

WEBINAR TRANSCRIPT

WEBINAR: Supporting clients/patients with PTSD to participate in good work

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Webinar Date: Tuesday 11 July 2023

Panellists:

- Dr. Craig Barnett (General Practitioner, NSW)
- Dr. Tony McHugh (Psychologist, VIC)
- Christie Stonham (Manager Shield Strategy AFP, NSW)

Facilitator: Professor Stephen Trumble (General Practitioner, VIC)

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Prof. Stephen Trumble (00:00:02):

Good evening, everybody, and welcome to tonight's webinar on supporting people with PTSD to participate in good work. We'll be using the term clients and patients interchangeably tonight, and we'll also be sorting out exactly what we mean by good work. But, before we start, MHPN would like to acknowledge the traditional custodians of the Land, Sea, and Waterways across Australia, upon which our webinar presenters and participants are located. We pay our respects to Elders past and present for the memories, traditions, culture, and hopes of Aboriginal and Torres Strait Islander Australia.

(00:00:38):

So, my name's Steve Trumble, and I'll be facilitating tonight's session. I'm a GP by background and professor of medical education at Melbourne Medical School. Tonight, Mental Health Professionals Network is partnered with Comcare to produce this webinar. And just for background, Comcare is a government regulator, workers' compensation insurer, claims manager and scheme administrator. It works with employees and employers, service providers and other stakeholders to minimise the impact of harm in the workplace, improve recovery and return to work, and to promote the health benefits of good work. So, we have disseminated the biographies of tonight's panellists with the webinar information invitation. So, in the interest of ensuring we can cover as much content as possible, we'll skip reading through the bios, but let's meet them one by one, starting with Dr. Tony McHugh, who's a psychologist based in Victoria. Hello Tony. Welcome.

Dr. Tony McHugh (00:01:40):

Thank you very much. Very glad to be here. Very important webinar. Happy to be involved.

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Prof. Stephen Trumble (00:01:45):

Great. So, what do then you find important particular area of work in your professional practise?

Dr. Tony McHugh (00:01:51):

I think this is one of the big issues that we don't work well enough at times. I think there's an emerging literature about how to work better with people to achieve functional outcomes and work as one of those things that we can see. Work's incredibly important to humans.

Prof. Stephen Trumble (00:02:10):

Fabulous. Well, we'll definitely be talking about that tonight. So, thanks for being with us. We're also joined by Dr. Craig Barnett, who's from New South Wales, and a general practitioner like myself. So, Craig, what do you find important about this area of work?

Dr. Craig Barnett (00:02:24):

I very much enjoy this, this kind of area, Steve, because you get the opportunity to, to not only work with your diagnostic skills and your management skills and communication with the patient, but you also get to often work with a larger team of people. So, I take sources of information from, say, my fellow psychologists and psychiatrists along with rehabilitation providers, and hopefully with management within the workplace to try to foster optimal outcomes for these people, who really struggle. I think one of the biggest challenges is there's a lack of common language and communication on some of this. So some people have very elegant communication about emotions and, and what's happening for them. Other people are really struggling to get that across and, and that may just present as behavioural change, whether that's anger or whatever. So that's one of the reasons I got involved in this.

Prof. Stephen Trumble (00:03:23):

Great. Well, we're certainly gonna touch on all of those issues tonight, so it's great to have you. Thanks very much. And last but definitely not least, also for New South Wales. Christie Stoneham, who's the manager of the SHIELD Strategy for the Australian Federal Police. So, welcome Christie. And could you just tell us in a few words what the SHIELD strategy actually is?

Christie Stonham (00:03:44):

Yeah, thanks Steve. It's a pleasure to be with you all tonight, representing the employer voice on this panel. On behalf of the AFP the SHIELD service delivery model is transforming the way health and wellbeing is delivered within the AFP. And a key part of my role is to focus on the continuum of work, health, safety and rehabilitation services within the AFP. And it's a pleasure to be here with you tonight to provide some insight to what the AFP are doing in this space.

Prof. Stephen Trumble (00:04:13):

Fabulous and always great to have the employer's perspective on these sorts of topics. So great to have you. Well, before we get started, just a few points to discuss about how the web player works. So, I'm sure many of you have been with us before, but I'll just run over these fairly quickly. To interact with the webinar platform to

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access the resources, you'll see you've got various options. There are three dots in the lower right corner of your screen where you can access information. And under the information tab, you'll find the slides, and the resources, including the case study that we are talking about tonight. There's a survey, a feedback survey to fill out for us. A couple more ground rules, please be respectful of other participants and panellists, particularly in the chat box. It's a fabulous place there to chat with others.

(00:05:01):

We can't see it, but the team in the back can keep an eye on it and let us know if copy if topics are coming up and I'll let us know. But please do keep your comments on tonight's topic in the chat box rather than catching up with old friends as the main part of that. So, what's gonna happen now is each panellist will give a short discipline-specific presentation, and then we'll go into a Q and A discussion between the panel. Our aim tonight is to discuss how practitioners and employers can work together to support patients with PTSD. And Tony said that working, sorry, Craig said that working together is so important, but patients with PTSD to participate in good work that supports their health and well-being. As Tony said, good work is so important for a healthy life.

(00:05:47):

I'm not gonna read those learning outcomes out loud because you can see them there and you can all read perfectly well, I'm sure. and you've also received the case that hopefully you've been able to read that and are aware of the sorts of issues that we'll be talking about. If you wanna revisit the case, click on the three dots at the bottom right of the platform. So, we're all set to go. And we will start with Dr. Tony McHugh, our psychologist colleague, who's gonna give us the psychologist's perspective in just a few minutes. So over to you, Tony.

Dr. Tony McHugh (00:06:20):

Thanks very much, Steve. We should not make assumptions, I think so. It's important to define PTSD the first thing we do. As you can see, it derives from the experience of threat of death, serious injury or sexual assault, or directly witnessing the same. That's according to DSM-5. It's important to note also that traumatization is perceptual, and no two people react to any given trauma in identical fashions. And we understand that PTSD cannot exist where an event has not been perceived as traumatic. That's referred to as the paradox of PTSD, and hence we talk about potentially traumatising events. These in five relocated PTSD from anxiety distress disorders, this was extremely contentious as the people who had in fact placed it there in the first place. Back in DSM-3, argued very strongly that this was not a sensible move. I think actually it is a stress disorder. I'm arguing against luminaries, but we're going to talk about PTSD tonight as per DSM-5 and ICD-11, they're overwhelmingly similar in definition. We won't be talking about complex PTSD and that might be the subject of another webinar in the future. Those classification changes, however, are very contentious, as I've alluded to around the debates regarding criterion eight, the causal criterion concept creep and expanding ideas of what harm might be to humans. Next slide, please.

