview. Despite its use in the general practice setting, our systematic review did not identify any studies describing its validity or reliability in assessing depression in the work context. The K10 is a 10-item measure of psychological distress that can be used as a brief screen to identify levels of distress. However, the K10 is a generic tool and is not specific to depression. Furthermore, while the K10 is also widely used in Australia, our systematic review did not identify any studies that evaluated its validity or reliability in assessing depression in the work context.

Given the strong evidence for the validity of the PHQ-9 in the work context, along with the absence of data about the validity of the DASS or K10 in the work context, we are confident in recommending the use of the PHQ-9 to assist GPs with diagnosing depression and assessing its severity. The PHQ-9, is very similar to the K-10 and is easily accessible, therefore we are confident that Australian GPs will be able to use it without difficulty. It must be noted that the PHQ-9 is a screening tool rather than a diagnostic tool. As such it is only an assistive tool at the disposal of a GP for use as part of the diagnostic process for depression. For instance, it can be used by GPs as a guide to ask the right questions during a clinical interview to assist in making a diagnosis of depression.

**Anxiety disorders**

The systematic review identified two studies each describing one tool that was assessed for specificity and sensitivity in a work context. These were the Four-Dimensional Symptom Questionnaire (4DSQ) and the DASS. Langerak et al., assessed the validity of the 4DSQ in a work context and found >70% sensitivity and specificity for detecting anxiety. The second study by Nieuwenhuijsen et al., assessed the validity of the DASS in a work context and found high sensitivity (92%) but only 40% specificity (positive case cut off score of 5).

Although the DASS had lower specificity for anxiety, compared with the 4DSQ, the GDG noted that the DASS 21 is manageable for use in the general practice setting, available and in the public domain, whereas the 4DSQ is a 50 item tool that may not be suitable for use in a GP consultation. Further, this instrument is not widely used in Australia and would therefore require additional training for GPs to use it. However, since the DASS had low specificity, it cannot be used to confirm a diagnosis; however, the content and structure of the DASS are suitable for use by GPs in a clinical interview to assist in making a diagnosis (i.e. as a screening tool). In addition, the DASS software is easily accessible, available in the public domain and can reasonably be completed within a GP consultation.
Tools for the diagnosis of anxiety disorders were discussed in three guidelines; NICE 2016 CG90, NICE 2011 GAD and Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2017 (Draft).

The NICE clinical guideline for depression included a review of the Hospital Anxiety and Depression Scale (HADS), which is a measure of depression and anxiety for people with physical health problems. A total of 21 studies were included in the review, however meta-analysis could not be conducted due to very high heterogeneity ($I^2=90\%$) from the different patient populations groups considered. The NICE clinical guideline specifically addressed generalized anxiety disorder; however, it did not recommend the use of any particular tool for the diagnosis of generalized anxiety disorder. Instead, the following recommendation was given: “There is insufficient evidence on which to recommend a well-validated, self-reporting screening instrument to use in the diagnostic process, and so consultation skills should be relied upon to elicit all necessary information.”

The RANZCP 2017 draft guideline recommends the use of four well-established 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. However, these tools require administration by a trained practitioner and require at least an hour to complete, so they would not be feasible to use in the general practice context.

The RANZCP 2017 draft guideline also recommends using either the Penn State Worry Questionnaire-3 (PSWQ-3) or the Generalized Anxiety Disorder-7 (GAD-7). The PSWQ-3 is a three-item generalized anxiety disorder-specific questionnaire. As such, it would not detect other anxiety disorders such as social phobia or generalized anxiety disorder which are described in the DSM-5. It would be difficult to use specific screening tools for each type of anxiety disorder and unreasonable to expect GPs to be familiar with utilising these tools. The GAD-7 is a seven–item screener for symptoms of generalized anxiety disorder. The more suitable option to identify anxiety, therefore, is the GAD-7, which considers many aspects of anxiety and can be used as a screening tool to assess the severity of a range of anxiety disorders.

Of the tools identified in this review, the GDG considers the DASS and GAD-7 to be most appropriate for use in the general practice setting. Since the DASS has high sensitivity but low specificity, it could be used along with a GAD-7 to assess anxiety.

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. They can also be used as tools 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 and to complete a diagnosis.

**Post-traumatic stress disorder**

Assessment of the Post Traumatic Stress Disorder Checklist-Civilian version (PCL-C) in a work context demonstrated high sensitivity (90%) and good specificity (79%) for the detection of PTSD 46.

The GDG considers the PCL-C to be a useful and feasible tool for use in the general practice setting. GPs may also note that a newer version of the PCL-C, known as the Post Traumatic Stress Disorder Checklist-5 (PCL-5) is now available. The PCL-5 is a 20-item tool that assesses the 20 symptoms of PTSD as described in the *DSM*-5. However, psychometric assessment is not yet available for this tool as it was only published recently.

**Substance use and addictive disorders**

The evidence review did not identify any relevant tools for the diagnosis of addictive disorders in the work context. The GDG utilised the NICE 2011 clinical guideline for alcohol use disorder 33 as the foundation for its recommendation. The clinical guideline recommends the following tools for identifying people with alcohol or substance use disorders: the Alcohol Use Disorders Inventory Test (AUDIT) (alcohol only), the Severity of Alcohol Dependence Questionnaire (SADQ) (alcohol only), the Leeds Dependence Questionnaire (LDQ), and the Alcohol Problems Questionnaire (APQ) (alcohol only).

The Alcohol Use Disorders Inventory Tool (AUDIT) may be used for case identification and initial assessment of the severity of a problem. NICE clinical guideline states that it has high internal consistency however there is no available data about the reliability of AUDIT in young adults 33. The committee discussed that most Australian GPs would be familiar with the AUDIT.

The GDG also considered potential value of using the AUDIT Alcohol Consumption Questions (AUDIT-C) tool. The AUDIT-C is a three item version of the AUDIT. It has been used in male veterans affairs patients, but not 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% 47.

Both the AUDIT and the AUDIT-C tools are easily accessible to Australian GPs and easy to complete.

The SADQ 48 is a 20-item questionnaire that may be used to assess the presence and severity of alcohol dependence. The NICE guideline 33 recommends use of the SADQ because it has high test-retest reliability (correlation coefficient ranged from 0.55 to 0.82 across individual questions); 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. The SADQ is freely available electronically.

The LDQ is a ten-item questionnaire designed for measuring substance dependence and severity. 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 has satisfactory test–retest reliability and internal consistency. It is freely accessible to Australian GPs and is quick and easy to use. The SADQ may be used to assess the nature and extent of the problems associated with alcohol misuse.

NICE references two studies that indicate that the APQ has high reliability and validity for assessing alcohol-related problems in people with alcohol use disorder. Despite high reliability and validity, we do not recommend APQ for assisting with the diagnosis and severity of an alcohol disorder as it is 1) skewed towards people with severe alcohol, 2) very long and 3) some of the questions in the APQ may be offensive to patients and therefore not appropriate.

Of the tools considered, the only tool that addresses substance use disorder is LDQ. Given that the LDQ had satisfactory reliability and consistency, and is accessible and easy to use, this tool may be used by GPs who suspect a substance use disorder in their patient.

The GDG recognises that patients with alcohol or substance use disorder sometimes have comorbid addictive disorders. We, therefore, consider it worthwhile for GPs to ask patients about their gambling habits or opioid use. The latter 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.

None of the tools recommended here require special training for their administration or interpretation and may be completed by the patient.
B. Is the mental health condition work-related?

According to national claims data, the most common causes of work-related stress are work pressure (32%) and work-related harassment and/or bullying (24%). Within the subcategory of work pressure, the most common instances of mental stress arise from work backlogs/deadlines, organisational re-structures, interpersonal conflicts, disciplinary actions, performance counselling or promotion disappointment. Other causes for work pressure include poor relations with boss or colleagues, role ambiguity and poor physical working conditions.

For a GP who is caring 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 a patient’s mental health condition. Embedded within this judgement is an understanding the contribution of any pre-existing illness or other non-work factors to a current mental health condition.

Whether a mental health condition has arisen out of work has significant implications on a patient’s recovery (for instance, determining the appropriateness of a current workplace or the duties that a patient would be expected to undertake at work) and success of a compensation claim (for those patients that choose to submit a claim). Nevertheless, determining whether work has contributed to a MHC is a key concern that has been described by Australian GPs. In particular, this was because claims relating to bullying and harassment were difficult to authenticate, and because clinicians found it difficult to distinguish between a mental health condition that developed as a result of work-related stress and pre-existing mental illness secondary to work.

Review Q2: 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?

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. 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.

Recommendation for future research

Consensus statement
A systematic review of the literature identified 13 tools in 13 studies. However only three of these studies\textsuperscript{53-55} reported both reliability and validity of tools in the work setting which can be used for assessing the probability of that a mental health condition has arisen as a result of work. These tools were the Work Environment Subscales of the Work Health Check (WHC)\textsuperscript{53}, the Workplace Stressors Assessment Questionnaire (WSAQ)\textsuperscript{55} and the FIT questionnaire\textsuperscript{54}.

