MENTAL INJURY TREATMENT GUIDELINES

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WorkCover QUEENSLAND

BACKGROUND

WorkCover Queensland monitors trends in the treatment and use of item codes through analysis of state-wide data. This helps us to ensure injured workers receive optimal quality of care and their return to work outcomes are maximised, in addition to maintaining a financially viable scheme that balances costs for employers.

These guidelines are designed to be a roadmap for visibility and transparency when treating workers with a work-related mental injury.

Medical interventions relating to mental injuries have been included in the guidelines. WorkCover employees will use these guidelines when approving requests for medical interventions relating to work-related mental injuries. It is important to note that these are **general guidelines** to assist with treatment and management of work-related mental injuries and there may be exceptions or extenuating circumstances relating to treatment requests. Should a provider seek an exception to the guidelines, it is recommended that they contact the Customer Advisor to discuss the request. Further expert medical opinion may be sought by WorkCover to assist with approving the requested intervention.

Conditions detailed in the explanatory notes of the Medicare Benefits Schedule (MBS) also apply to the medical items schedule of fees, with some noted exceptions. The schedule is available at worksafe.qld.gov.au.

Where an intervention is identified for a second opinion, WorkCover employees will seek the assistance of the Medical and Allied Health Panel (MAHP) or an Independent Medical Examiner (IME) prior to approving the intervention. WorkCover will share with you the information received from a MAHP or IME for your information, review and comment.

It is important to note that some therapies currently have emerging evidence supporting their efficacy and the current Association and College position is to research and explore these further. These treatment modalities will be reviewed and monitored regularly. These guidelines will be updated in line with the evidence based research supporting the relevant treatment modality.

These guidelines will also be used for post payment data analysis to identify ongoing payment trends and issues.

WorkCover acknowledges the expertise and contribution of all stakeholders, particularly members of Royal Australian and New Zealand College of Psychiatrists (RANCZP) and the Australian Psychological Society (APS), that provided comment for the review of the mental injury guidelines.

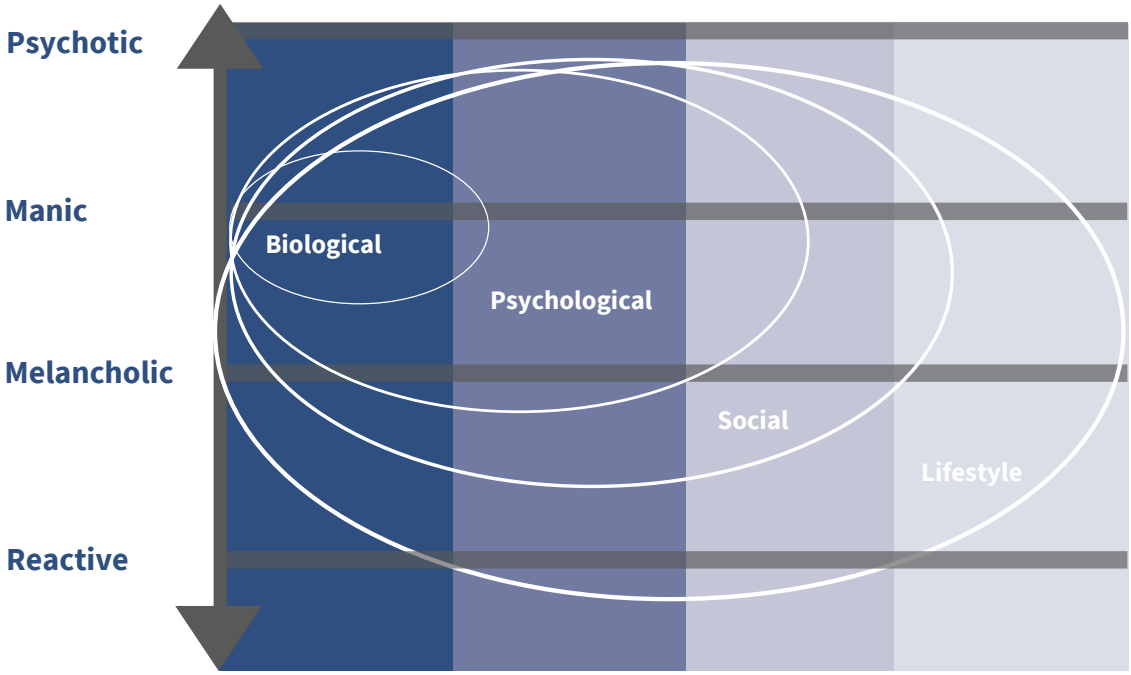
WORKCOVER MODEL

WorkCover is committed to ensuring workers receive optimal quality care delivered in a timely manner, which supports a return to work outcome, whilst acknowledging the challenges of the compensation setting.