(00:08:01):

Let's consider the nature development of maintenance of PTSD the onset of PTSD. It may occur after a potentially traumatising event from one month on, that is one month of symptoms, three months of chronic chronicity. It, it means that you've got a chronic condition. Commonly comorbid with PTSD anxiety, the most common comorbidity, mood and substance disorders. There are clear pre, peri and post-event risk factors for

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PTSD, not all have the same predictive power. Gender and age, for example, are considered to be weak predictors. Peri traumatic reactions and post responses are perhaps the strongest indicator predictors and post-trauma support is a particularly strong predictor. There are many, many theories models of PTSD and many expert bodies offer information, describe research and offer clinical guidance such as the PTSD centre in Phoenix, Australia. I believe strongly that we are ethically obliged to know and implement such knowledge and treatment. Those graphs show that symptoms decline naturally for people over the first-year post-trauma. They also show that there are different trajectories, and we need to be very, very mindful, that I'll talk more about that later, perhaps. Next slide, please.

(00:09:32):

All humans have latent vulnerabilities, which are typically only expressed in the context of negative life events and potentially traumatising events. This is explainable in terms of a 1962 theory by a very important psychologist, Paul Neil. The stress diathesis or diathesis stress construct. It's an explanatory model of stress responses that clients actually like, and PTSD suffers readily acknowledge. PTSD, as the graph suggests, is a disorder of recovery and most affected by recover, although different courses exist. Next slide, please.

(00:10:13):

How is PTSD best treated? One of the most important parts of tonight's presentation, perhaps the stage model of, of treatment is essential. And many people have spoken about this. Terry Keane is one who suggests six stages of treatment. John Briere suggests four. And implicit in all of them are education and building a client personalised model of recovery and wellbeing. That is a term you may hear me refer to a number of times tonight. Also included are affect management, cognitive work, behavioural experiments, and exposure like interventions. Early symptom reduction is important. That's what causes people to show up often, but treatment is about more than symptoms. The meaning of what has occurred, current functioning and the meaning of that functioning to the self and to others are critical. Early treatment. Addressing the big three is critical, the big three emotions are anxiety and anxious. Avoidance is particularly important to address depression in the form of hopelessness. Helpful helplessness and pointlessness is also important to address, but particularly important in my research and experience clinically is to address anger, because it's a moral emotion and, and is connect to so many other emotions that appear post-traumatically. And it's an unrecognised until recently PTSD potentiator. Angry PTSD as I refer to it, as more than the very useful construct of post-traumatic embitterment disorder by Linden, and I would encourage you all to go looking for that construct. It's readily available through Google searches, for example, both especially relevant when there is perceived or actual injustice, nonetheless.

(00:12:04):

Recovery hinges on the following. New learning and adaptation to trauma focused CBT interventions. They include cognitive therapy, cognitive processing therapy, EMDR, and above all, prolonged exposure. They are the four evidence supported treatment interventions. This is best done in an envelope of slowness, as suggested by Daniel Kahneman, and it's such an important book, 2011, I would encourage you all again to go looking for it. And we need to emphasise mental toughness, hardiness, coping, self-agency and purpose, and Charles Bonanno and Lazarus are very important here. And I encourage you all to remember your Nietzsche. The first quote's a bit tongue in cheek, but it is what he did say. And everyone thinks it's the military, but it was Nietzsche.

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Important, he said, if you have the why, the how will follow. It's very important for people to have a recovery ambition and to learn the treatment tactics and strategies that will help them. Next slide, please.

(00:13:16):

This is a fairly busy slide and other speakers, particularly Christie, are going to speak to elements of this. But as you can see, there are four stakeholder parties. There's the employer, the scheme, the worker, and the treater. And I've underscored some things there that I think are important because time is precious. Mental health policies have to exist, but they have to be enacted and leaders through to managers and all staff need to live and promote the truth of them. Also, promoting diverse recovery stories is important in by employers. Schemes need to act with dignity, empathy, wisdom and enabling client dignity. Rather, a need to really understand what mental health is in debunk myths for the worker or the client to understand there are important health benefits to work, I won't talk much to that as Christie will talk to that. But again, to develop a personal model of recovery and wellbeing by adopting tools, tactics, and a sense of how they're going to recover. And for the treater, it's in our obligation to engage in efficient and effective treatment, debunk myths, implement and translate evidence-based practise to develop in conjunction with the client, their personal model of recovery and wellbeing. And to know our code in the sense that sometimes it's important to know when to conclude treatment sooner rather than later. That's what I've got to say for the present time. I will hand it back to Steve. Thank you very much.

Prof. Stephen Trumble (00:14:58):

Thanks so much, Tony. And I'm gonna jump on an immediate question that's come up from Richard who hadn't come across the word awfulism before. I must say I've not either. Can you just tell us in a few words what awfulism is? It sounds appropriately awful.

Dr. Tony McHugh (00:15:14):

Awfulism is what angst-ridden people suffering from depression will talk about quite a bit. That things are awful. They are terrible, they are intolerable. It's a deep form of depression or depressive cognition where people are describing with great power how terrible things are for them. And sometimes it's important, not sometimes it's frequently important to reality check, reframe, help people develop different takes on those ideas.

Prof. Stephen Trumble (00:15:49):

Great. Alright, thanks so much. And thank you also for giving us such a firm foundation to think further about the case on. You've already answered a number of the questions that have come up before the, the webinar. So, let's now move on to Craig. So clearly Craig, Tracey in the case here is spending time with her GP, but let's hear your take on what happens from the GP perspective when you're helping somebody like her.

Dr. Craig Barnett (00:16:18):

Thanks Stephen. And look, thank you Tony. Cuz there's a lot of things in there that sort of sort of reflecting what I do in day-to-day practise. I want the audience to first think about a, a psychologically injury as a wicked problem. We'll come back to what wicked means in a moment, but I want you to really focus. It is a wicked problem. It's a very tricky one to solve. You need tailored management, as we just heard from Tony, the need to sort of personalise and understand what's going on for the individual. So, unlike something like a shoulder

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injury where you can say, well, look, we're gonna go through this sort of rehab process and, and we're gonna lift a certain amount of weight. And then at 16 weeks you should be right to get back to work. It's not quite so straightforward because it will depend on the exact circumstances, the resources the person has, their background and of course what sort of work they're, they're required to do, and how the exposure has then affected that. It mental health situations, as I'm sure all the psychologists in the room are well aware, has a lack of visible features. So, someone could present to, to work or present to the gym or wherever. And they may look fine, but it doesn't necessarily tell you what's going on be on under the skin there. And so, they may actually be very scared, very vulnerable rather confused and not sure what's actually going on more why they're having these emotional responses. As I alluded to a little earlier the communication in this space of mental health is incredibly difficult.