The Work Environment Subscales of the Work Health Check (WHC) aims to measure features of the psychosocial work-environment that are associated with employees’ experiences of stress and health. It differentiates from the WHC\textsuperscript{53}, which assesses health behaviours, health prevention activities, medical history, personality, perceived stress and psychosomatic symptoms. Gadinger et al.,\textsuperscript{53} conducted a cross-sectional study to analyse the validity and reliability of the Work Environment Subscales of the WHC. A total of 941 employees who represented 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 (α=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 Workplace Stressors Assessment Questionnaire aims to systematically monitor employees’ perceptions of workplace-related stressors\textsuperscript{56}. It comprises 22-items covering six major domains: demands, control, support, role, rewards and relationships. The authors report that the WSAQ had good reliability (α 0.69-0.93), but scale rated low on validity (r=0.11-0.56).

Given the low validity of both the WES and the WSAQ and the absence of validity and reliability data for other tools the GDG 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.

Despite the WES and the WSAQ not having sufficient evidence that they are reliable and valid, the GDG considers the content of these tools to be useful and relevant for a clinical assessment. As such, GPs can use these tools to guide history taking and clinical assessment.

In the absence of a validated tool, a clinical judgement about the work-relatedness of a mental health condition should be made using a good history of the injury, the person’s circumstances and current and past medical history. A person’s GP is ideally equipped – with their own knowledge of the patient and their history – to determine whether the current injury 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.
A note on the implications of making a determination of the work-relatedness of a MHC

It is important for GPs to be aware that whilst they are required often to provide an opinion about the work-relatedness of a mental health condition, their opinion does not stand alone as the determining factor in a compensation claim, but is considered along with other evidence (e.g. from psychologists, the injured worker and from other sources).

It is important also for GPs to have awareness of the legislation that is relevant for their patients, and the implications for their patient. In particular, GPs should be cognisant of the definitions of work-relatedness and be aware that these might vary between compensation jurisdictions. For instance, in some jurisdictions, a patient with a previous psychiatric history will not be eligible to claim for a psychiatric injury.
C. How can I ensure that the patient understands and acknowledges the diagnosis?

The RACGP Standards for General Practices 4th edition 57 state that 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.” For patients with mental health conditions, the level of understanding and acknowledgement of a diagnosis can impact on the effectiveness of management strategies and ultimately on patient recovery. In a work context, additional social concerns such as those associated with workplace discrimination or stigma or financial security may also influence a patient’s willingness to understand and accept a diagnosis of a work-related mental health condition.

The following guidance has been developed to assist GPs on how 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 the implications of the diagnosis, including an understanding of recovery expectations. We emphasise that communication about a diagnosis must provide an optimistic view for recovery.
Review Q8. 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?

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

<table>
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<tr>
<th>Consensus statement</th>
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<tbody>
<tr>
<td>a. patient concerns such as the potential for stigma or discrimination;</td>
</tr>
<tr>
<td>b. a patient’s socio-cultural background which may affect their acknowledgement of a mental health condition;</td>
</tr>
<tr>
<td>c. negotiating patient confidentiality and sharing of information with a person’s family or carer, if necessary.</td>
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</table>

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.

<table>
<thead>
<tr>
<th>Consensus statement</th>
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<tbody>
<tr>
<td>To ensure that the diagnosis of a work-related mental health condition is understood by the patient the GP should:</td>
</tr>
<tr>
<td>a. provide information to the patient about the nature of the mental health condition, recovery expectations and the range of treatments available;</td>
</tr>
<tr>
<td>b. provide the patient with educational material in a format that they can understand;</td>
</tr>
<tr>
<td>c. promote a patient-centred recovery based approach.</td>
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</tbody>
</table>

The guideline development evidence review team searched for existing clinical practice guidelines and identified nine guidelines. The guidelines ranged in quality with the lowest scoring 67% and the highest scoring 97% on the AGREE-II checklist. Recommendations within these 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.

Four themes arose from these guidelines: i) general principles involved in diagnosis that impact on a patient’s understanding; ii) the value of establishing a therapeutic alliance; iii) what information is
helpful to facilitate a patient’s understanding and acknowledgement of their diagnosis; and iv) the content of this information.

The value of establishing a therapeutic alliance

Two guidelines discussed the value of establishing a therapeutic alliance. Both guidelines were based on low quality evidence, however the recommendations were labelled as strong. These were:

- 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) (Trangle et al., 2016, STRONG).
- Psychiatrists should work to establish and maintain a therapeutic alliance so that the patient’s care is a collaborative endeavour (American Psychiatric Association 2010, Recommended with substantial clinical confidence).

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

The NICE 2016 guidelines offered a number of consensus-based recommendations regarding principles to consider when diagnosing a patient with depression. These were:

- 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. These were:

- Provide information about the nature and course of depression and range of treatments available (NICE 2016, consensus).
- Advise patients to be vigilant for mood changes, negativity and hopelessness (NICE 2015, consensus).
- Provide psycho-education around physical injuries that may lead to mental health symptoms (UNSW 2013, consensus).
- Provide education about panic disorder and its treatment (American Psychiatric Association 2010, STRONG for).
Factors to consider when offering information packages to a patient

A number of NICE guidelines and the American Psychiatric Association (APA) 2010 guidelines provide guidance about the type of information that should be given to patients. These were:

- Language that is readily understandable to the patient American Psychiatric Association (2010 STRONG for) 66, (NICE 2016 consensus) 67
- Provide information appropriate to their level of understanding about the nature of depression and the range of treatments available (NICE 2015 young people) 70
- Avoid clinical language without adequate explanation (NICE 2016 consensus) 67
- Provide and work proficiently with independent interpreters (that is, someone who is not known to the person with depression) if needed. (NICE 2016 consensus) 67

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

With regards to the NICE 201667 recommendation “Be respectful of and sensitive to diverse background”, the GDG replaced “diverse background” (NICE 2016) 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 GDG also removed the word “sensitivity” (NICE 2016) as this phrase has negative connotations attached to it.

When providing information to patients about their symptoms and diagnosis, GPs can use this opportunity to help the patient to understand their own stress response to a situation or stressor. This may assist the patient to develop more healthy coping strategies in the future.

The GDG considered that recovery expectations are often formed at the time of diagnosis. We therefore agreed that in order to provide a positive recovery expectation to patients at the time of diagnosis, GPs be realistic but optimistic about recovery. A final consensus statement was therefore developed to advise GPs to promote a patient-centred recovery based approach at the time of diagnosis.

NOTE: The GDG also felt that it was appropriate for GPs to adopt the same optimistic and realistic approach with regards promoting recovery for patients who have a work-related musculoskeletal injury; as this may assist to prevent the development of a secondary mental health condition.
D. Is the patient developing a comorbid mental health condition?

The presence of two or more chronic conditions is common in general practice and can often complicate the assessment and management of MHCs such as depression. In Australia, 75% of 65-74 year olds presenting to a GP with depression commonly have a comorbidity. Comorbidities are also prevalent in younger people with depression - Pefoyo et al., found that up to 35% of patients aged between 18-65 years presenting with depression had at least one comorbidity.

Patients with a chronic physical condition are at a higher risk for developing a comorbid MHC such as depression. This may be due in part to a patient having unrealistic recovery expectations from their original illness. Additionally, slow physical or psychological recovery and/or protracted return to everyday activities, such as returning to work, may also prompt the emergence of a MHC.

Taking this into account, we aimed to identify factors that assist a GP to detect a comorbid work-related MHC in patients who have a physical or psychological primary injury.

Review Q3. In workers, what factors assist in the early detection of a comorbid work-related mental health condition?

<table>
<thead>
<tr>
<th>GPs may consider the following factors to assist in the early detection of a comorbid work-related mental health condition:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• job strain</td>
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<tr>
<td>• failure to return to work following injury</td>
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<tr>
<td>• past experience of, and response to, treatments</td>
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<tr>
<td>• greater pain intensity, where physical injury was the precursor to the mental health condition</td>
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<tr>
<td>• lower self-efficacy (i.e. the capacity for one to cope with difficult demands through one’s own effort)</td>
</tr>
<tr>
<td>• lack of social support and personal relationship status (i.e. relationship problems)</td>
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<tr>
<td>• perception of injustice of the compensation claim process</td>
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<tr>
<td>• any comorbid medical condition</td>
</tr>
<tr>
<td>• any comorbid substance misuse</td>
</tr>
<tr>
<td>• a chronic physical health problem</td>
</tr>
<tr>
<td>• past history of depression</td>
</tr>
<tr>
<td>• pre-existing depressive disorder or other anxiety disorder</td>
</tr>
<tr>
<td>• insomnia, low mood, anhedonia and suicidal thoughts</td>
</tr>
</tbody>
</table>

Recommendation

LOW quality evidence

GRADE: Weak FOR
A search of the literature identified four original studies\textsuperscript{75-78}. These studies used either a case control, cross-sectional or cohort design 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 justice within the compensation scheme with mental health outcomes 12 months after a moderate or severe injury\textsuperscript{76}. A total of 433 participants were included in the analysis. This study found that pain severity, pain catastrophizing, 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).