It is important to note that WorkCover can only cover **work-related** mental injuries. These injuries could span Adjustment Disorders, Major Depressive Episodes, Anxiety Disorders and Post Traumatic Stress Disorders (PTSD) arising from work related events.

WorkCover endorse and apply the Biopsychosocial and Lifestyle Model (BPSL)[1] to the management and treatment of psychological and psychiatric injuries arising from work related events.

The BPSL Model provides a useful framework for understanding the factors that contribute to development of mood disorders and for planning clinical management. It encompasses biological, psychological and social perspective alongside lifestyle factors and is referred to as the BPSL Model. Typically, mood disorders arise from factors from more than one domain. Consequently, a broad range of treatments are usually needed to satisfactorily treat mood disorders, anxiety disorders and PTSD.



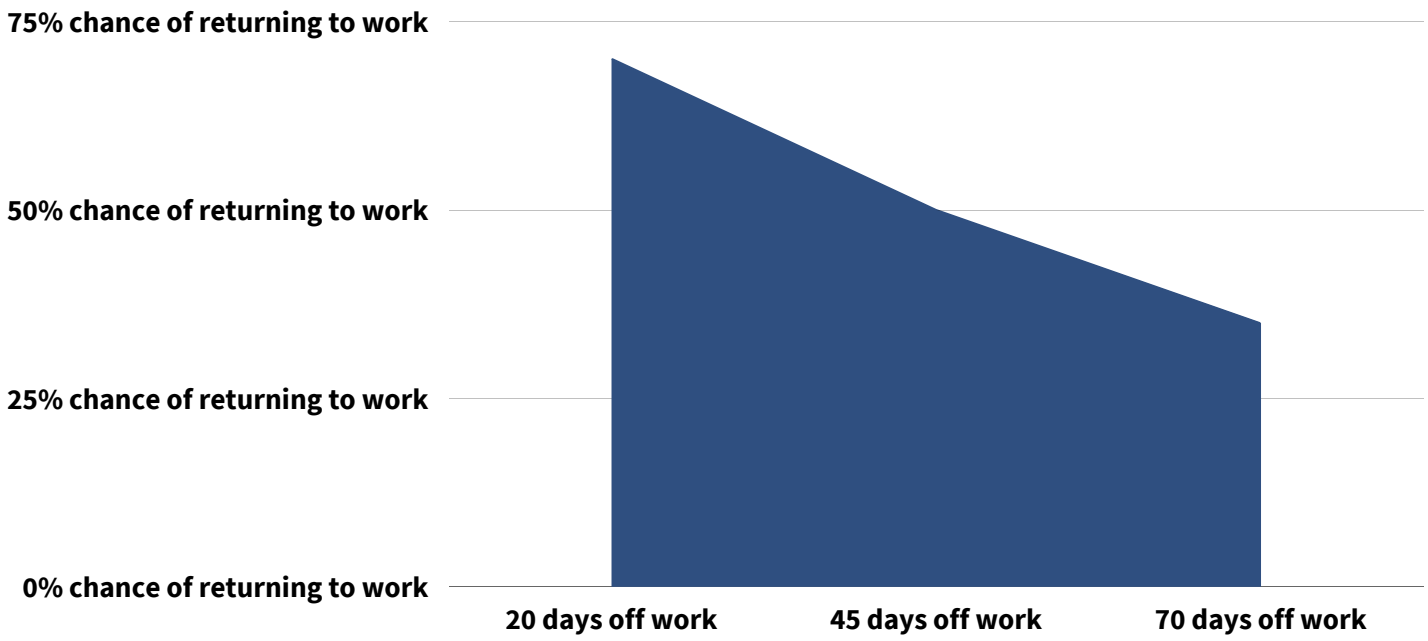
Biological Treatments	Psychological Treatments	Social Treatments	Lifestyle Treatments
Antidepressants Antipsychotics Mood stabilisers Electroconvulsive therapy Transcranial magnetic stimulation	Brief cognitive behavioural therapy Formal cognitive behavioural therapy Interpersonal therapy Mindfulness Acceptance & commitment therapy Schema therapy Exposure therapy	Family psychoeducation Family / friends Formal support groups Community groups Caregivers Employment (inc graduated return to work) Housing	Exercise Diet Smoking cessation Alcohol cessation Ceasing drugs Managing substance misuse Sleep