(00:17:59):

And I think if you were to stand a small group of claims managers and patients and perhaps GPs, perhaps psychologists perhaps some psychiatrists and some social workers all in the one room, I'm sure that we would find very different approaches in the way language is used to communicate what's happening for the person. And with that comes the other problem, which is often misunderstanding both in that communication but also in perceived ideas and beliefs. As a very clinical example, I have a lovely person who unfortunately has some fairly significant PTSD symptoms, and one of their relatives constantly says to them, oh, you just need to pick yourself back up and get back to what you were doing, you'll be fine. But of course, that's not the position that the person is in. And similarly, that can happen in workplaces where people put their own spin or judgement on things. And finally, the risk, if the person's mismanaged, and I can't emphasise this enough if the psychologist, psychiatrist, the GP is on the phone to an insurer and says, look, there's a serious problem here. This person is actually deteriorating and becoming suicidal. There needs to be action on that, and people need to be communicating. I recently, unfortunately, received a letter from a from a rehab provider in that exact circumstance. And the letter basically says we tried to phone the patient a couple of times and they did not answer, period. No question as to whether they had suicided or whether they OD'd on the floor or what further was to take place.

(00:19:56):

And in fact, no contact with me except by snail mail. But look, it's so important. This is managed well because it is a risk of very negative outcomes. And I think sometimes workplaces don't necessarily understand the nuances of that, but nor are they exposed to just the same as I'd be a fairly hopeless accountant or a not so flash engineer. But we do have success if we work on this. If we work as a team, our wicked problem can be reduced. May have the next slide, please. I don't lay any great claims to to academia with this diagram, but this is a diagram I use on a daily basis to think about where my patient is at and how we might return them to work down the very bottom.

(00:20:53):

So, it's slightly unusual in that we're starting at the bottom of the diagram. It's where is the person themselves at? Can they actually get up out of bed in the morning? Can they actually get themselves dressed? Or do they deter, degenerate into tears and feel a need to return back into hiding in their bed? Can they actually organise basic things like remember to get their clothes on, know where the car keys are remind the children perhaps to

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take their lunchbox and so on. So down at that very basic level, you know, are they functioning as a person, and can they care for themselves? If they're not, there's a lot of serious consequences that flow from that, both for the family and for the workplace that need to be considered. And then further up the scale is, is are they capable in a safe environment of having interactions?

(00:21:47):

Can they, for example, go to a cafe with perhaps a trusted friend or significant others and have that cup of coffee, or does things like their hypervigilance, their anxiety prevent that? And on occasions, this is where rehab providers, if they're very attuned, and also our psycho psychologists, if they're attuned to the situation and given the latitude can actually make a big difference here. So sometimes meeting with an independent, trusted person that actually knows what's going on for the person and monitoring what's happening to them can then perhaps take them to a quiet coffee shop and at the right time and see how they're responding, help talk them through how to manage that. And then, and then at the end of the hierarchy we have, we have contributing to work. Work has some expectations, there's some rules, there's a cognitive load there and there's certain expectations and certain complex socially interactions. And under our workers' compensation schemes across the country, which were very fortunate to have those in existence, we look to set aside the routine workload in such a way as to optimise an ability to come back into a workplace. Next slide please.

(00:23:13):

You remember I said a wicked problem. I'll let you read that rather than me reading the whole thing out. But wicked problems are these complex things that have multiple elements involved. So sure, as a general practitioner, I'm looking at my patient, but I'm also thinking about how we might integrate them back into their social fabric at home. And then of course, further into, into a workplace environment. And this requires really key things, needs to be that communication, we need employer significant others in the workplace to sort of understand a little about what the patient's going through and what's good or bad, and a way of communicating that information. And one of the tips, for example, is in the case of people becoming anxious or feeling overwhelmed on a particularly bad day one of the I can't remember which one, whether it was Black Dog or the other one had suggested that one of the things to do was just to have a little red card.

(00:24:19):

And if there was a red card on the desk, don't talk to Bob or don't talk to Jeanie today because they're only just managing to cope with what they've got in front of them. Understanding what's going on, and we've mentioned there the communication difficulties around language. For example, perhaps a, you know, a rigour that to a works on scaffolding and so forth is not going to have very erudite language about their emotions and what they're feeling. They're just going to experience some of the things that perhaps Tony's touched on, such as that anger and need to sort of blame somebody for what's taken place. And there needs to be this agreement. If we are to address this as a workplace and human concern, we need to reach a position where there's safety.

(00:25:12):

Think about those things like suicide, drug abuse or alcohol abuse, and the person needs to be capable of managing themselves, but also taking that a little further to actually be meaningful and manage their responses

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in the workplace. Next slide. So, what do you expect from this? And I was really heartened to hear Tony, in Tony's talk there that he was mentioning that time slow being steady about this. People's emotional state does not change or an alter very rapidly in the situation of significant mental health illness such as PTSD. So, whereas something like a shoulder, you may be expecting to see an increase every, every two or three weeks, and you wonder why if you got to five weeks and there was no change it may be quite normal to see four or five, six weeks before, before you see significant changes.

(00:26:15):

But obviously there needs to be that kind of feedback loop of watching what's happening and understanding what the what's going on for the person at their individual and tailoring those those treatments. And so in particularly in time, if there's any insurance fund managers list listening out there you know, when a clinician, an experienced clinician says to you, look, I don't think this person's going to actually achieve any upgrade for a period of time that may be three months, it may be six months in, in the more extreme it's important to recognise what that means. And just as Tony was saying be prepared to actually say where we are and where we're going. And so, acceptance of an outcome is important, if we were to move some of our mental health stuff in the more extreme PTSD into a physical arena, would we expect someone with quadriplegia to be out there running? And the answer is, don't be ridiculous, Dr. Barnetta, that's, that's kind of being a little silly, but sometimes I find exactly the same situation in mental health where the expectation of an outcome is beyond what the person's managing to achieve and showing through their trajectory over time and showing in the information coming from multiple parties, not just myself. So, understanding what the outcome is to be for a person is really important. Thank you.

Prof. Stephen Trumble (00:27:52):

Thanks so much, Craig. And both you and Tony now have brought up the issue about time for treatment. how long, and I might ask, I know we'll get to the Q and A shortly, but I just might ask both of you, how long you budget for sessions with somebody suffering from PTSD both from the GPs perspective and the psychologist's perspective. I mean, how long is a piece of string, I guess, but what's your general experience?

Dr. Tony McHugh (00:28:20):

Craig, would you like to go first?