Anderson et al.,\textsuperscript{75} 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 6 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% percent higher than patients who returned to work, p<.001).

Pjanic et al.,\textsuperscript{78} 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 study sample comprised 274 patients. The primary difference in the patients who completed the study versus 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 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 were included).

The systematic literature search was supplemented with a search for clinical practice guidelines that included recommendations pertaining to the detection of comorbid mental health conditions. A total of 16 guidelines addressed the factors assisting in early detection. Of these, seven guidelines\textsuperscript{67-69,79} offered specific recommendations for factors assisting with early detection of a
comorbid mental health condition and were, therefore, adapted for use in this guideline. The recommendations that were considered by the GDG for adaption or adoption in this guideline are as follows:

- Consider the diagnosis of generalized 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.* [UK NICE, 2011 GAD, consensus] 42

- 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, strong] 67

- 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, seeking specialist advice if necessary. [UK NICE, 2015, HIGH] 68 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 Alcohol MOD] 33

- 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] 63

- 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, HIGH] 67

- As part of the comprehensive assessment, consider how the following factors might have affected the development, course and severity of the person's GAD: *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.* [UK NICE 2011 GAD, LOW] 42

- 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, VERY LOW] 79
Given the high quality of these guidelines and relevance to Australian general practice, all of these recommendations were adapted for inclusion in the present guideline. The GDG recognises that GPs, as part of their usual care, may already consider some of the factors that are listed for consideration in the above recommendation (e.g. insomnia, anhedonia etc.) as part of initial history taking and diagnosis; however, the GDG considers it prudent to be explicit about these factors to remind GPs about what factors to consider.
5. Management

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

GPs play an important role in guiding the treatment of mental health conditions to achieve personal recovery and return to work for their patients. GPs are often the first clinicians to discuss the potential diagnosis and possible management strategy, thereby a realistic and optimistic attitude can set the tone for a positive recovery trajectory for their patients.

In a national study, which was undertaken as a prelude to this guideline, Australian GPs reflected that treating a patient with a work-related mental health condition was complex. GPs indicated that complexities often arise from the management of symptoms that may relate to more than one mental health condition, delivery of therapies for more severe cases, managing mental health conditions in patients who have a physical work-related injury, determining whether a return to work could be incorporated within a treatment strategy, and finally the GP’s limited expertise and confidence in managing patients with a work-related mental health condition.

Therefore our review questions focussed on what GP strategies might result in the highest level of personal recovery and/or return to work.

Review Q4. In patients with a mental health condition, what GP strategies result in the highest level of personal recovery and/or return to work?

<table>
<thead>
<tr>
<th>Recommendation for future research</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Consensus statement</td>
</tr>
<tr>
<td>GPs should refer to existing high quality guidelines for the management of mental health conditions.</td>
</tr>
<tr>
<td>Recommendation</td>
</tr>
<tr>
<td>In patients with a secondary work-related mental health condition, work-directed cognitive behavioural therapy is effective at improving return to work.</td>
</tr>
<tr>
<td>MOD level evidence</td>
</tr>
<tr>
<td>GRADE: Weak FOR</td>
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</table>
The systematic literature review included 17 original studies and nine systematic reviews; that addressed the review question. Of the 17 original studies, eleven were randomised controlled trials (RCTs), and the other six were non-randomised design studies. Anxiety, depression were addressed together in most studies, with some also including adjustment disorder, PTSD or other mental health conditions. One study considered PTSD alone.

Nine of the eleven RCTs were undertaken in a work-context while two did not consider work. Interventions from the nine studies that considered work were grouped into the following themes: 1. Interventions that incorporated an aspect of multidisciplinary collaborative care; 2. Enhanced primary care; 3. A social worker-led approach; 4. Guideline based care by occupational physician; 5. Other (individual or group therapy or minimal intervention). The interventions that did not consider work investigated the effects of cognitive behavioural therapy (CBT) vs counselling vs GP usual and an internet based self-help CBT.

Interventions that incorporated an aspect of multidisciplinary collaborative care

Bender et al. investigated the effect of a multidisciplinary assessment and treatment program comprising return to work 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, 6 months after the intervention. This study was rated LOW due to a serious risk of bias.

Volker et al. investigated 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, plus an email decision aid compared with occupational physician treatment as usual. This study found a higher rate of RTW with the intervention but this was not significant.

Shippe et al. investigated 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 6 months in favour of the collaborative care. The study was rated as LOW due to a serious risk of bias.

Netterstrom et al. investigated the effect of a collaborative approach comprising a specialist in occupation medicine, psychologists, and a care manager on personal recovery and RTW rates in patient with stress or depression compared with GP usual care. The study found no significant effect
on symptom reduction, however it did find a significant improvement in RTW three months after the intervention.

Vlasveld et al., 82 also investigated the effect of a collaborative approach comprising a specialist in occupation medicine, psychologists, and a care manager on personal recovery and RTW rates in patients with stress or depression compared with GP usual care. The study found no significant effect on symptom reduction and no significant effect on RTW 12 months after the intervention.

**Interventions that emphasised enhanced primary care**

Rost et al., 89 investigated the effect of an enhanced primary care intervention (physicians and care managers trained in guidelines based management of depression with pharmacotherapy) on antidepressant use. This study found no evidence that an enhanced primary care management program reduced the number of months of antidepressant use. This study found no difference in sick leave between intervention and usual care.

van der Klink et al., 95 studied an “innovative activating intervention” vs. 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 significant rate of either partial or full return to work rates at 3 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.

**An intervention using a social worker-led approach**

Brouwers et al., 102 investigated 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”) on symptom improvement compared with GP usual care. This study found a non-significant trend towards symptom improvement but no significant effect on RTW rates.

**Guideline based care by occupational physician**

Rebergen et al., 84 investigated the effect of care delivered by occupational physicians trained in guideline based care on return to work outcomes in police men and women compared with occupational physician usual care. The study found a significant improvement in RTW rates at 12 months in patients who received the intervention.

**Intervention focussing on individual or group therapy**

Nystuen and Hagen 94 undertook a subgroup analysis of patients with psychological distress and burnout in an RCT including patients on sick leave. The intervention involved individual or group “solution focussed practice” that encompassed coping strategies, peer support and goal setting. The
intervention resulted in significantly better mental health status at 6 months than treatment as usual and no difference in length of sick leave.

**Minimal intervention**

Fleten and Johnsen ⁹¹ 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” focussing on information about return to work on modified duties. The study found no difference in length of sick leave at 12 months.

**Non-work related interventions**

Kivi et al., ⁹³ investigated an internet-based cognitive behavioural therapy (iCBT) vs. usual care for depression. The intervention involved a 12 week interactive self-help program comprising of 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 participants who received iCBT or usual care.

Holst et al., ⁹² was a secondary evaluation of patient’s experiences of the intervention from the above RCT. 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 found it stressful because of the limited contact with the therapist nature of the self-help iCBT.

King et al., ⁸⁸ investigated the effect of CBT, non-directive counselling or 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.

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 suggests that collaborative care had no significant effect on RTW, although there was a trend towards improving RTW rates.

In addition to primary studies, the review identified eight systematic literature reviews ⁹⁶ ⁹⁸ ¹⁰¹ ¹⁰³ that addressed the question.

Nigatu et al., ¹⁰¹ 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 ⁸¹ ⁸² ⁸⁴ ⁸⁵ ⁹⁴ ¹⁰² were also identified in our evidence search. 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 return to work 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.,\textsuperscript{103} evaluated 23 studies describing the effectiveness of interventions aimed at reducing work disability in employees with depressive disorders. Two studies in this review\textsuperscript{82,89} 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 included 9 studies describing interventions that were aimed at facilitating RTW for workers with adjustment disorders\textsuperscript{98}. Two studies in this review\textsuperscript{84,90} were also identified in our evidence search. The studies included in this review described 10 psychological interventions: five were based on CBT and the other five were based on problem solving therapy. Of the CBT-focused studies, two focussed 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 effective at assisting people to return to work compared with CBT. Specifically, the authors’ main findings and conclusions were that 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.
- Moderate quality evidence that problem solving therapy significantly enhanced partial RTW at 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.

Cullen et al.,\textsuperscript{100} reviewed 36 studies describing interventions aimed at improving RTW outcomes in workers with musculoskeletal or pain-related conditions and a comorbid mental health condition\textsuperscript{104}. 