[1] Adapted from Malhi, Gin & Bassett, Darryl & Boyce, Philip & Bryant, Richard & Fitzgerald, Paul & Fritz, Kristina & Hopwood, Malcolm & Lyndon, Bill & Mulder, Roger & Murray, Greg & Porter, Richard & Singh, Ajeet. (2015). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. Australian & New Zealand Journal of Psychiatry. 49. 1087-1206. 10.1177/0004867415617657.

WORKCOVER - RETURN TO WORK PHILOSOPHY

The Royal Australasian College of Physicians Position Statement on realising the health benefits of work highlights that being off work for long periods of time can significantly reduce the likelihood of a worker ever returning to work.

In addition to the RACP Position Statement, best practice frameworks from both Superfriend and SafeWork Australia support a biopsychosocial approach to treatment and rehabilitation, and early intervention to improve recover at work/return to work outcomes. For injured workers, as the time for them off work increases, the chance of return decreases.



A workers social and economic wellbeing, including wherever possible recovery at work, or return to work, should be a central outcome of best practice. We all have a responsibility to:

- understand the health benefits of good work and of early intervention;
- have a commitment to collaboration; &
- take an evidence-based approach to ensuring the best outcomes.

If worker can stay at work after an injury, or get back to work gradually while they recover, they're more likely to recover quicker and be able to get on with their life.

Staying connected to their workplace, even if their work tasks are adjusted, means they can maintain a daily routine and get back some control and independence. This helps with their physical recovery as well as supporting their mental health and general state of mind.

APPROVED TREATMENT INTERVENTIONS

Applicable fees and item codes are outlined in the WorkCover Medical Table of Costs.

WorkCover only support and fund evidence-based treatment interventions. In determining this, WorkCover refers to the relevant practice guidelines of the applicable Associations. Experimental treatments are generally not approved within the WorkCover scheme.

Medical intervention	Descriptor	Delivery Mode	Approval
Cognitive Behavioural Therapy (CBT)	Cognitive Behaviour Therapy (CBT) is a relatively short term, focused approach to the treatment of many types of emotional, behavioural and psychiatric problems. The application of CBT varies according to the problem being addressed, but is essentially a collaborative and individualised program that helps individuals to identify unhelpful thoughts and behaviours and learn or relearn healthier skills and habits. Each session should be accompanied with 'out of session' tasks, to help achieve real changes and consolidate any shifts in thinking. Mindful based strategies and exercise physiology services can be beneficial as a value add to the CBT treatment.	Outpatient	**Approved by WorkCover as per Table of Costs.** **NOTE: Prior approval of service is required.** **Average treatment course 10-12 sessions (framework as per Medicare Scheme). Sessions commence weekly for the 1st 4 weeks and then fortnightly for the remainder.** **Usually takes 6-8 weeks (estimated) to see improvement.** **Maximum treatment approval is 16 sessions.**

Trauma Focussed CBT (TF-CBT)	This treatment is a phased and component-based treatment. The three phases of TF-CBT are: • Stabilisation; • Trauma narration and processing; and • Integration and consolidation. Like EMDR, it is exposing the worker to the event (imaginal). There is also an 'in vivo' (biological) component to this treatment. WorkCover will consider on a case by case basis (with the appropriate specific justification) support for the worker with an 'out of office' session(s).	Outpatient. May be delivered inpatient as part of a private psychiatric hospital admission and program.	**Approved in WorkCover for trauma related incidents as per Table of Costs.** **NOTE: Prior approval of service is required.** **Average treatment course 12-16 sessions, but it is important to note response time is variable.**
Interpersonal Psychotherapy (IPT)	Psychotherapy is a modality of treatment in which the psychiatrist and patient(s) work together to relieve psychopathological conditions and functional impairment through focus on: ▪ the therapeutic relationship ▪ the patient's attitudes, thoughts, affect, and behaviour and ▪ the social context and development. Useful for assisting with interpersonal difficulties at work or home, that is impacting on the worker's capacity to return to normal functioning.	Outpatient	**Treatment should be given as per a structured plan.** **NOTE: Prior approval of service is required.** **Maximum of 16 sessions.** **Delivery is usually more frequent at the start of course and becomes less frequent (e.g. monthly) as the course progresses.**