Dr. Craig Barnett (00:28:22):

Yeah, look, I look for, again, it's always based on degrees of what's actually happening and how people are responding. I certainly have ex-police persons who we've worked with over two or three years and have achieved outcomes for them. Now, the outcome may not be going back to to a very industrious taxing work environment, but I'm really pleased to say that in some of those cases, we actually have people working two and three days a week and coming home enjoying that work even though the work in some respects is very light on, and I mean cognitive and physically can compared to their past workload and abilities. But it's a very positive human outcome.

Prof. Stephen Trumble (00:29:19):

Great. And Tony, what about in your experience, how long do you generally plan for?

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Dr. Tony McHugh (00:29:23):

Look, it depends on many things. The intensity of the distress with which the person presents initially, the history of their traumatization, their personal characteristics, and those human vulnerabilities, as I said, we all have them. But as a rule of thumb, that two-year period that Craig referred to when I was at the Austin over a couple of decades, we ran a treatment programme where we provided two years of treatment, both group and individual and psychiatry. In my own practise, I would average about 45 sessions across 18 months or so with seriously traumatised police. But there's a project in Victoria that I've been involved in called Blue Hub, and the average number of sessions provided is 28, and that's to remission or termination of treatment and with most people returning to work where they have been working. So, it varies, but we need to work actively and optimistically because there's a really negative thing that happens in more and more treatment, treatment effectiveness tails off, it becomes iatrogenic and people start thinking, I must be really, really unwell and people aren't telling me. So, I think the more effective and efficient we can be, the better.

Prof. Stephen Trumble (00:30:50):

Right. Thank you so much for that. And both of you've mentioned the police force or different police forces. So now we go to Christie to hear your presentation. Thanks, Christie from the AFP.

Christie Stonham (00:31:02):

Thank you, Steve. I'll start with some high-level context from an AFP perspective. And as some of you would I guess quite rightly, assume the high-risk nature of work undertaken by the AFP provides an interesting picture in terms of injury and claims profile. So, by way of example, mental stress is one of the highest mechanisms of injury in relation to accepted claims over the last four years. And psychological injury claims have recently overtaken the rate of physical injuries in the AFP and account for a significant part of our premium costs. Alongside the psychological injury obviously comes time off work which directly links to a productivity cost as well. Given it takes longer to recover from a psychological injury rather than a physical injury. Funding for SHIELD was received in late 2020 and represents the single biggest wellbeing investment in AFP's history.

(00:32:02):

From my perspective, it recognises the unique stresses and inherent risks associated with policing, along with community expectation that we do more to protect those who serve us. The slide on your screen visualises the six key components of our service delivery model and examples of what they include, noting that we are still working towards full maturity. Through SHIELD, the AFP is transforming the way health and wellbeing services are delivered to all AFP employees by shifting the AFP's health model to be one focused on prevention and enhancing operational capability and member experience. However, we are realists and appreciate it will take a time for that cultural shift for it to be realised. Next slide please.

(00:32:50):

To better support our diverse footprint, we moved away from a centralised model with limited health and wellbeing services to establish multidisciplinary teams in each major geographical location with a strategic centre that develops the governance standards and quality assurance processes to promote a consistent service delivery around the country. SHIELD is considered a deployable capability, which offers access to dedicated teams of clinicians and health professionals who, who understand the unique nature of work within

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the AFP. The multidisciplinary team model you can see on your screen is designed to provide holistic and connected care. However important to note that these locally based teams are complemented and supported by a nationally based team, including an occupational hygienist, occupational therapist, and dietitians. In context of the case study, we have before us tonight SHIELD may have been utilised to deploy early intervention from a psychological perspective immediately after the incident, which may have minimised the ongoing impact to Tracey that we, that we now see described. Another pathway would be the early access programme. So, in recognising that getting access to support as early as possible is critical to recovery, and that support will look different for every person. The AFP have also invested in an early access programme that works complimentary to SHIELD and provides flexibility in terms of treating preferences and offers a pathway to be reimbursed for medical treatment, physio, imaging, and limited periods of leave. Next slide please.

(00:34:29):

In the AFP, we're investing in our safety culture, culture at a strategic level and encouraging command or the business to lean into their role of managing risk indicators as opposed to having the organisation often in partnership with Comcare as our insurer, manage the realised risk, knowing that it'll take time to realise the full benefit of that ongoing cultural shift. We are concurrently working to enhance return to work outcomes and reduce the amount of time people are out of the workplace if an illness or injury should occur. And this slide focuses on that. We're taking a multifaceted approach to uplifting the capability and awareness of key stakeholders in the return-to-work process and helping them AFP move beyond just their legislative requirements or obligations and really seeking to promote the concept of good work and how that can be achieved. The inner circle on this slide represents the model of shared responsibility required to enhance return to work outcomes. But important to note that this slide represents the stakeholders we have the most direct relationship or influence over in the AFP. However, a key group has been referenced by Craig and Tony before me also includes the trading team, but I'll come back to that in my next slide.

(00:35:45):

The outer circle reflects the integrated and holistic approach being taken across multiple pillars of effort to enable that capability uplift through the establishment of a working group across the organisation focused on return to work, we were able to get feedback from those within the business to understand what were considered barriers in regard to return to work, some practical, practical examples of what we are doing to enhance return to work outcomes. In response to that information gathered includes leveraging off the semi embedded model of SHIELD and developing strong relationships with commands. So, we can be considered a trusted partner with open lines of communication. The model also enhances the case manager's knowledge of the work environment so they can guide return to work conversations appropriately. We are empowering leaders and developing leaders to drive return to work outcomes by investing time and effort in tailoring training and education packages for different levels of our workforce to help them understand their legislative obligations, their role in influencing a positive safety culture. And relevant to this topic, the practical steps to follow once someone becomes ill or injured, which has a primary focus on achieving good return to work outcomes and includes tools, templates, reference materials to make the process easy for them to follow.

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(00:37:06):

We're also being innovative with our governance. For example, with return-to-work processes or engagement in good work in general, it requires coordination and integration between the client, the supervisor, and health services. We've recently introduced a piece of governance called the Employee Support Board, which brings all relevant stakeholders together with a common goal of developing an employee support plan that has structured goals, activities, and objectives. The people involved in that process is largely driven by the individual and may include the supervisor, the rehab case manager, clinicians, a workplace rehab provider, and any additional support that person would like to include, including family members if they so choose. We're also in the process of developing suitable duties register to ensure that there is always a pool of tasks and projects that can be undertaken by someone demonstrating capacity to return to work, however, may not be able to return to the pre-injury position just yet due to medical restrictions. Next slide. Thank you.