Draft Clinical Guideline version: 12-01-18
This review included a study that was identified in our evidence search. The interventions described in this review were categorised into four domains: i) health-focused interventions; ii) service coordination interventions; iii) work modification interventions; and iv) multi-domain interventions. The authors found the strongest evidence for 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 strong evidence for work-focused CBT and strong evidence against traditional CBT.

A systematic review conducted by Jayakody et al., reported findings from 8 RCTs and found that regardless of type (aerobic vs. non-aerobic), exercise may reduce anxiety symptoms but is less effective than antidepressants but 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., included 10 studies, 85% reported high risk of bias. This study concluded that exercise cannot replace conventional treatments, such as selective serotonin reuptake inhibitors or cognitive-behavioural therapy, though, can still be recommended as an additional treatment modality.

A systematic review conducted by Druss et al., was informed by two out six included RCTs from 2001 and 2003 and found that rates of abstinence from alcoholism were significantly greater in the intervention (75% vs. 48%) in medically ill patients with alcoholism. A subgroup of those with addictive related medical and mental disorders also showed significantly greater abstinent rates (69% vs. 55%), while there was no difference in the full group with addiction and other comorbidities.

Dorflinger et al., assessed the effect of primary care physicians trained in CBT on MHC outcomes. Two out of nine included studies evaluated the effect of primary care physicians trained in CBT on patients’ MHC outcomes. One showed a significant improvement in global psychological distress, the other found no difference on depression and anxiety outcomes.

There are few studies that have been undertaken in the general practice setting to address strategies for managing work-related mental health conditions. Some shortcomings of the evidence are: 1. The focus on RTW or a reduction in the duration of sick leave, rather than patient recovery outcomes; 2. Existing systematic reviews have generally grouped and addressed different mental health conditions together, without giving regard to the specific requirements of individual diagnoses, (e.g. the management of a substance use disorder and depression are notably distinct); and 3. The systematic reviews used different approaches to analyse interventions Nigatu et al.,
discussed all intervention types together, while Nieuwenhuijsen et al.,\textsuperscript{103} discussed interventions grouped by design.

The GDG concluded that the evidence for GP interventions to improve personal recovery and RTW in patients with a primary work-related mental health condition is inconsistent. However, there appears to be some value in prescribing exercise, as an adjunctive treatment for patients with mental health conditions. 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.

For patients who have a primary work-related mental health condition, the GDG recommends that GPs draw upon current high quality guidelines for the management of mental health conditions. It is important to be aware, however, that the key parties who are involved in the recovery of patients with work-related mental health conditions often extend beyond the patient and the core clinical team. Other key people or groups to consider involving in the patient’s care are the person’s employer, a return to work coordinator, compensation scheme claim’s officer, and other relevant clinicians (e.g. a physiotherapist for patients who have comorbid musculoskeletal injuries). In addition, 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 in treatment planning.

When discussing treatment approaches for Aboriginal and Torres Strait Islander people, GPs should be sensitive to cultural needs and dealing with current and past trauma. A range of high quality resources that have been designed for clinical use are located at the Australian Indigenous HealthInfoNet:\url{http://www.healthinfonet.ecu.edu.au/other-health-conditions/mental-health/resources/practice-resources/guidelines}

For patients with a secondary work-related mental health condition, there is strong evidence in favour of work-focussed CBT at reducing sickness absence, compared with traditional CBT.\textsuperscript{104} The GDG has therefore recommended that GPs use work-focussed CBT for those patients who develop a secondary mental health condition, following a primary work-related injury.

For all patients with work-related mental health conditions, treatment is likely to involve a collaborative effort between key parties. The GDG recommends that GPs refer to the RANZCP guidelines on communication between psychiatrists, general practitioners and psychologists for best practice approaches to referral, communication and shared care.\textsuperscript{109}
B. Why isn’t the patient’s condition improving as expected?

GPs have a central role in monitoring the progress in the recovery and providing advice regarding appropriate medical treatments needed for recovery. In patients with a work-related mental health condition, a number of factors can promote or delay recovery. For example, there is strong evidence that a patient’s recovery expectations 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 induced.

As the primary certifier of sickness certificates GPs, are actively and regularly involved in a patient’s recovery as they might see a patient to provide updated sickness certificates, or manage other clinical conditions. These consultations with the patient should be used opportunistically to monitor a patient’s mental health as part of their care.

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.
Review Q5. In patients with a diagnosis of a work-related mental health condition what factors adversely affect progress in the patient’s condition?

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

a. Medical factors
   - persistent symptoms prior to going on sick leave
   - higher degree of severity of mental health conditions (distress, depression, anxiety and somatization)
   - longer duration of symptoms and longer sick leave duration at baseline
   - extensive physical injury
   - chronic pain
   - quality of rehabilitation services;

b. Health behaviours and attitudes
   - alcohol intake, smoking, drug dependence
   - overweight, underweight
   - attitude towards return to work
   - reduced expectations by patients about being able to return to work;

c. Employment/workplace factors
   - job/work stress
   - poor communication with supervisor/employer
   - harassment and bullying as a precursor to the mental health condition;

d. Personal/patient factors
   - stressful life factors outside of work
   - patients aged >40 years.

Recommendation

HIGH level evidence
GRADE: Strong FOR

One systematic review\textsuperscript{112} and eleven original studies\textsuperscript{3 86 87 113-120} were identified in the literature search. Of the eleven original studies, one was a prediction study which used the results from an RCT, and the remaining ten were cross-sectional, case control or cohort studies.
The systematic literature review \textsuperscript{112} 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. \textsuperscript{115} utilised the data from an RCT that compared the effectiveness of an intervention by social workers to usual care by general practitioners 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 find factors that predict RTW after three and six months in 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 RTW. These were:

- Persistent symptoms prior to going on sick leave;
- Higher degree of severity of mental health conditions (distress, depression, anxiety and somatization);
- Longer duration of symptoms and longer sick leave duration at baseline.

In addition, the patients’ expectations about being able to RTW within 6 weeks of their sick leave predicted indeed a higher return to work rate 3 months later. Moreover, patients who had recently been in contact with the occupational physician had significantly lower chances of RTW 3 months after baseline.

The ten remaining studies \textsuperscript{3 86 87 113 114 117 118 120-122} were conducted in a range of countries including Norway, the Netherlands, Sweden, USA and four studies in Australia \textsuperscript{3 87 118 121}. These studies addressed factors that affect RTW outcomes in patients with anxiety, depression, PTSD, adjustment disorder and other unspecified mental health conditions. These studies used a range of methods including two which involved the analyses of large databases \textsuperscript{87 113}. Despite a high overall risk of bias due to the nature of the study designs, the total number of patients was over 300,000. Due to the large number of patients included in the studies, along with 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. These are:

- Employment/workplace: supervisor employer communication, harassment and bullying as precursor to MHC; job/work stress
- Medical factors: greater MHC symptom severity; extensive physical injury; chronic pain; quality of rehabilitation services
- Health behaviours: Alcohol intake, smoking, drug dependence, overweight, underweight, attitude towards recovery
- Personal/patient factors: Stressful life factors outside of work; older age (>40)
- Increased likelihood in certain employment sectors: Agriculture, construction, wholesale and retail, financial services.

While the majority of the factors described in the literature are considered to be relevant to the Australian context, our GDG 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 individually. Secondly, this study was undertaken in an international context, which may not reflect the Australian context. Indeed, the GDG also noted that high-risk employment sectors are likely to vary depending on the region, state of the economy and other factors.
C. What can I do for a patient who is not improving?

For a GP who is caring for a patient with a work-related mental health condition who is not improving, it is important that GPs have knowledge of strategies they can use to address non-improvement and enhance patient recovery and return to work. A range of approaches including engagement with the patient’s workplace or the use of clinical strategies such as cognitive behavioural therapy (CBT), telemedicine, and pharmacotherapy could be used by GPs to address non-improvement in a patient’s condition.\(^{123-127}\)

Taking this into account, the GDG conducted a literature search to identify strategies that GPs could use to address non-improvement of a patient’s mental health condition or earlier return to work.

Review Q6. In patients with work-related mental health conditions who are not improving, what strategies should a general practitioner undertake to improve the patient’s condition?

<table>
<thead>
<tr>
<th>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.</th>
<th>Recommendation for future research</th>
</tr>
</thead>
<tbody>
<tr>
<td>In patients with a persistent mental health condition that has arisen out of work, GPs 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.</td>
<td>Consensus statement</td>
</tr>
<tr>
<td>Where no work-related or non-work-related stressors can be identified, and where persistent depression is present, a GP could consider the following evidence based approaches to treat the persistent depression: a. Collaborative care between relevant health professionals for patients with persistent depression; b. Cognitive behavioural therapy as an adjunct to pharmacotherapy for patients with treatment-resistant depression.</td>
<td>Recommendation HIGH quality evidence GRADE: Weak FOR</td>
</tr>
</tbody>
</table>
The evidence review identified six original articles\(^{123-126,128}\). Of the original studies that were identified in the review, all addressed strategies that can improve a patient’s condition, however only one addressed non-improvement in a work-related context\(^{124}\).