Acceptance and Commitment Therapy (ACT)	ACT is a form of psychotherapy. It uses acceptance and mindfulness strategies mixed in different ways with commitment and behaviour-change strategies, to increase psychological flexibility. Recommended as an alternative form of CBT to enhance return to work for the following: • chronic pain • tinnitus • mental illness • work-related strain. Generally, not recommended as a primary treatment for anxiety and depression.	Outpatient	**Approved by WorkCover as per Table of Costs.** **NOTE: Prior approval of service is required.** **Average treatment course 13-20 sessions. Sessions commence weekly for the 1st 4 weeks and then fortnightly for the remainder if progress is being made.** **Usually takes 6-8 weeks (estimated) to see improvement.** **Maximum treatment approval is 20 sessions.**
Progressive Muscle Relaxation (PMR)	This is used not for relaxation purpose per se. It is used more on a clinical level to ensure that clients have an awareness of the first signs of a stress response and can utilise their arousal reduction strategies early rather than allowing the elevation increasing to a level where it is difficult to control.	Outpatient	**Approved by WorkCover as part of the CBT treatment regime (outlined above).** **NOTE: Prior approval of service is required.**

Eye Movement Desensitization and Reprocessing (EMDR)	Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment originally designed to alleviate the distress associated with traumatic memories. During EMDR therapy, the worker attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimuli. Eye movements are used during one part of the session. After the clinician has determined which memory to target first, they ask the worker to hold different aspects of that event or thought in mind and to use their eyes to track the clinician's hand as it moves back and forth across the client's field of vision. EMDR therapy is an eight-phase treatment. WorkCover will consider on a case by case basis (with the appropriate specific justification) support for the worker with an 'out of office' session(s).	Outpatient. May be delivered inpatient as part of a private psychiatric hospital admission and program.	**Approved in WorkCover for trauma related incidents as per Table of Costs.** **NOTE: Prior approval of service is required.** **Not approved for the treatment of specific phobias, panic disorder and agoraphobia.** **Generally, 12 sessions maximum, but it is important to note response time is variable.**
Repetitive Transcranial Magnetic Stimulation (rTMS)	rTMS is an effective and evidence-based treatment for depression. There is limited clinical study data to confirm the efficacy of rTMS in the treatment of PTSD conditions. rTMS involves the focal application of a localised, pulsed magnetic field to the cerebral cortex, inducing small electrical currents which stimulate nerve cells in the region of the brain involved in mood regulation and depression. Magnetic fields are passed through the skull to the brain using a coil placed on the patient's head. The treatment is non-invasive and does not involve seizure induction or loss of consciousness. The patient is completely alert during the procedure and an anaesthetic is not required.	Outpatient.	**Approved by WorkCover for depressive conditions only as per Table of Costs.** **NOTE: Prior approval of service is required.** **Not approved for PTSD treatment** **Average treatment course 15-20 sessions (3-4 weeks, delivered daily Monday-Friday).**

Electroconvulsive Treatment (ECT)	Electroconvulsive therapy (ECT) is a therapeutic medical procedure for ***severe*** and ***treatment resistant*** psychiatric disorders. This means the disorder has failed to respond to a range of more conventional and safer treatments. ECT is used only for the most profound cases of Melancholic Depression and often only where the depression is associated with significant neuro-vegetative disturbance, catatonia, or other psychotic features. It is not a long-term treatment and is generally provided as a course of treatment (average of 8-12 sessions).	Inpatient as part of a private psychiatric hospital admission and program. Final treatments only may be completed as outpatient.	**Approved by WorkCover as per Table of Costs.** **NOTE: Prior approval of service is required.** **Average treatment course 8-12 sessions.** **ECT treatments given 3 times per week.**

NON-APPROVED TREATMENT INTERVENTIONS

Treatment interventions that are not approved by WorkCover

Experimental treatments are not approved within the WorkCover scheme. As stated previously, WorkCover only support and fund evidence-based treatment interventions. In determining this, WorkCover refers to the relevant practice guidelines of the applicable Associations and the appropriate testing levels as determined by the NHMRC.

