The webinar will begin shortly. While you wait . . .

Access the Good Work Design Resource from Comcare

Evidence shows that good work design can improve worker health and wellbeing whilst supporting participation and productivity. Access this suite of resources that aim to raise awareness and build capability to design good work.

www.comcare.gov.au/safe-healthy-work/healthy-workplace/good-work-design

WEBINAR

mhpn Mental Health Professionals' Network

Australian Government Comcare

Supporting clients/ patients with PTSD to participate in good work

Tonight's panel

Dr. Tony McHugh
Psychologist

Dr. Craig Barnett
General Practitioner

Christie Stonham
Manager Shield Strategy - AFP

Facilitator:
Prof Stephen Trumble
General Practitioner

The webinar platform

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Options: Click on this button to access Web-player features such as ‘Info’ and ‘Ask a Question’.

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Learning outcomes

Through a panellist exploration of PTSD and work participation, this webinar will provide participants with the skills and knowledge to:

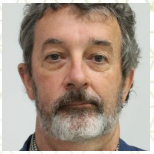
1. Identify the challenges for PTSD patients engaging with and participating in the workplace, including phobic avoidance, anxiety symptoms and co-morbid conditions.

2. Discuss practitioner challenges in helping PTSD patients to leverage the health benefits of good work, including how to constructively engage with the workplace and other stakeholders.

3. Discuss the risks and opportunities for patients/clients with PTSD participating in work.

4. Recommend ways to manage safe and sustainable work participation for patients with PTSD, including the options and resources available to support work participation.

PTSD defined



Dr. Tony McHugh

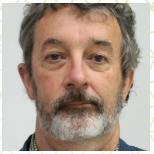
Derives from the experience threat of death, serious injury or sexual assault or directly witnessing same

“Traumatisation” is, however, perceptual - no two folk react identically, we talk of potentially traumatising events (PTEs) and understand PTSD cannot exist where an event is not perceived as traumatic (a la the Colosseum). This is termed the “Paradox of PTSD” (McNally).

DSM 5 relocated PTSD from anxiety to stress disorders - as prior DSM III & IV conceptualisations were judged to inadequately reflect clinical reality. DSM 5 & ICD 11 have taken an overwhelmingly similar approach, with one exception: complex PTSD (not in DSM 5) (not the subject of this webinar).

Those classificatory changes remain contentiousness with ongoing debate about them; e.g., around criterion A and concept creep (see Haslam et al.).

Nature, development & maintenance of PTSD



Dr. Tony McHugh

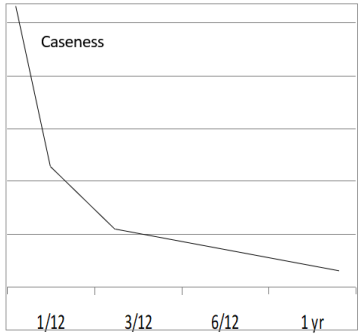
Onset may occur soon after a PTE (1/12 on) or be delayed.

Commonly comorbid - esp., with (most commonly) anxiety, mood & substance disorders.

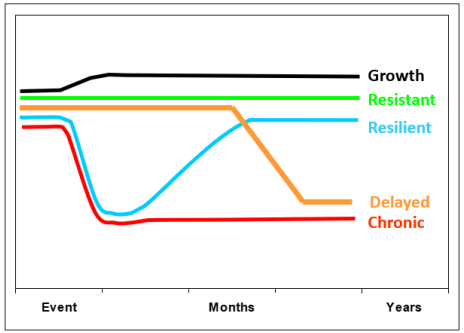
Clear (pre, peri & post event) risk factors exist for PTSD. Not all have the same predictive power (gender, age = weak; peri & post responses = strong predictors).