This study by Franche et al.,\(^{124}\) 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 (over 6 months) was related to under diagnosis and undertreatment and the length of time off work due to injury. The authors conclude that resolution of depressive symptoms in workers with a musculoskeletal injury may be a reaction to the physical injury. Therefore they suggest that these patients may not require specialty mental health services. Instead, supportive counselling by a health professional may be adequate.

The remaining five (non-work-related) studies included three RCTs\(^{123,128,127}\) and two cohort studies\(^{125,126}\). 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.,\(^{123}\) 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 providers and off-site depression care manager, pharmacist, psychologist and psychiatrist. The practice-based approach included only an onsite primary care provider and onsite 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 6 months, however no difference was found at 12 months. The GDG considers that the telemedicine approach described in Fortney et al\(^{123}\) telemedicine was used as a method for multidisciplinary teams to communicate and work collaboratively.

Wiles et al.,\(^{127}\) 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 a pharmacotherapy approach. The study also reported a greater quality of life for patients in the intervention arm after 12 months.

Thompson et al.,\(^{128}\) 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 125 126 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.

The quality of the studies that investigated either collaborative care or CBT as an adjunct to pharmacotherapy were both of high quality. The GDG therefore felt that it was important to develop a recommendation based on this evidence. It should be noted, however that the search strategy was restricted to compensable work only. Had the search been more generalised we would anticipate significantly more evidence for strategies to manage treatment-resistant mental health conditions in general. Given the restricted search criteria, the GDG gave the recommendation a GRADE of weak FOR, despite the one high quality study upon which it is based. Collaborative care between clinicians is important to ensure that the patient’s needs are kept at the centre of any treatment plans. GPs should refer to the RANZCP guideline 109 for best practice approaches to clinical collaboration between GPs and psychiatrists.

The GDG also developed a consensus statement with the following considerations: First, it is important 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). Secondly, where a GP is not in a position to manage a work-related stressor (e.g. ongoing bullying), the GP should advocate to the workplace on behalf of the patient to help to manage the stressor. Experienced GPs on the GDG recommend using case conferences as a useful method for 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.
D. What strategies are effective at managing comorbid mental health conditions?

People with work-related musculoskeletal injuries are at a risk of developing secondary mental health conditions such as depression, or excessive substance use. In addition, patients with work-related psychological injuries are at an increased risk of developing further mental health conditions.

Patients are not likely to initiate discussions about comorbidities such as harmful alcohol consumption with their doctor due to GP consultations being too brief, the stigma attached to a diagnosis, and the perception that their GP lacks skills in this area. However, the general practice setting care is an established context for addressing health-related behaviours and thus can be a useful setting for identification of comorbidities such as alcohol misuse and problematic gambling in patients with a work-related mental health condition.

Taking this into account, the GDG sought to explore the literature for strategies Australian GPs can adopt to detect, manage and better address comorbidities in patients presenting with a work-related mental health condition.
**Review Q9. In patients with work-related mental health conditions, what interventions are effective at managing comorbid substance misuse and addictive disorders by GPs?**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs should note the presence and severity of comorbidities in their assessments, with a view to considering their implications for treatment planning.</td>
<td><strong>Consensus</strong></td>
</tr>
<tr>
<td>GPs should use an integrated approach for people with work-related mental health conditions and comorbid substance use disorders.</td>
<td><strong>Consensus</strong></td>
</tr>
<tr>
<td>Individual-based trauma-focussed psychological therapy delivered along with substance use disorder therapy is more effective than usual treatment for PTSD.</td>
<td><strong>Recommendation</strong></td>
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<td></td>
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<tr>
<td><strong>In the context of PTSD and substance use disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>a. The trauma-focussed 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.</td>
<td><strong>Consensus</strong></td>
</tr>
<tr>
<td>b. 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.</td>
<td><strong>Consensus</strong></td>
</tr>
</tbody>
</table>

A review of the literature produced a single high quality RCT 131. This study investigated brief interventions to reduce problematic drinking, which included 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.

Since 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 high quality clinical guidelines and / or systematic reviews. A search for relevant clinical guidelines and systematic reviews produced clinical guidelines 33 42 63 132-135 and two high quality systematic reviews 136 137. Of
the seven guidelines, three were produced in Australia \(^{63,134,135}\), three were produced in the UK \(^{33,42,133}\) and one guideline (Department of Veteran’s Affairs) was produced in the USA \(^{132}\). Two key themes emerged from the clinical guidelines and systematic reviews: 1) Assessment and monitoring; and 2) treatment approaches.

**Assessment and monitoring**

Three guidelines specifically addressed the issue of assessment and monitoring; *NICE 2011 Alcohol* \(^{33}\), *Department of Veteran’s Affairs 2015* \(^{132}\) and *Phoenix 2013* \(^{135}\). *NICE 2011 Alcohol* guidelines \(^{33}\) 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 *Department of Veteran’s Affairs 2015* guideline \(^{132}\) for the monitoring of substance use disorders. This guideline was created using evidence and it was graded WEAK for. The Phoenix guidelines \(^{135}\) add further advice, in the form of good practice points, about the nature and content of assessments as follows:

- “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”.

This last point was adapted for inclusion as a consensus statement in this guideline.

**Treatment approach**

Five guidelines addressed treatment approaches for patients with alcohol and/or substance misuse and a comorbid mental health condition; *NICE 2011 GAD* \(^{42}\); *Black Dog Institute 2015* \(^{63}\); *Department of Veteran’s Affairs 2015* \(^{132}\), *NICE 2011 Alcohol* \(^{33}\); *NICE Drug Misuse 2007* \(^{133}\).

Four guidelines \(^{63,133,134,135}\); recommended using an integrated approach for people with comorbid mental health conditions and a substance use disorder. The Black Dog Institute 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 \(^{63}\) and the
Phoenix guidelines added a more detailed caveat “In the context of PTSD and substance use disorders, the trauma-focussed 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.” 135 These recommendations were all based on expert consensus.

By contrast, a recent review 136 concluded that individual trauma-focused psychological therapy delivered alongside substance use disorder therapy did 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. Roberts et al., 136 reviewed 13 studies that described four types of treatments: psychological therapies with a trauma-focused component; psychological therapies with a non-trauma-focused interventions; treatment as usual and other active psychological therapies on PTSD and substance use disorder. Roberts et al. 136 found that individual-based trauma-focussed 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 (4 studies; author rating: very low quality evidence);
- Not more effective than treatment as usual for treating substance use disorder at follow-up but was effective long term (4 studies; author rating: very low quality evidence);
- Either trauma-focussed psychological therapy or psychological therapy for substance use disorder alone did not improve either PTSD or substance use disorder (1 small study; author rating low quality evidence);
- Non-trauma-focused psychological therapy:
  - Compared with psychological therapy for substance use disorder alone showed no effect on PTSD or substance use disorder outcomes
  - Compared with treatment as usual resulted in no improvement in PTSD and no relevant studies for substance use disorder.”

Given the high quality of this review, the GDG felt confident in building a recommendation based on the outcomes. However, we also adopted the recommendation by Phoenix Australia 135, which emphasises that 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 Phoenix guidelines 135 added a further important 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.” The GDG considered it important to also adopt this recommendation for the present guideline.

Ipser et al., 137 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 SSRIs; there were insufficient data to establish differences in treatment efficacy between medication classes or patient subgroups.

In the context of comorbid PTSD and mild to moderate depression, the following consensus points from the Phoenix guidelines are also relevant: 1. “health practitioners may consider treating the PTSD first, as the depression will often improve with treatment of the PTSD. 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 33 132 133 recommend that nuanced evidence-based treatment approaches be used for individual patients. These recommendations were all based on expert consensus.
E. What is appropriate communication with the patient’s workplace?

A GP’s engagement with the patient’s workplace can have enormous benefits for the recovery of their patient. For instance, communication with a patient’s workplace can provide important information that can assist in planning appropriate management strategies, monitoring progress of a patient’s condition and determining readiness for and capacity of a patient to return to work.

A review comprising a search for original literature and for systematic reviews was undertaken to identify evidence for the nature of communication between a GP and their patient’s workplace that enables a collaborative and patient-centred approach to managing a work-related mental health condition.

Review Q7. What is appropriate communication with the patient’s workplace, in order to appropriately manage a work-related mental health condition?

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>MOD level of evidence</th>
<th>GRADE: Strong FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs 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.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>HIGH level of evidence</th>
<th>GRADE: Strong FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs should consider using a trained return-to-work coordinator to coordinate and negotiate return to work amongst stakeholders, if available.</td>
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</table>

<table>
<thead>
<tr>
<th>Consensus statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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

A review of the evidence identified two cross-sectional studies and one high quality clinical practice guideline that was developed in the USA that addressed this review question. Together, this literature highlighted three key themes that can facilitate communication between a practitioner and a patient’s workplace, in the context of work-related mental health conditions. These were: 1) consideration of the key stakeholders who would add value if they were to be involved in communication about a patient’s management; 2) content of the communication; and 3)
principles about communicating patient information, specifically patient confidentiality and focussing on the worker’s needs.