(00:38:14):

As mentioned earlier, the model of shared responsibility includes with treating teams as they play a key role in the promoting of both return to work with the employee and health benefits of good work. As we know, there is a limited window of time to influence positive outcomes. For example, the longer someone is off work, the less likely they are to return to work. It's evidence that if someone is off work for 20 days, the chance of ever getting them back to work is about 70% and that percentage drops significantly as days outta the workplace increase. So, from an employer's perspective, it is helpful if practitioners can be overt and provide advice on alternative duties, whether that be internal or external to the immediate workplace, including any modifications that may be required. There is also data that shows that if a healthcare provider contacted the patient's workplace, it was twice as likely that the injured worker would return to work.

(00:39:14):

Sometimes, it is important for a practitioner to understand if there are any non-medical factors delaying or return to work. And the best way to do that is to ask the relevant people, for example, the employee, the supervisor, or the rehabilitation provider. Ask the question, what in your opinion are the barriers for returning to work? It is also great if practitioners can be available for and participate in case conferences when appropriate, including responding to requests for information or reports as it will help the employer meet their obligations and also assist your patient on their recovery journey. Next slide, please.

(00:39:54):

Employers should strive to create a culture that promotes and celebrates good health and ensure everyone understands what they can do to contribute to that. However, when injury or illness does occur, employers obviously play a crucial role in realising return to work outcomes. Every workplace will experience challenges with return to work and the answers to challenges you may experience likely sit within your business. So set up the right forums or avenues to enable that information to filter the to the top so you can do something about it. It's never a case of one size fits all as the needs of each agency differ. And in the AFP, we have a very unique risk profile and operating environment. While we take as much guidance and advice that we can from Comcare and seek to deploy best practise case management, we have to be agile and ensure the frameworks governance and training implemented suits our operating environment. And while it is recognised that recovery will take longer from a psychological injury, it doesn't mean you should take a passive approach, ensure that

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you are empowering all the right people to play an active role and try to achieve return to work outcomes and always remain in contact with the employee. I'm happy to leave that there for the moment. Steve, thank you. And hand back to you.

Prof. Stephen Trumble (00:41:14):

Great, thanks so much indeed, Christie. I'm very taken by the diagram you've got for SHIELD there. It surely requires somebody clever to get it that put on the SHIELD held by Chris Evans as Captain AFP. It's a, it's a compelling image of everything there. It's great.

Christie Stonham (00:41:30):

That's definitely not my creative licence!

Prof. Stephen Trumble (00:41:33):

Alright, I'll put my camera on so you can see me blushing at that pop culture reference. Thanks for that. It's so good to hear about the communication that's needed. In fact, people have been asking questions about what we can do to try to get more information from healthcare providers when you are putting together a programme. Do you have any quick tips for the audience on how you can get information from healthcare providers like Craig and Tony that actually help you do work at your end, at the employer's end?

Christie Stonham (00:42:03):

Yeah, absolutely. A good tip from our perspective is making sure we're very direct and targeted with the questions that we ask. Don't leave it to be ambiguous or misinterpreted by the person receiving the request. Be very clear with what you are asking and relate it as much as you can to the role requirements. What is the scope of the role? What is required of the individual, and what is the specific question you are asking? The clearer your question is, the clearer the response can be.

Prof. Stephen Trumble (00:42:31):

Great. Thanks so much. And we've now got a good half hour or so for group discussion. So, thanks everybody for keeping your presentations concise and really what we need to focus on. Look, there are so many questions that have come in and that people have been asking during the webinar so far. But one that's cropped up a few times is when people are seeing that the workplace itself contributes to the cause of PTSD. There was one particular question about whether bullying in the workforce, bullying in the workplace can meet the diagnostic requirements for the diagnosis of PTSD when there's not the major trauma and things that have been discussed by Tony. And then following on from that, what we can do to return a worker to a workplace that they're finding difficult as in fact, Tracey was. So, who wants to pick up on that one to begin with? I guess the diagnostic issue might sit with you, Tony, if that's okay, about what happens if bullying is seen as the trigger for the person's distress?

Dr. Tony McHugh (00:43:42):

Very good question. Diagnosis is an art. If diagnoses become expanded to include things that weren't in the original diagnostic classifications, I think we run the risk of disorders becoming less meaningful. Bullying is something that is unacceptable, always has been, always will be. I don't think someone has to have PTSD when

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a clear-cut case of bullying is in place and the bullying needs to be treated for its effect on a person's psychology, particularly anxiety, depression, anger, those sorts of things. We are dealing with humans. We're not dealing with diagnostic concepts, and I think distress is enough. And I, I think assisting people to deal with improper workplace behaviour does not require a diagnosis of PTSD. I'd add one final thing if I may. I talked about predictors of recovery in PTSD and it's how a person is received after an event, how they are treated. I have a, have had a complete conversion across my working life. I now agree with the luminaries who say that is the most important thing in predicting trajectory of recovery. And Christie's touched on it, Craig's touched on it. I can't emphasise enough how an empathic response sometimes a firm empathic response because there is a problem with increasing concepts of harm. But I think the response of the workplace, the scheme, the people surrounding the client is so incredibly important. I'll leave it there.

Prof. Stephen Trumble (00:45:45):

Yeah, thanks Tony. And even in the instant before Tracey's car was struck by another car the case tells us that she was finding her work difficult. She was going through a marriage relationship, breakup, separation. So, I mean these sorts of predisposing is a bad concept, but I gather different people will receive that sort of impact differently depending on where they are in their life at that point in time. And I think you'd perceive that in general practise a lot, wouldn't you Craig, that there are different people exposed to the same levels of trauma who come out of it completely differently and some of those resilience issues that Tony mentioned. What are your thoughts on that?

Dr. Craig Barnett (00:46:33):

Yeah, look, absolutely. I couldn't agree more. And hence part of the wicked problem is the very individually individual nature of this sort of an injury. So, you know, in the case of our particular, a particular patient whose name just escapes me. Tracey, Tracey we would, you know, you really want to just know a little bit about what was going on leading up to this, and we've got a little bit in the case there, but, you know, how is that whole divorce situation going and, and what sorts of triggers that's caused for her? Has it, has it dwelled up all sorts of issues around perhaps things like you know, child support and, and living arrangements and, and the life. So that's going to come into the mix. Although I think, I think for most we would see the fairly traumatic event of this accident. And certainly, if we accept that the case is written almost as a storytelling from her viewpoint at the scene of a colleague with blood over their face and not moving, I think for many people even with a fairly strong background will find that really challenging and this sort of thing. And exposure is one of the great problems that our emergency services such as the police that that Christie has been talking about face on a daily basis. So, they not only have daily risks, they also have cumulative risks of this taking place.

