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Dear Professor Mazza,

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

Thank you for inviting The Royal Australian College of General Practitioners (RACGP) to provide feedback on the above guideline. The RACGP would firstly like to congratulate you and your team on the development of this guideline.

As the cornerstone of Australia's primary healthcare, general practitioners (GPs) are well placed to facilitate a patient's return to work after a work-related mental health incident. We recognise that treating patients with work-related mental health conditions is complex and often requires prolonged consultation times.

The RACGP understands the difficulties in forming this guideline; we recognise this may in part be a consequence of the scarcity of available evidence. The practical implications of the recommendations and consensus statements make it difficult for GPs to make any pragmatic change to the diagnosis and management of patients with work-related mental health conditions. The guideline could benefit from the inclusion of recommendations and consensus statements on what GPs need to do differently when a patient presents with work-related mental health conditions.

It would also be useful to have the guideline's recommendations and consensus statements presented clearly and concisely at the start of the publication. We suggest a format where the key questions are supported by tables, such as the one presented on page 28. While the inclusion of the flowchart is helpful, further clarity is required to assist GPs in guiding them to make clinical decisions. We also suggest avoiding the use of terms such as 'should', especially in cases where the evidence is weak.

The guideline does not currently provide GPs with any practical and clinical information on how to delineate work-related mental health conditions from general mental health conditions. Despite the lack of evidence, it would be beneficial to GPs if the guideline could include factors (ie red flags) that might indicate a mental health condition is work-related.

Specific feedback

Flowchart

- **'Is it a mental health condition?' –** This only provides tools for some common conditions and neglects advice on when to use (the more common) 'acute stress reaction' and 'adjustment disorder'. Additionally, it downplays the need to do a full assessment
- **'Is this patient developing a comorbid mental health condition?' –** This is section is confusing as it seems to be discussing patients who already have a work-related injury and may be at risk of developing a secondary mental health condition. This is a parallel but somewhat different issue to developing a work-related mental health condition de novo.
  - We suggest this section could be divided into patient-related versus work-related factors; this comes up later in 'Why is the patient not getting better?', but needs to be addressed much earlier.
  - It may be more helpful if the flowchart asked 'Is this a primary or secondary mental health condition?'
  - The key question, 'How to make a decision to attribute the mental health symptoms to work', is without advice and needs to be examined and explored

Executive summary

- The key question, 'Is this workplace safe for my patient?', does not provide sufficient guidance. A focus on 'patient' versus 'work environment' factors would make this a more useful decision aid.

Management

- This section includes factors to consider why a patient is not getting better, and then how to treat the underlying condition which only provides advice about depression
  - Advice specifically related to work-related injury would be useful, even with a lack of evidence. For example:
    - Make sure you have optimised treatment for the underlying mental health condition (as per usual treatment protocols)
    - Discuss with the patient about their own and work-related factors that might be affecting progress
    - Seek independent remediation (or case management, or whatever is likely to be best) to negotiate the changes that need to be done to achieve safe return to work.
  - The information on post-traumatic stress disorder (PTSD), while interesting, is possibly out of the realm of the work most GPs do. Instead, guidance on **when** to refer for trauma-focussed PTSD treatment, or what GPs can do to assist in cases where such therapy is not available or refused, should be provided
  - There should be greater emphasis on the advice for GPs:
    - When a patient refuses to follow a treatment plan that relate to their eligibility for worker's compensation
    - If a patient does not consent to communication with the workplace

Background

- The recommendations and consensus statements provided does not seem to help GPs overcome some of the barriers that were previously identified

Acute stress and adjustment disorder

- The general advice requires clarity on how GPs can intervene early. For example, do patients who present with an acute stress reaction do better if they return to work more quickly? Under what circumstances is it safe to do so?

Clinical questions

- This section is useful, but is not clearly answered when one reads the flowchart or key recommendations and consensus statements
  - Despite a lack of evidence, GPs need more expert advice on these specific questions if the guide is to be of interest to general practice
  - A review of questions 4 and 5 seem to be the most important, but these are not clearly outlined in the flowchart or summary

Page 27

- There is an error regarding Mental Health Skills Training (MHST) not encouraging GPs to make a diagnosis
  - It is a requirement of the Medicare Benefits Schedules (MBS) mental health item numbers that a diagnosis be made
  - GPs may worry about the consequences for the patient, but MHST is not the reason behind this problem

Page 29

- While the PHQ-9 is useful in assisting GPs with diagnosis and severity assessment, we emphasise this should be used alongside comprehensive assessment. Diagnosing and determining severity are dependent on a GP's clinical judgement and experience.
- We suggest the term 'should' be replaced with 'could' as much of the focus is on the evidence for screening tools in the 'work-place' context, and less on evidence for what works or will work in clinical general practice
- We also suggest providing guidance on how to interpret PHQ-9 – cut scores should be mentioned in the evidence paragraph

Page 34

- Section B includes information on patients who choose to submit a claim, but it does not provide advice for GPs on how to guide patients in making this decision.
  - This is a common area of challenge for GPs as patients often ask the GP for their opinion
  - The guideline could direct GPs to some other approaches to assist (eg structure problem solving)

Page 35

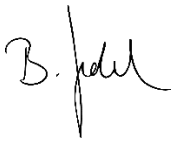
- There should be a greater emphasis on the role of GPs as advocates for their patients in the case of work-placed injury

Page 46

- Clarity is required on the definition of 'collaborative care', especially given some of the studies suggest multidisciplinary care might not work. Additionally, some of the types of intervention may get patients back to work quicker, but might not help them feel better

Thank you once again for the opportunity to provide feedback to the guideline, and I hope our feedback and comments are useful.

Yours sincerely



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