**Nature of communication with a patient’s workplace**

The USA guideline stated two recommendations that the GDG considered to be relevant for the Australian general practice context. The first 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” was based on moderate level evidence.

The GDG considered this recommendation to be feasible for Australian GPs however the GDG made minor amendments to the wording of the recommendation.

A second, consensus-based, recommendation in the USA guideline stated that “return to work practices (in the context of coordinated care) maintain a focus on the workplace and on worker’s needs and functional capacities.”

The GDG strongly agreed with this recommendation and therefore adopted it verbatim.

**Content of the communication**

The USA guideline also offered advice about the content of communication that would facilitate return to work. The USA recommendation specifically stated “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 with regard to using coordination and negotiation amongst stakeholders. The second part of the recommendation, that pertaining to the use of a trained return to work coordinator was an adaption of a NICE guideline, which was also consensus based.

In Australia, trained return to work coordinators are 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 return to work coordinator is restricted. We, therefore, suggest using a trained return to work coordinator only if one is available.
Principles about communicating information

Sylvain and colleagues 139 highlighted the importance of preserving patient confidentiality. This Canadian study described GPs’ practices with people experiencing work disability due to depressive disorders and explore how a 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. GPs in this study overwhelmingly described grappling with their own intention to preserve their patients’ confidentiality as a key barrier to collaboration with their patients’ workplaces.

The GDG recognises that GPs are cognisant of patient confidentiality, however, we wish to reinforce this notion about appropriate communication to those who are less experienced in the field and to build confidence in clinicians who are less experienced. We, therefore, added a footnote to state that “communication with a patient’s workplace should only occur with a patient’s consent”.

The second study 138 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. In Finland, occupational physicians commonly work within a workplace to assist a patient’s return to work. This relationship with a workplace is markedly different from what could be expected from Australian GPs who would rarely have ongoing relationships with their patient’s workplaces. This study was therefore not used in the recommendation.
**F. Is the patient ready to return to work?**

The health benefits of engaging in good work are widely recognised and promoted as a strategy for facilitating recovery following all work-related injuries. As such, participation in work is frequently considered to be a recovery goal, and may even form a component of a management strategy. However, for a person with a work-related mental health condition a person’s capacity to respond to existing or possible new stressors should be considered when determining the suitability of their work participation.

Determining whether a patient has the capacity to return to work, particularly patients with work-related mental health conditions is a reported challenge in practice. For example, GPs are more likely to certify patients with mental health conditions as unfit for work compared with patients who have a musculoskeletal injury, with the latter more frequently certified with capacity to return to work on alternative duties.

Additionally, some GPs have expressed concern with regards discontinuing sickness certificates for their patient where the patient is not 100% fit, as this may cause the patient to feel as though the GP is undermining their therapeutic alliance and thus could put a strain on the doctor-patient relationship.

Taking these challenges into account, a search for original literature and for systematic reviews was undertaken to identify evidence factors that GPs should consider to aid them in determining whether their patient has capacity to return to work.
Review Q10. In workers with a mental health condition, what information should a GP consider to determine whether a person has capacity to return to work?

<table>
<thead>
<tr>
<th>GPs should consider the following patient and work-related factors when determining whether a person has the capacity to return to work:</th>
<th>Consensus statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Physical and psychosocial capability including</td>
<td></td>
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<tr>
<td>o depression severity</td>
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<tr>
<td>o presence of comorbidities</td>
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<tr>
<td>o presence of sleep disturbance</td>
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<tr>
<td>o higher conscientiousness pre-injury</td>
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<tr>
<td>o attitude towards work</td>
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<tr>
<td>o patient motivation to work</td>
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<tr>
<td>o work ability</td>
<td></td>
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<tr>
<td>o personal circumstances</td>
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<tr>
<td>o social deprivation (social / cultural disadvantage)</td>
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<tr>
<td>o being male</td>
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<tr>
<td>o being older age</td>
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<td>o differential diagnosis</td>
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<tr>
<td>b. Work-related factors including</td>
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<tr>
<td>o work environment</td>
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<tr>
<td>o GP’s knowledge about the patient’s workplace and its limitations</td>
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<tr>
<td>o suitability of work</td>
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<tr>
<td>o size of the workplace</td>
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<tr>
<td>o conflicts with the person’s supervisor</td>
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<tr>
<td>o ongoing work-related stressors (e.g. conflict in the workplace)</td>
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</tr>
<tr>
<td>o availability of duties that are non-stigmatizing and, where possible, commensurate with the worker’s level of experience and seniority</td>
<td></td>
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<tr>
<td>o size of the workplace</td>
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</tbody>
</table>
The evidence review produced 12 records. Of these 11 were original papers: three RCTs and eight cross-sectional or cohort studies. In addition, one clinical guideline was identified.

Both of the RCTs were conducted in The Netherlands. In the first study, the effect of treatment as usual along with occupational therapy on rates of long term patient recovery and long term fulltime return to work, and predictors of these rates. Long term symptom remission was predicted only by baseline depression severity, however, long-term RTW 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 whereby predictors of recurrent sickness were compared between participants who achieved partial or full return to work at 6 and 12 months. 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.

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. 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; older age; differential diagnosis (e.g. possible malingering).

One clinical guideline focussing on emergency workers with PTSD was produced in Australia. The guideline 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. – This is a guideline for employers, however a GP may recommend that positions could be provided.

- 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.”

Whilst there was much heterogeneity in the study designs, these studies produced a list of factors that should be considered by a GP to determine whether a person has the capacity to return to work. In addition, the GDG felt that the list of factors did not address the question in its entirety. For instance, a key consideration for GPs, which was not identified from the literature, was to assess the extent of a patient’s recovery and readiness to work. A consensus statement has been offered that takes into consideration the available evidence and draws on the expertise of the GDG.
The consensus statement has been divided into two themes: Patient factors – psychological and physical capability, and motivation to work; and Work-related factors – work suitability and work environment.

**Patient factors – psychological and physical capability**
- Degree of severity of the mental health condition – the nature of a mental health condition and a person’s recovery to date should be at the forefront of a GP’s mind when considering whether a person has the capacity to return to work.
- Degree of functional impairment (workability) from the MHC – the ability of a person to function is a second crucial consideration when determining return to work.
- Degree of motivation to work – This takes into account reasons for why a person wants to return to work, such as patients with a high work ethic or high conscientiousness. Whilst we are strong advocates for the benefits of good work, GPs should be cognisant that some patients may be keen to return to work before they are ready.
- Presence of comorbidities – the presence and nature of physical or psychological comorbidities should be taken into consideration when deciding whether a person has the capacity to return to work.
- Presence of sleep disturbance – sleep disturbance may restrict a person’s ability or willingness to return to work and should therefore be considered.
- Personal circumstances – patients with psychosocial issues and family responsibilities, including financial circumstances, are less likely to return to their existing workplace. A GP should consider these circumstances when deciding whether a person should return to an existing workplace.

The GDG chose to exclude a number of personal factors that were identified in the literature for the following reasons: Social deprivation, being male and being older are covered within personal circumstances. In addition, the GDG did not feel that these factors should specifically influence a GP’s decision about determining whether a person has the capacity to return to work. “Considering a differential diagnosis” – the GDG feels that a GP who has created a therapeutic alliance with their patient should not at this stage need to consider a differential diagnosis.

**Work-related factors – work suitability and work environment**
- Work environment – The work environment refers to the suitability of the work conditions in which a person would work. This includes the conflicts with other employees in the workplace, physical conditions of the workplace and other work processes and procedures.
• Work-related stressors – The GDG considered it important to differentiate work-related stressors (e.g., conflicts in the workplace) from the work environment as the presence of work-related stressors are likely to have a negative impact on 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 guidelines. It refers to the suitability of the work activities that a person would undertake.

• Size of the workplace – The size of a workplace can influence recovery. For instance, workers in smaller organisations may have more autonomy or flexibility. Workers in larger organisations on the other hand may have better access to support systems such as rehabilitation providers and other wellbeing programs.