Prof. Stephen Trumble (00:48:11):

Sure. So, Christie, the way the case is set up, there was about four weeks between the incident and really Tracey coming to attention. Do you feel that there should have been more proactive strategies going on from the employer's side during the four weeks between the incident and the claim or the cry for help?

Christie Stonham (00:48:34):

Yeah, absolutely. I also think there was a room, room for opportunity for the employer to intervene even before the incident. I guess that the case study outlines some of the context there and it really describes some of the compounding psychosocial hazards that were developing for Tracey in terms of increased work demand. There

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were also personal stresses that she was experiencing that I guess contributed to I guess her moving up that mental health continuum before the incident actually occurred. So, there's an obligation and an opportunity for the employer to identify those signs and symptoms in an employee and intervene early to provide support, show empathy, and reduce some of the psychosocial hazards in place in from that perspective. But like you also mentioned, as soon as the incident occurred there wasn't an opportunity for early intervention straight away. And from my perspective in the AFP, we would've definitely recommended engagement with a psychologist sooner rather than later to undertaken a debriefing process, for example, that may have given insight to some of the indicators that a more serious injury may develop, and some psychoeducation or targeted treatment could have been provided sooner rather than later.

Prof. Stephen Trumble (00:49:57):

Sure. Thanks for that. I should have mentioned before that I'm a presiding member with medical panels more on the the WorkCover WorkSafe side of the system. And I must say the number of times we sit on a panel with hundreds of thousands of dollars of legal fees and stomach linings being expended, and you think, why do people feel obliged to throw petrol on a small fire after an incident? But it does seem to be that we are not as good at managing these emerging problems, these wicked problems before they become too wicked. Anyway, do any other panellists have any comment to make before we move on to the next question? Craig, look like you were about to fire up there.

Dr. Craig Barnett (00:50:45):

<laugh>. Yes. Look, I'm just a bit curious, Christie, and, and forgive me cause it's a bit of a devil's advocate question. Certainly for many of my people that work in things like coal mines and all sorts of things if they were to turn up to work and say, oh look boss, I'm going through a bit of a breakup and you know, it's really getting on top of me and you want these extra reports done I'm not sure what response they're likely to get from an employer. So how does the AFP assure that that can happen? Cause after all the workplace needs output.

Christie Stonham (00:51:24):

Yeah, absolutely. And that speaks to part of the, the wicked problem associated with the cultural shift required in organisations to, to reduce the stigma associated with having those open conversations and making sure people know that it is safe and that they'll be heard if they engage in those conversations. Cause if people have a negative experience in trying to have that conversation, chances are they're not gonna have another one anytime soon.

Dr. Craig Barnett (00:51:49):

Mm-hmm. <affirmative>.

Christie Stonham (00:51:50):

So, it's gonna take a a lot of time to, I guess across industries to, to reach that kind of maturity level. But I think we, we all have to start somewhere and making a, I guess, a cognizant effort in regards to our, our strategy, our leadership frameworks and our general cultural aspirations will eventually have a force multiplier effect in that space. But it will take time.

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Dr. Craig Barnett (00:52:14):

Thanks Christie. Thank you.

Prof. Stephen Trumble (00:52:15):

Thanks. And then to Tony, Tony, someone's asked the question, what is the status of early professional debriefing in PTSD events? I must say, having worked as a GP in Marysville after the fires in 2009 people didn't seem to be that ready for professional debriefing immediately after the fires. But what are your thoughts about early intervention, professional debriefing when there's been an obvious incident?

Dr. Tony McHugh (00:52:44):

A very good question and a very good observation too Steve. Often, I think we are trying to apply things to people, to clients that they're not actually seeking. I can remember when the Kosovo's came to Australia in the mid-1990s. A lot of people went to Bandiana and places like that offering psychological interventions, including debriefing. They pretty soon got the message. We don't want that. We want things that remind us of where we come from, came from materials to make all kinds of clothes, et cetera. They wanted practical assistance to go to the question. We really don't talk these days much about debriefing. I think debriefing done skillfully was probably a very useful thing, but often it wasn't done as skillfully as it could be. We now tend to talk about developing skills, psychological first aid and watchful waiting. And something that Christie referred to before isn't obvious watching for when people are really having intense reactions, because in most people, their symptoms die down. But if someone's having nightmares or dreams as indeed, I think Tracey was having, these are signifiers for maybe we should be doing something more. But mandatory group-based professional debriefing, we don't really advocate for that anymore.

Prof. Stephen Trumble (00:54:19):

Mm-hmm. <affirmative>, thanks for that. And while we've got you, you did quote the famous philosopher I thought it was Kelly Clarkson, what doesn't kill you make you stronger, but apparently it was Nietzsche first, but that issue about, I noted down mental toughness, hardiness and coping I've been seriously beaten up by medical students who are interpreting that sort of call out for resilience as being a way of putting responsibility on them for a damaged traumatic health system that they're being dropped into. Any thoughts about that issue of who has sort of responsibility for hardiness?

Dr. Tony McHugh (00:55:03):

Look, I think it's like all things human. It's a shared responsibility. I can't insist on any client having what I call a personalised model of recovery, right? We've talked for decades about keeping clients at the centre of our care. I don't know anyone who would say they weren't trying to do that, right? But true effective treatment is collaborative, encouraging the individual, the system, the employer, the scheme, everyone to engage around how do we help this person understand that they are the most important. All the other parts are important, but they are the most important aspect of recovery, that they are the agent of change. And it's not a critical thing, it's not a damning thing. It's when people finally have a plan for how they're going to get better because their treatment team has encouraged them to think optimistically about that, then I think really good things can happen I'll leave the dilemmas of the health system to others, but I don't think it's the responsibility of students. I worked in a public hospital for 20 years. Everyone's got a part to play in that.

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Prof. Stephen Trumble (00:56:20):

Absolutely. Yeah. So, what about you, Craig? I mean, we often find ourselves as GPs being almost recruited onto the, the patient's side of the struggle with their employer that's going on. Do you find yourself in that situation? How do you balance your Yeah. Commitment to the patient while also doing what's in their best interests?

Dr. Craig Barnett (00:56:42):

Yeah. Look, thanks Steve. If I might just digress, just a fraction on and pick up on Tony's comment and your comment about, about resilience. And I would love to say this is my thought, but it's not. It was a wonderful GP at a rural medicine conference in Port Macquarie this year. And she liked Tony as a very dedicated academic. And she stayed in front of the audience, and she was really sick and tired of hearing the word resilience. And her reason for saying so was she said, the reason is it's looking at one part of it. It's saying what the qualities are that the patient needs to have. She said, now think of that like a soccer ball. If you bounce that on concrete or bounce that on a good playing field, it bounces really nicely.