Treatments that are not approved by WorkCover are outlined in the table below:

Medical intervention	Descriptor
Deep Brain Stimulation (DBS)	DBS is used only as a treatment of last resort in extremely debilitating conditions. It has an uncertain evidence base for both efficacy and side effects. It is regarded as an experimental treatment.
Mild Brain Stimulation (MBS)	See Deep Brain Stimulation (DBS) above.
Dialectical Behaviour Therapy (DBT)	Dialectical Behaviour Therapy (DBT) is a modified version of cognitive-behavioural therapy (DBT) designed to primarily treat Borderline Personality Disorder (BPD). BPD is a disorder which arises due to genetic predisposition and often in combination with early childhood traumatic experiences. DBT is rarely, if ever, used for the treatment of other conditions. Borderline Personality Disorder cannot arise as a result of a workplace issue.
Transcranial Direct Current Stimulation (tDCS)	tDCS has an uncertain evidence base for both efficacy and side effects. It is regarded as an experimental treatment.
Schema therapy	Schema therapy is a newer type of therapy which combines elements of CBT, psychoanalysis, attachment theory and emotion-focussed therapy.
Psychodynamic therapy	Psychodynamic therapy is the psychological interpretation of mental and emotional processes.
Equine Therapy (Eagala)	Equine-assisted psychotherapy incorporates horses into the therapeutic process. Workers engage in activities such as grooming, feeding and leading a horse while being supervised by a mental health professional.
Medicinal Cannabis (e.g. CBD oil)	Most medicinal cannabis products are currently unregistered medicines and access to these products is through the Commonwealth Special Access or Authorised Prescriber Scheme. More research is being done on the uses of medicinal cannabis - the current scientific evidence base supporting its efficacy and outcomes is limited.

WorkCover approve the relevant pharmacotherapy for the treatment and management of work-related mental injuries, where an evidence-based practice supports its use and efficacy.

It is noted there is a wide variety of psychotropic medication which are often used in combination, prescribed by treating practitioners. WorkCover expects that psychotropic medications are prescribed in accordance with conventional practices, particularly regarding maximum doses and combinations of medications.

Common treatment practices involve starting with SSRI or SNRI medications, gradually titrating up doses, before either switching to an alternative agent or using agents in combination, as per the table below.

Typical recommendation[a]	Antidepressant Class	Generic Name of Medication	Principal Mechanism of Action	Features of depression for which antidepressant is most likely to be useful
1st line	SSRI	Citalopram, Escitalopram, Fluvoxamine, Fluoxetine, Paroxetine, Sertraline	Selective 5-HT reuptake blockade	Anxiety
	NARI	Reboxetine[b]	Reuptake inhibitor for noradrenaline and adrenaline	Activation (e.g., motivation & withdrawal)
	NaSSA	Mirtazapine Mianserin	Blocks the reuptake of serotonin via 5-HT_{2A} & 5-HT_{2C} receptors. Also blocks $5HT_3$ & Alpha-2 receptors.	Insomnia, circadian disruption, weight loss, reduced appetite
	Melatonergic agonist	Agomelatine	Melatonin agonist (M1 and 2 receptors) and 5-HT_{2C} antagonist	Sleep problems, sexual dysfunction, poor hedonic drive
	NDRI	Bupropion[c]	Blocks the action of the noradrenaline transporter and dopamine transporter	Fatigue
2nd line	SNRI[d]	Desvenlafaxine, Venlafaxine,[e] Duloxetine, Milnacipran	Block both serotonergic and noradrenergic reuptake. Latter leads to an increase in prefrontal dopamine.	Melancholia; severe depression. *Velafaxine*: treatment resistant depression. *Duloxetine*: pain
	TCA	Amitriptyline, Clomipramine, Dothiepin, Imipramine, Nortryptiline Trimipramine Doxepin	Block NA reuptake. Some also block 5-HT reuptake. All TCAs inhibit H_1, α1, & M_1, receptors. Some also block 5-HT_{2C} & 5-HT receptors. Broad spectrum of actions, including blockade of voltage-sensitive sodium channels.	Pain Melancholia
	Serotonin Modulator[f]	Vortioxetine	5HT1a agonist, 5HT1b partial agonist, 5HT3a and 7 antagonist 5HT transporter inhibitor	Melancholia Severe *depression* Enhances *cognition*
3rd line	MAOI	Phenelzine, Tranylcypromine	Irreversibly inhibit the mitochondrial enzymes MAO-A (metabolises 5-HT, NA & DA) and MAO-B (preferentially metabolises DA)	Melancholia Atypical symptoms[f] Treatment resistant depression
	Reversible MAOI	Moclobemide	Reversible inhibitor of MAO-A (RIMA)	Mild to moderate depression with anxiety
Adjunctive	SARI	Trazodone	Serotonin 2A/2C antagonist and reuptake inhibitor (at high dosage). At low doses blocks 5-HT2A, α1, & H_1 receptors (hypnotic action)	Used when patients do not respond well to 1st line