Conflicts with supervisor – ongoing or new conflicts with a person’s supervisor can hinder recovery and should be taken into consideration when determining if a person should return to a workplace.
### 6. Abbreviations

#### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4DSQ</td>
<td>Four-Dimensional Symptom Questionnaire</td>
</tr>
<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
</tr>
<tr>
<td>AGREE</td>
<td>Appraisal of Guidelines for Research and Evaluation</td>
</tr>
<tr>
<td>AGREE-II</td>
<td>Appraisal of Guidelines for Research and Evaluation II</td>
</tr>
<tr>
<td>AMED</td>
<td>Allied and Complementary Medicine Database</td>
</tr>
<tr>
<td>AMSTAR</td>
<td>A Measurement Tool to Assess Systematic Reviews</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>APQ</td>
<td>Alcohol Problems Questionnaire</td>
</tr>
<tr>
<td>APS</td>
<td>Australian Psychological Society</td>
</tr>
<tr>
<td>AUDIT</td>
<td>Alcohol Use Disorders Inventory Test</td>
</tr>
<tr>
<td>AUDIT-C</td>
<td>AUDIT Alcohol Consumption Questions</td>
</tr>
<tr>
<td>BDI</td>
<td>Beck Depression Inventory</td>
</tr>
<tr>
<td>BSI</td>
<td>brief symptom inventory</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CES-D</td>
<td>Center for Epidemiologic Studies Depression Scale</td>
</tr>
<tr>
<td>CR</td>
<td>Consensus Recommendation</td>
</tr>
<tr>
<td>DASS</td>
<td>Depression Anxiety Stress Scale</td>
</tr>
<tr>
<td>DSM-5</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>DTA</td>
<td>Diagnostic Test Accuracy</td>
</tr>
<tr>
<td>GAD</td>
<td>Generalised Anxiety Disorder</td>
</tr>
<tr>
<td>GAD-7</td>
<td>Generalised Anxiety Disorder-7</td>
</tr>
<tr>
<td>GDG</td>
<td>Guideline Development Group</td>
</tr>
<tr>
<td>GDS</td>
<td>Geriatric Depression Scale</td>
</tr>
<tr>
<td>GHQ</td>
<td>General Health Questionnaire</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GPMHSC</td>
<td>General Practice Mental Health Standards Collaboration</td>
</tr>
<tr>
<td>GRADE</td>
<td>Grading of Recommendations Assessment, Development and Evaluation</td>
</tr>
<tr>
<td>HADS</td>
<td>Hospital Anxiety and Depression Scale</td>
</tr>
<tr>
<td>HBoGW</td>
<td>Health Benefits of Good Work</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>iCBT</td>
<td>Internet-Based Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>TAU</td>
<td>Treatment As Usual</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UNSW</td>
<td>University of New South Wales</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>VIC</td>
<td>Victoria</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
</tr>
<tr>
<td>WES</td>
<td>Work Environment Scales</td>
</tr>
<tr>
<td>WHC</td>
<td>Work Health Check</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WSAQ</td>
<td>Work Satisfaction Assessment Questionnaire</td>
</tr>
</tbody>
</table>
## 7. Appendices

### Appendix A. Tasks for the development of the guideline

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Tasks of the Research team</th>
<th>Tasks of the GDG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Undertake interviews and analyse data</td>
<td></td>
</tr>
<tr>
<td>Nov 2016</td>
<td>Constitute the Guideline Development Group</td>
<td></td>
</tr>
<tr>
<td>Dec 2016 – Feb 2017</td>
<td>CIs, project manager and evidence reviewers: Formulate search strategy and Undertake round#1 searching of the evidence</td>
<td>Meeting 1: Refine the guideline scope and key questions; agree to provisional timeline</td>
</tr>
<tr>
<td>Feb 2017 – May 2017</td>
<td>CIs, project manager and evidence reviewers: Undertake round#2 searching of the evidence, Review evidence and Develop first draft of the guidelines</td>
<td>Meeting 2: Review evidence and determine need for further searching</td>
</tr>
<tr>
<td>Aug 2017</td>
<td></td>
<td>Meeting 3: Review evidence and first draft of the guideline and implementation plan</td>
</tr>
<tr>
<td>Aug 2017 – Sep 2017</td>
<td>Amend the guidelines following the GDG’s recommendations</td>
<td>Meeting 4: Ratify the draft guideline and implementation plan</td>
</tr>
<tr>
<td>Nov – Dec 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan 2018</td>
<td>Release draft guidelines for public consultation to key stakeholders. Distribute draft implementation plan for feedback.</td>
<td></td>
</tr>
<tr>
<td>Feb-Mar 2018</td>
<td>Consolidate feedback from public consultation. Amend the guideline. Amend implementation plan to align with the amended guidelines</td>
<td></td>
</tr>
<tr>
<td>Apr 2018</td>
<td></td>
<td>Meeting 5: Review and amend the guideline following feedback from the public consultation</td>
</tr>
<tr>
<td>July - Aug 2018</td>
<td>Submit draft guideline, implementation plan and other documentation to the NHMRC. Prepare dissemination material. NHMRC external scientific review.</td>
<td>Meeting 6: Finalise the draft guideline and implementation plan for NHMRC approval</td>
</tr>
<tr>
<td>Sep 2018</td>
<td>CIs, project manager and Implementation sub-committee: Prepare written responses to address issues by reviewers and NHMRC council members as requested by the NHMRC</td>
<td></td>
</tr>
<tr>
<td>Sep 2018</td>
<td>Prepare guideline for publication. Prepare dissemination material. Independent AGREE II Assessment.</td>
<td>Provisional Meeting 7: Ratify responses prepared for NHMRC reviewers and/or NHMRC council members</td>
</tr>
<tr>
<td>Oct 2018</td>
<td>NHMRC approval</td>
<td></td>
</tr>
<tr>
<td>Nov-Feb 2019</td>
<td>Disseminate guideline and relevant material.</td>
<td>Disseminate guideline and relevant material.</td>
</tr>
</tbody>
</table>
Appendix B. Declarations of Interest Form

Clinical guidelines 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 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 Project Manager, in advance of the meeting or work. You are also asked to inform the Project Manager of any change in 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 DIOform 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.

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
</tbody>
</table>

*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 organization 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 ☐ No ☐

1b Consulting, including service as a technical or other advisor

Yes ☐ No ☐

This form has been adapted from: WHO 850 E LEG (16/06/2010). Accessed on 17/11/16 from:
http://www.who.int/iccs/methods/harmonization/areas/mutarencity_doi.pdf
**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 organization 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 □ No □]

2b. Non-monetary support (include equipment, facilities, research assistants, paid travel to meetings, etc.) [Yes □ No □]

**INVESTMENT INTERESTS**

Do you have current 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 □ No □]

3b. Commercial business interests (e.g., proprietorships, partnerships, joint ventures) [Yes □ No □]

**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 □ No □]

4b. Proprietary know-how in a substance, technology or process [Yes □ No □]

**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 organization? [Yes □ No □]

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 □ No □]

**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

---

*This form has been adapted from: WHO 8/50 E LEG (16/06/2010). Accessed on 17/11/16 from: http://www.who.int/iccs/methods/harmonization/areas/mutuanceiv_doi.pdf*
Clinical guidelines for the diagnosis and management of work-related mental health conditions

Have you received any 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.

<table>
<thead>
<tr>
<th>Nos. 1 - 4.7</th>
<th>Type of interest, question number and category (eg., intellectual property &amp; rights, copyrights) and basic descriptive details.</th>
<th>Name of company, organization, or institution</th>
<th>Belongs to you, a family member, employer, research unit or other?</th>
<th>Amount of income or value of interest (if not disclosed, is assumed to be significant)</th>
<th>Current interest (or year ceased)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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. 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.

Date: ___________________ Signature: ___________________

This form has been adapted from: WHO 8:0 E LIB (16/06/2010). Accessed on 17/11/16 from: http://www.who.int/ircs/working Papers/dietary_aus/muttaericyr_doi.pdf
## Appendix C. Patient Health Questionnaire-9 (PHQ-9)

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

### 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)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half of the two week period</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little pleasure or little interest in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Having little energy or feeling tired</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling negative about yourself or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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

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

#### GAD-7

<table>
<thead>
<tr>
<th>Over the last two weeks, how often have you been bothered by the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Having trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*(For office coding: Total Score T_____ = ___ + ___ + ___)*

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.
Appendix E. Depression Anxiety Stress Scales (DASS)

Source: http://www2.psy.unsw.edu.au/dass/down.htm

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

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

Source: https://www.mirecc.va.gov/docs/visn6/3_PTSD_CheckList_and_Scoring.pdf

Instruction to patient: Below is a list of problems and complaints that veterans 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.

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

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division.
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?
   - Never
   - Monthly or less
   - 2-4 times a month
   - 2-3 times a week
   - 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?
   - 1 or 2
   - 3 or 4
   - 5 or 6
   - 7 to 9
   - 10 or more

3. How often do you have six or more drinks on one occasion?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - 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?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - 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?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - 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?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- No
- Yes, but not in the past year
- 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?

- No
- Yes, but not in the past year
- Yes, during the past year

**Scoring the AUDIT:**

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

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.
Appendix H. Severity Of Alcohol Dependence Questionnaire (SADQ)

Source: https://www.alcohollearningcentre.org.uk/Topics/Latest/Severity-of-Alcohol-Dependence-Questionnaire-SADQ/


Please recall a typical period of heavy drinking in the last 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.
   