There are many theories and models of PTSD and many expert bodies offer information, describe research and offer clinical guidance (see US VA PTSD Center & Phoenix Australia). <u>We are ethically obliged to know and implement such knowledge in treatment.</u>

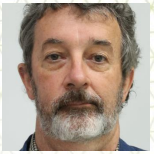
PTSD: SXs & 1st 12/12s



Prototypical recovery patterns over time (Bonanno, 2005)



Nature, development & maintenance of PTSD (2)

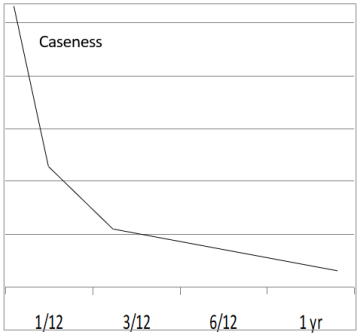


Dr. Tony McHugh

All of us have latent vulnerabilities which are typically only expressed in the context of negative life events and PTEs. This is explainable in terms of the stress-diathesis construct - an explanatory model of stress responses with good face validity/readily accepted by PTSD sufferers.

PTSD is considered a “disorder of recovery” and most affected by it recover; although different courses exist (see Friedman; Shalev; Bonanno

PTSD: SXs & 1st 12/12s



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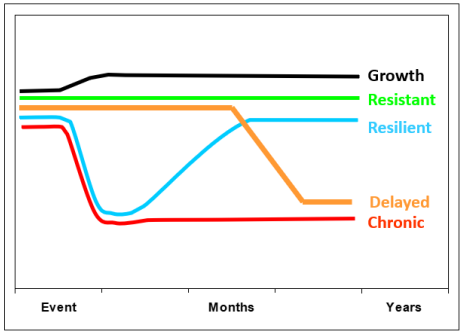


How is PTSD best treated?

Dr. Tony McHugh

A staged treatment approach is essential [see Keane (6); Briere (4)] – via interventions education aimed at building a client personalised model of recovery and wellbeing (PMoR/W); e.g., affect management, cognitive work, behavioural experiments & (behavioural & imaginal) exposure

Early symptom (Sx) reduction is important, but treatment is about more than SXs - the meaning of what occurred, current functioning and meaning of that functioning (to self & others) are critical. Addressing the "big three" is critical; i.e:

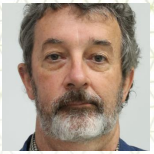
- anxious avoidance
- depressive hopelessness, helplessness, awfulism and pointlessness &
- anger - in its connection, as a moral emotion, with so many other emotions is a critical but, until recently, unrecognised) PTSD potentiator

Angry PTSD is more than the very useful construct of posttraumatic embitterment disorder (Linden). Both are esp. relevant where there is perceived/actual injustice nonetheless

Recovery hinges on the new learning/adaptation implicit to trauma focused (TF) CBT interventions; viz., Cognitive therapy (see Ehlers), Cognitive processing therapy (see Resick), Eye Movement Desensitization and Reprocessing (see Shapiro) & (above all) prolonged exposure (see Foa)

This is best done in an "envelope of slowness" (a la Kahneman) that emphasises mental toughness, hardiness and coping and self-agency and purpose (see Bonnarno & Lazarus). Do remember your Nietzsche:
What does not kill you, makes you stronger ... If you have the why, the how will follow.

Best supporting individual to RAW/RTW: Individual/shared responsibilities



Dr. Tony McHugh

Employer	Scheme
▪ have MH policy & ENACT it ▪ engage in "watchful waiting" but, where necessary, encourage workers to seek early access to interventions involving evidence-based practice (EBP) ▪ challenge myths (the worker's needs cannot be accommodated, the perfect job exists etc.) & ▪ promote diverse recovery stories**	▪ fund effective treatment, while acting with empathy, wisdom & enabling client dignity** ▪ supporting realistic, paced & worker-suited jobs there are four broad options ▪ illustrate & promote MHL literacy & debunk myths
Worker	**Treater**
▪ not engage in myths (living in a bubble is best)** ▪ acknowledge the Health benefits of Work (HBsoW): such benefits are partly-perceptual and no perfect job exists - good job fit with a person's skills & abilities is the point ▪ develop a PMoR/W and adopt the tools, tactics and strategies central to that & ▪ increase MH literacy (MHL); e.g., around • recovery trajectories • implementation & translation of EBP (active shoppers/clients do better)	▪ debunk myths (more & more treatment is better - it is iatrogenic, beyond a point) ▪ provide EBP treatment that is efficient & effective** ▪ coach implementation & translation of EBP and where necessary apply ACTIVE PTSD treatment ▪ assist clients to develop a PMoR/W & adopt associated tools, tactics and strategies & ▪ act responsibly - there is a law of diminishing marginal returns; know when you are done (& make the Code your friend)!