(00:57:30):

Now bounce it in a swamp and see what happens. It doesn't matter how good your resilience is, it won't bounce. And I thought I thought that little description was actually very good because certainly as a GP, I do encounter occasionally situations where workplaces are perhaps just not accepting of mental health condition. And no matter what the determination and the resiliences of the patient and the treating team, that can be very, very tricky. But thankfully they're not common, but it does happen. In terms of working with the workplace look, most of the time if I'm dealing with something like PTSD as a significant mental health diagnosis, I'll have, I'll want the patient to be involved with a team. I'll want a psychologist and I'll usually want a rehab rehabilitation provider. And I might I might be a little cheeky if I may Stephen say not just any rehabilitation provider, many rehabilitation providers of physios or OTs and sure have some psychological knowledge, but I would really prefer someone that's got a psychology type background or has lots of experience in this area so that they know it's not just about the physical vulnerabilities and know how to communicate with the workplace about finding what that safe work is, you know, such as our outpatient Tracey.

(00:58:54):

I think I think unless Tony were to overrule me, I think for the moment we're not gonna be very keen with her sort of driving too far or having anything that's particularly taxing. What we want to is try to get her stable and have some sort of graded return to something that looks like a workplace progressively depending on how her self-state is going.

Prof. Stephen Trumble (00:59:18):

Yeah. And I mean, in a, having a really well trained, experienced OT is familiar with mental health issues, can be a fabulous member of the team, that's for sure. So, Christie, is the AFP providing a swamp or a plexi-paved court there for the board who you've balanced on? Is that what your SHIELD program's all about really? Is it making a firm foundation?

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Christie Stonham (00:59:42):

Absolutely. There, there is a really key focus on prevention and that is embedded in that is the education component and focused on building resilience within AFP members across their career life cycle. Cuz, we know the inherent risks that they're gonna face in, in the role that they are performing. So yeah, a hundred percent right SHIELD is focused on that. but not just focusing on building the resilience, it's how we adapt the leadership and the culture to be more accommodating and managing those risk indicators as opposed to allowing risk to be realised in the form of injury or illness.

Prof. Stephen Trumble (01:00:21):

Yeah, and Craig mentioned some success he'd had with a quite badly injured police officer who managed to get back to some sort of work within the environment. I still remember a surgeon saying after he slipped and cut his extensor off in his fingers, could no longer operate, and he said, I'm a surgeon. I search, it's what I do. How do you deal with this issue of AFP officers who are no longer able to do what attracted them to the job in the first place? I mean, they might, they might have wanted to be sort of active policing officers rather than whatever work they might. How do you show that to be good work for them?

Christie Stonham (01:01:02):

Mm and that's a real challenging situation Steve and most people who join the AFP join it for a career that, that they're in it for the long haul and they strongly identify as a police officer. So that's often a barrier to achieving return to work outcomes cuz it's hard for them to adjust, I guess the mental model of what I guess bringing value to the community means to them if they can't perform that role of a police officer anymore. So, it often takes a little bit longer in those extreme circumstances. But we have, I guess, varying levels of success in regards to return to work outcomes in that situation. But we are, we'll always be guided by the medical advice and very open to engaging or exploring opportunities outside the AFP as well if it means getting people engaged in meaningful work.

Prof. Stephen Trumble (01:01:56):

Okay. So, you can have somebody deployed elsewhere within the Commonwealth Public Service system or, or finding other suitable work with an employer who has the need of those skills?

Christie Stonham (01:02:09):

Yeah, absolutely. We follow the return-to-work hierarchy as outlined by our insurer. But we definitely look external to the AFP and within the, the broader Commonwealth when the medical advice supports us with that. Absolutely.

Prof. Stephen Trumble (01:02:23):

Okay. Thanks for that. So, we'll be moving to the final phase of the webinar shortly. Maybe one final question, and this is I think probably directed obviously best at, at Craig, it's about the use of mental health care plans and psychologists who are providing sessions which are obviously strictly time limited, although there's a calendar year issue there.

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Dr. Craig Barnett (01:02:43):

Mm-hmm. <affirmative>.

Prof. Stephen Trumble (01:02:44):

Do you find that the mental health care plan system gives you enough referring capacity, or is it really not enough when Tony's saying 45 sessions is about a starting point or a budget?

Dr. Craig Barnett (01:02:57):

Wow, that's the loaded question, Steve. Thanks for that one. <laugh>.

Prof. Stephen Trumble (01:03:01):

Okay, so we'll move on to the-

Dr. Craig Barnett (01:03:03):

<laugh>. Look, I think the mental health care plan is, is a very helpful fallback. I've had occasions where claims with workplaces are challenged and at least allows me to provide some additional care to keep keep the person in contact with their psychologist. And obviously if it's a situation well outside of the workplace and the workplace doesn't have any funding arrangement in place, then certainly the mental health plan provides some benefit. Unfortunately, as I'm sure psychologists, GPs and I'm sure a number of health professionals watching this thing there's a great gap has opened up over the last 30 years between what the Medicare system pays for or refunds to the patient as opposed to what the cost of delivering those services are. And that creates a great problem.

(01:03:58):

I now have very much I see on a daily basis a two-tiered health system. People who have got money in their pocket and can get a mental health plan and afford the treatment. And a very long line of people who fall by the wayside because they do not have access to financial resources. And so, they're on very long waiting lists with I'm gonna say charity, that's not quite fair, but charity like situations where bulk building is still occurring often being propped up by either goodwill or some other, some other financial process.

Prof. Stephen Trumble (01:04:40):

Sure. So mental health practitioners in very short supply, we've got a full range of practitioners, psychiatrists through to social workers and all points in between, but they are a limited resource. Maybe we can just have a final comment from Tony before we move to the wrap up about the sort of words you might use when coming to the end of a therapeutic relationship with a client or when you've achieved the goals that you've sought. What sort of words do you use when helping a worker understand that their sessions have come to an end?

Dr. Tony McHugh (01:05:17):

To use the analogy, it's a bit like parenting. If you want to raise a good child, it starts from day one and if I get my TARDIS and I go back long enough, I can remember that I was taught that from the point of assessment, we're heading towards conclusion. So, I'm saying those kinds of things to people early days, it's just like getting

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to having an adolescent child and starting to parent, then it's too late. You parent from day one, you prepare people for release from day one, we really shouldn't be having unexpected conversations about conclusion. It should be planned all the way along, checking in and really making clear that more and more treatment is not necessarily better treatment. I have reviewed cases in some of my other roles where I won't tell people how much treatment, but if I said 45 was a ballpark, you can multiply by a factor of five or six.