   ALMOST NEVER     SOMETIMES     OFTEN     NEARLY ALWAYS

2. The day after drinking alcohol, my hands shook first thing in the morning.
   
   ALMOST NEVER     SOMETIMES     OFTEN     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.
   
   ALMOST NEVER     SOMETIMES     OFTEN     NEARLY ALWAYS

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.
   
   ALMOST NEVER     SOMETIMES     OFTEN     NEARLY ALWAYS

5. The day after drinking alcohol, I dread waking up in the morning.
   
   ALMOST NEVER     SOMETIMES     OFTEN     NEARLY ALWAYS

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.
   
   ALMOST NEVER     SOMETIMES     OFTEN     NEARLY ALWAYS

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.
   
   ALMOST NEVER     SOMETIMES     OFTEN     NEARLY ALWAYS

8. The day after drinking alcohol, I felt very frightened when I awoke.
   
   ALMOST NEVER     SOMETIMES     OFTEN     NEARLY ALWAYS

9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.
   
   ALMOST NEVER     SOMETIMES     OFTEN     NEARLY ALWAYS

10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.
    
    ALMOST NEVER     SOMETIMES     OFTEN     NEARLY ALWAYS
11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.
   ALMOST NEVER  SOMETIMES  OFTEN  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 beers).
   ALMOST NEVER  SOMETIMES  OFTEN  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).
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

15. I drank more than one bottle of spirits per day (OR 3 bottles of wine OR 30 units of beer).
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

16. I drank more than two bottles of spirits per day (OR 6 bottles of wine OR 60 units of beer).
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

Imagine the following situation:
1. You have been completely off drink for a few weeks
2. 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.
   NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT

18. My hands would shake.
   NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT

19. My body would shake.
   NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT

20. I would be craving for a drink.
   NOT AT ALL  SLIGHTLY  MODERATELY  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
Appendix I. Leeds Dependence Questionnaire (LDQ)

Source: [https://www.alcohollearningcentre.org.uk/_assets/leeds_dependence_questionnaire-ldq.doc](https://www.alcohollearningcentre.org.uk/_assets/leeds_dependence_questionnaire-ldq.doc)


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 last 4 weeks and tick the closest answer to how you see yourself.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Nearly Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you find yourself thinking about when you will next be able to have another drink or take more drugs?</td>
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<tr>
<td>Is drinking or taking drugs more important than anything else you might do during the day?</td>
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<tr>
<td>Do you feel that your need for drink or drugs is too strong to control?</td>
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<tr>
<td>Do you plan your days around getting and taking drink or drugs?</td>
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<tr>
<td>Do you drink or take drugs in a particular way in order to increase the effect it gives you?</td>
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<tr>
<td>Do you drink or take drugs morning, afternoon and evening?</td>
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<tr>
<td>Do you feel you have to carry on drinking or taking drugs once you have started?</td>
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<tr>
<td>Is getting an effect more important than the particular drink or drug you use?</td>
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<tr>
<td>Do you want to take more drink or drugs when the effects start to wear off?</td>
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<tr>
<td>Do you find it difficult to cope with life without drink or drugs?</td>
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Appendix J. Four-Dimensional Symptom Questionnaire (4DSQ)


The following is a list of questions about various complaints and symptoms you may have. Each question refers to the complaints and symptoms that you had in the past week (the past 7 days, including today). Complaints you had before then, but no longer had during the past week, do not count.

Please indicate for each complaint how often you noticed that you had it in the past week by putting an “X” in the box under the answer that is most appropriate.

**During the past week, did you suffer from:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>no</th>
<th>sometimes</th>
<th>regularly</th>
<th>often</th>
<th>very often or constantly</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Dizziness or feeling light-headed? -</td>
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<td>2</td>
<td>Painful muscles? - - - - - - - - - - - - - -</td>
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<td>3</td>
<td>Fainting? - - - - - - - - - - - - - - - - -</td>
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<td>4</td>
<td>Neck pain? - - - - - - - - - - - - - - - - -</td>
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<td>5</td>
<td>Back pain? - - - - - - - - - - - - - - - - -</td>
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<td>6</td>
<td>Excessive sweating? - - - - - - - - - - - - -</td>
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<td>7</td>
<td>Palpitations? - - - - - - - - - - - - - - - -</td>
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<td>8</td>
<td>Headache? - - - - - - - - - - - - - - - - -</td>
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<td>9</td>
<td>A bloated feeling in the abdomen? - - - - -</td>
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<td>10</td>
<td>Blurred vision or spots in front of your eyes? - - - - - - - - - - - - - - - - -</td>
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<td>11</td>
<td>Shortness of breath? - - - - - - - - - - - - - - -</td>
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<td>12</td>
<td>Nausea or an upset stomach? - - - - - - - - -</td>
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**During the past week, did you suffer from:**

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<tr>
<th></th>
<th></th>
<th>no</th>
<th>sometimes</th>
<th>regularly</th>
<th>often</th>
<th>very often or constantly</th>
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</thead>
<tbody>
<tr>
<td>13</td>
<td>Pain in the abdomen or stomach area? - - - -</td>
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<td>14</td>
<td>Tingling in the fingers? - - - - - - - - - - -</td>
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<td>15</td>
<td>Pressure or a tight feeling in the chest? - - - - - - - - - - -</td>
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<td>16</td>
<td>Pain in the chest? - - - - - - - - - - - - - - -</td>
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<td>17</td>
<td>Feeling down or depressed? - - - - - - - - - - -</td>
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<td>18</td>
<td>Sudden fright for no reason? - - - - - - - - - - -</td>
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<td>19</td>
<td>Worry? - - - - - - - - - - - - - - - - - - - - - -</td>
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<td>20</td>
<td>Disturbed sleep? - - - - - - - - - - - - - - - - -</td>
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<td>21</td>
<td>A vague feeling of fear? - - - - - - - - - - - - - - - - -</td>
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<td>22</td>
<td>Lack of energy? - - - - - - - - - - - - - - - - -</td>
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<td>23</td>
<td>Trembling when with other people? - - - - - - - - - - -</td>
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<td>24</td>
<td>Anxiety or panic attacks? - - - - - - - - - - - - - - - - -</td>
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</table>
During the past week, did you feel:

<table>
<thead>
<tr>
<th>Question</th>
<th>no</th>
<th>sometimes</th>
<th>regularly</th>
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<th>very often or constantly</th>
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<tr>
<td>25. Tense?</td>
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<td>26. Easily irritated?</td>
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<td>27. Frightened?</td>
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During the past week, did you feel:

<table>
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<tr>
<th>Question</th>
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<th>sometimes</th>
<th>regularly</th>
<th>often</th>
<th>very often or constantly</th>
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<tbody>
<tr>
<td>28. That everything is meaningless?</td>
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<td>29. That you just can't do anything anymore?</td>
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<td>30. That life is not worth while?</td>
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<td>31. That you can no longer take any interest in the people and things around you?</td>
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<td>32. That you can't cope anymore?</td>
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<td>33. That you would be better off if you were dead?</td>
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<tr>
<td>34. That you can't enjoy anything anymore?</td>
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<td>35. That there is no escape from your situation?</td>
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<tr>
<td>36. That you can't face it anymore?</td>
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</table>

During the past week, did you:

<table>
<thead>
<tr>
<th>Question</th>
<th>no</th>
<th>sometimes</th>
<th>regularly</th>
<th>often</th>
<th>very often or constantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. No longer feel like doing anything?</td>
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<tr>
<td>38. Have difficulty in thinking clearly?</td>
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<td>39. Have difficulty in getting to sleep?</td>
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<tr>
<td>40. Have any fear of going out of the house alone?</td>
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</tbody>
</table>

During the past week:

<table>
<thead>
<tr>
<th>Question</th>
<th>no</th>
<th>sometimes</th>
<th>regularly</th>
<th>often</th>
<th>very often or constantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. Did you easily become emotional?</td>
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<tr>
<td>42. Were you afraid of anything when there was really no need for you to be afraid? (for instance animals, heights, small rooms)</td>
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<td>43. Were you afraid to travel on buses, streetcars/trams, subways or trains?</td>
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<td>44. Were you afraid of becoming embarrassed when with other people?</td>
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<td>45. Did you ever feel as if you were being threatened by unknown danger?</td>
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<td>46. Did you ever think &quot;I wish I was dead&quot;?</td>
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</tbody>
</table>
47. Did you ever have fleeting images of any upsetting event(s) that you have experienced? - - - - - - - - - - - - - - -

48. Did you ever have to do your best to put aside thoughts about any upsetting event(s)? - - - - - - - - - - - - - - -

49. Did you have to avoid certain places because they frightened you? - - - - - - - - - - - - - - -

50. Did you have to repeat some actions a number of times before you could do something else? - - - - - - - - - - - - - - -

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8. References


57. Royal Australian College of General Practitioners. Standards for general practices (4th edition) including Interpretive guide for Aboriginal and Torres Strait Islander health services. 4th ed, 2010.


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