Psychological Injury: A “wicked” problem

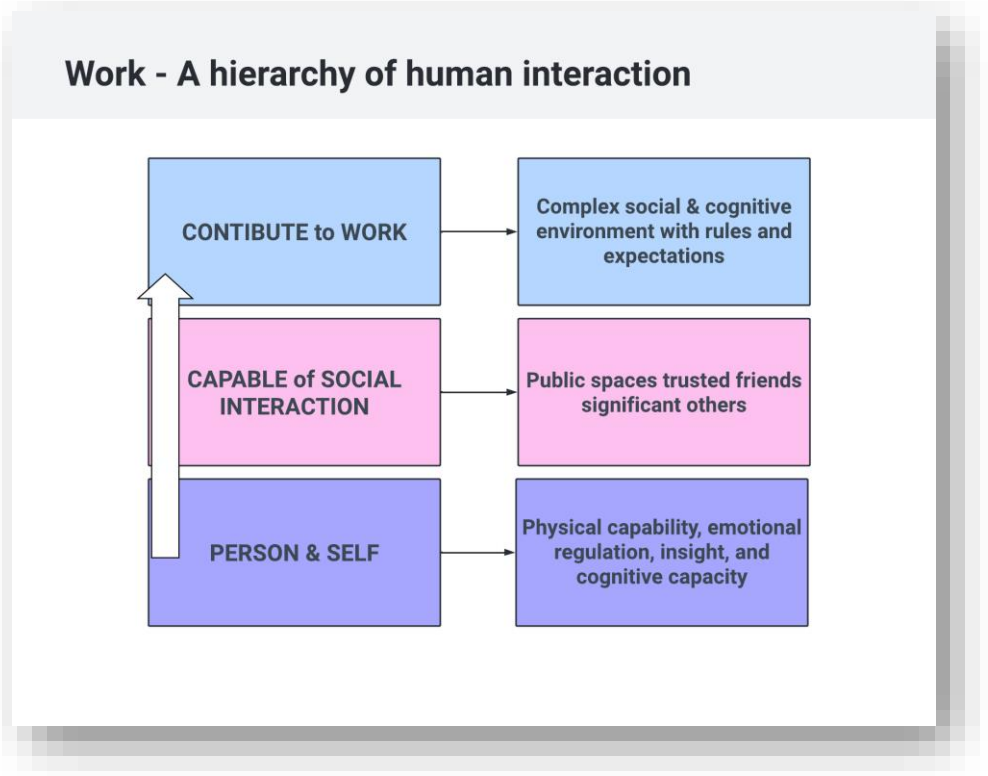
Dr Craig Barnett

- Tailored management.
- Lack of visible features.
- Communication & emotional language.
- Misunderstanding; often through preconceived ideas & beliefs.
- Risks if person is mismanaged.

BUT we can have successes.

Hierarchy of Social Interaction

Dr Craig Barnett



What do we do to further a solution for a wicked problem?

Dr Craig Barnett

- *"The key to effective approaches to tackling **wicked problems** is creating a shared understanding between the stakeholders about the problem, and shared commitment to the possible solutions. This does not necessarily mean that there is complete agreement about the nature of the problem, but that the stakeholders understand each other's positions well enough to have an intelligent dialogue about the different interpretations of the issue, and to exercise collective intelligence about how to solve it."*

Moore, T. 2011. *Wicked problems, rotten outcomes and clumsy solutions: children and families in a changing world*

What to expect, what is success?

Dr Craig Barnett

- Time?
- Acceptance of an outcome?

Christie Stonham

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SHIELD Overview

1. **Education:** focussed on physical injury prevention, mental health and trauma literacy physical-injury prevention and support for shift workers.
2. **Prevention:** health assessments, specialist assessments that are role specific, physical and mental health exercise programs, vaccinations, wearable technology and access to dieticians and occupational therapists.
3. **Early Intervention:** peer support network, critical incident debriefing and early intervention programs.
4. **Treatment:** assessment, diagnosis and care planning for physical and psychological injuries and illnesses, case management support, referrals to external service providers for management and rehabilitation of physical and psychological injuries and illnesses, and return-to-work support after injury or illness.
5. **Transition Support:** to help with pre and post-retirement, recruitment/on boarding, and pre and post-deployment.
6. **A Centre of Excellence:** that will produce research to guide the health and wellbeing delivered through SHIELD.