(01:06:22):

And what message is that giving people when they have had that much treatment? Someone's not telling me the truth about how unwell I am. So, I want people to think about assertive active treatment and proper treatment planning. There are always gonna be hiccups where the original estimate might have to go out by a few sessions to recover a situation, but right from day one, we should be talking about when we both know that the time is coming and I say to people, it will be a sad day, but it will be a great day when we have to part.

Prof. Stephen Trumble (01:07:01):

Mm-hmm. Mm-hmm. Right. Thanks. So, while you've got the speaking stick, maybe we can get you to sum up in just a couple of minutes your thoughts about this topic and we'll go around the, around the room.

Dr. Tony McHugh (01:07:11):

Thank you. I said at the start this, this is such an important topic. It's got so much meat to it, we can't do it justice, but my take home messages are around diagnosis and formulation. An accurate diagnosis and appropriate formulation is empowering of the individual through us explaining why it is so, what the symptoms mean, what recovery looks like, et cetera. Treating assertively, I've made that point a number of times. These schemes quite rightly, don't want to see supportive psychotherapy. They're funded by the Australian public, and they want to see effective and efficient treatment being delivered. And if we are not doing that, we're in violation of our various codes and we are not acting in the best interests of the client. The point is to attempt to, with their personal model of recovery at the heart of what we do, reestablish their functioning.

(01:08:11):

So, focusing on functioning is really, really important. Scores on metrics, unless we've done them multiple times, and I mean 10, 15 times over the course of treatment, they are not objective. They vary at any point in time. Cross-sectionally, it's hard to interpret them. Working with optimism is the next one. Showing people of the possible, you know, demonstrating optimism and encouraging them to be optimists. And finally, a bit of a negative kind of thing to comment on. But we must, must help people address their irritability where it is a problem. Irritability with the employer, irritability with the person who caused the accident or the event irritability with themselves. Sometimes there can be considerable shame about being on these schemes and where the shame anger is only a hair spread for ways. So, anger is such an impediment to recovery. We talk a bit about moral injury these days.

(01:09:16):

I think it's an okay enough concept, it's a bit pat at times. I think there are some things to be morally troubled about. Let's be realistic. A much more helpful idea, I think is traumatic embitterment disorder, that's Linden. It's a bit different to my idea of angry PTSD but I think people are more often angry when having PTSD than

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classically anxious. And I think the move in DSM-5 was, in my opinion, but I'm arguing against some giants, believe me. But in my, I think it was the appropriate thing to do. Thank you. Alright, thank you for that. And Craig, your final thoughts.

Dr. Craig Barnett (01:09:58):

Oh, look, I fully support the comments of Tony. This is a really massive topic. I wanna return to the wicked problem. That communication is so important and it's communication at multiple levels across multiple people. So, what's happening, what's happening to Tracey's partner or, you know, obviously there's stuff going on with the separation there, but had that not been the case, how is that functioning and how is the mental health situation and the work cover claim affecting or Comcare claim affecting the household? These are really very important things, and it may have income in indications as well. So, as you are dealing with the psychological issues and the, and the sort of medicine of the psychological situation as a GP, I'm also running parallel a whole lot of other things. What's going to happen if the income stays as it is?

(01:10:54):

Have they got options to, to mitigate that? Are they far enough ahead on the mortgage? All that sort of thing comes, comes in into it. And how are they socially functioning? I think the hierarchy that I use is a really nice little practical tool. And hearts back to some of it's lovely to hear, you know, Tony's very well-founded detailed knowledge pointing out that function is what we really wanna look at and that this, the rating scales and stuff have some benefit, but always look at what's in front of you. And for employers like Christie and others making available the relevant people, the people that have the power to make decisions to share the information. And also, those contact points. I had by, for various reasons, had to contact Comcare the other day to find that the number that I'd been provided with was just a general call centre. And the person I was talking to sure had access to the case, but had no knowledge of what, what was going on. And particularly for psychological cases, this can be a bit of a problem. Thank you.

Prof. Stephen Trumble (01:12:08):

Okay. Well thanks Craig. And the employer does have the final word. So, Christie, what's your sum up?

Christie Stonham (01:12:17):

Thank you. In summary, there's a couple of points I'll touch on. And the first one is that employers obviously play a crucial role in realising return to work outcomes, but ultimately they should have a strategic focus on preventing injury and illness and enabling early intervention that's reflected through their strategic documents, their cultural aspirations and leadership frameworks, as that will all help to, I guess, shape the culture and reduce the stigma associated with discussing and reporting mental health issues. Tony touched on it earlier as well, but human-centered design is important in developing processes and focusing on the employee experience. It's incredibly important as an employer that you balance the experience of the person against the need to deliver on operational outcomes, which I know can be a challenge. Lean into the problem, don't do it alone. There's significant power in top-down leadership and using executive sponsors or champions can be incredible, incredibly powerful through being an influential communicator within the business. Debunking myths associated with return-to-work processes and Red Manning and providing critical end user input to new initiatives and governance to ensure it is fit for purpose. And I guess my last point will be stay in contact with



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the employee. Don't let them be out of sight, out of mind. Keep their needs at the front and centre of your thoughts and make sure they feel valued and connected to the workplace still. Thanks.

Prof. Stephen Trumble (01:13:49):

Fabulous. Thank you so much. Thank you to all our panellists. I'm just gonna ask people not to leave us straight away. We've got a couple more things to, to do in this last minute. And the most important is to get you to give us some feedback on tonight's webinar. It's really important to us to know how it's gone and what we could do to improve these webinars and make sure that we are meeting your needs. So please do get on to the feedback links, which you can do by that QR code there or to the SurveyMonkey address, which will be there as well. So please give us feedback. For more information about Comcare, you can visit their website. The next webinars coming up for MHPN will be on Emerging Minds Practice skills to promote infant and parent mental health in the first twelve months of life, which is on Tuesday the 15th of August.

(01:14:44):

And then another one in August on the 24th, which is looking at and relevant to tonight, Latest innovations to embed and sustain trauma-informed care on Thursday the 24th of August. Now, you might be aware that MHPNS networking programmes support practitioners to meet network with others from their local community, and there are more than 350 of these networks across the country. So, you can visit the MHPN website to find your nearest one. If you want to start one up, you can also send a message in offering to do that, to start up a network around your area geographically and of expertise. Before I close apart from thanking our panellists again and also for the very active discussions that were occurring amongst participants tonight I would like to acknowledge the lived experience of people, carers, and colleagues who have lived with mental illness in the past, and those who continue to live with mental illness in the present. So, thank you to everyone for your participation this evening, and I wish you a good evening.