SHIELD SHIELD SHIELD SHIELD SHIELD SHIELD SHIELD SHIELD SHIELD SHIELD SHIELD

Christie Stonham

OFFICIAL

Our Multi-disciplinary Teams

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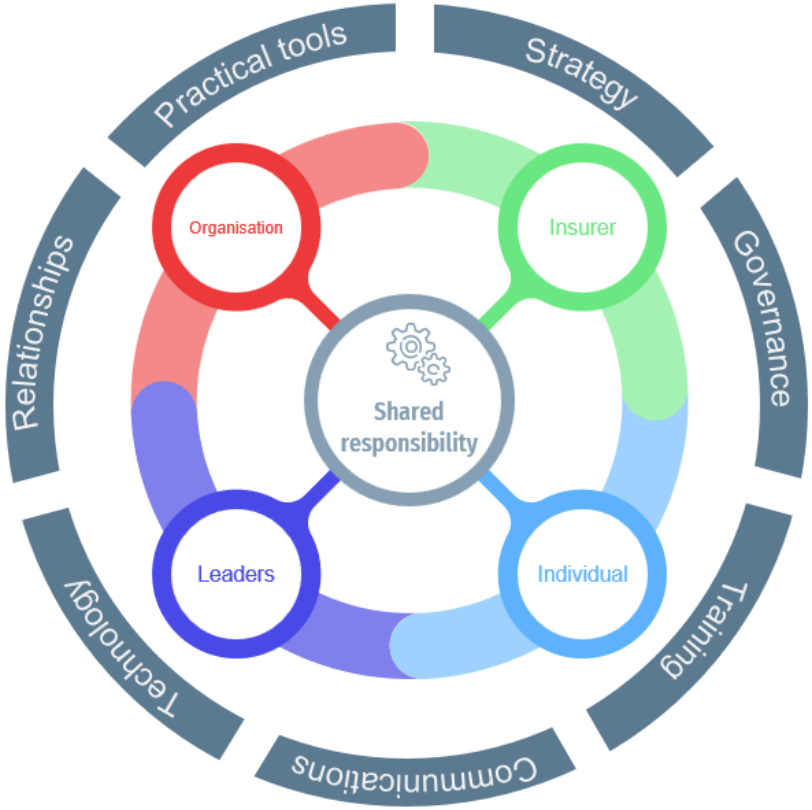
Enhancing return to work outcomes

Christie Stonham



What does an employer want from a clinician in a RTW situation?

Christie Stonham

- ***Promotion*** of return to work with the employee and health benefits of good work.
- Understand any ***barriers*** to an individual's recovery or return to work.
- Indication whether the member has capacity to engage in any activity/work ***internal or external*** to the immediate workplace and ensure it is ***clearly documented.***
- Provide *a**dvice*** on alternative duties or modifications required for the workplace.
- Clarity on what ***ongoing treatment*** looks like and whether this will compliment or hinder a return to work.
- ***Timeframes*** to return to work.
- Be available for, and participate in, ***case conferences*** when appropriate.
- ***Respond to requests*** for information and reports.

Tips for employers

Christie Stonham

- Focus on prevention and early intervention – reduce the realised risk of injuries and illness occurring in your workplace
- Engage with your workforce and understand what they consider to be barriers in regards to achieving positive return to work outcomes
- Implement strategies and initiatives that are suited to your operating environment
- Be patient – understand that it will often take longer to recover from psychological injuries
- Don’t do it alone – build a model of shared responsibility between the organisation, leaders, your employees, your insurer and treating professionals

Q&A Session

Tony McHugh
Psychologist

Dr. Craig Barnett
General Practitioner

Christie Stonham
Manager Shield Strategy - AFP

Facilitator:
Prof Stephen Trumble
General Practitioner

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Resources and further reading

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1. 

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Emerging Minds Practice skills to promote infant and parent mental health in the first twelve months on Tuesday 15th August at 7.15pm

Latest innovations to imbed and sustain trauma informed care on Thursday 24th August at 7.15pm.

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WEBINAR

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Supporting clients/patients with PTSD to participate in good work

Thank you for participating