Notes: (1) SSRI, selective serotonin reuptake inhibitor; NARI, noradrenaline reuptake inhibitor; NaSSA, noradrenaline and specific serotonergic antidepressant; NDRI, noradrenaline-dopamine reuptake inhibitor; SNRI, serotonin and noradrenaline reuptake inhibitor; TCA, tricyclic antidepressant; SM, serotonin modulator, MAOI, monoamine oxidase inhibitor; SARI, serotonin antagonist and reuptake inhibitor. (2) In New Zealand, certain antidepressants are not funded unless suitable alternatives have been trialled first.

***References:** (Boulenger et al., 2012; Citrome, 2015; Katona and Katona, 2014; McIntyre et al., 2014; Mahableshwarkar et al., 2015; Sanchez et al., 2015; Schatzberg et al., 2014).

[a]**There** is some flexibility in terms of 1st, 2nd, and 3rd treatment, based on patient's symptoms (e.g., MAOIs would be prescribed 1st line for atypical depression); [b]Atomoxetine is prescribed for ADHD and is therefore not recommended 1st line for depression; [c]Only indicated in Australia for smoking cessation; [d]SNRIs have been positioned as 2nd line only because of greater toxicity in overdose; [e]Low dose; [f]Evidence is equivocal Trimipramine: refractory insomnia.

Reference: https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/mood-disorders-cpg.aspx

It is recognised that benzodiazepines can become medications of dependence and they should be prescribed carefully, for short periods of time. The risk of dependency should be openly discussed with the patient. This is in line with the recommendation from the Australasian Chapter of Addiction Medicine.

Practitioners seeking further information or guidance are recommended to reference Professor Stahl's Essential Psychopharmacology Prescriber's Guide (6th edition).

PRIVATE HOSPITAL ADMISSIONS

WorkCover will not fund the following private hospital admission requests requests unless there is compelling evidence outlining and supporting the need for admission:

- for the initiation of psychiatric medications; or
- to switch psychiatric medications; or
- to wean down psychiatric medications.

Further, all private hospital admissions require prior approval from WorkCover before the admission.

TREATMENT

It is critical for the optimal management of work-related psychological and psychiatric injuries that the treating Psychiatrist/Psychologist provide WorkCover a clear and detailed description of the treatment programs including timeframes, patient centric goals and expected outcomes.

COMPLEMENTARY THERAPIES

WorkCover only supports and funds evidence based treatment interventions and therefore do not approve the use of complementary therapies.

GENERAL

WorkCover will only approve medical interventions that are undertaken to treat changes caused by the **work-related injury or event (WRI).**

Where a claim has been accepted as an aggravation of a pre-existing medical condition, WorkCover must consider whether the proposed medical intervention is to treat changes caused by a work-related injury or event or pre-existing changes. If the medical intervention is to treat pre-existing changes WorkCover will not be able to cover the intervention.

Early diagnosis and timely requests for appropriate psychological/psychiatric interventions are critical.

During the decision-making process for approval of psychological/psychiatric interventions, WorkCover will:

- consider available medical information from treating practitioners
- review the Mental Injury Guidelines
- consider the worker's past medical history and determine if further information is required
- if further information is required, request clarification from treating practitioner regarding the rationale for proposed intervention and relationship of request to accepted WRI,
- if a second opinion is warranted, seek independent medical opinion (IME/MAHP)
- if contrary independent opinion is obtained, discuss further with treating practitioner
- consider the weight of all medical information and evidence provided to make decision
- ensure decision is communicated to treating practitioner and the worker.

DEFINITIONS

- Aggravation: A factor which may or may not be work-related that has caused worsening of pre-existing changes of a permanent nature.
- Exacerbation: A factor which may or may not be work-related that has caused a temporary worsening of a pre-existing medical condition.
- Recurrence: A recurrence requires no identifiable incident as trigger to resumption of symptoms or signs related to the pre-existing medical condition.
- New Injury: An identifiable new incident must be shown to have caused the injury.
- Disability: A decrease in, or the loss or absence of, the capacity of an individual to meet personal, social or occupational demands.

REFERENCES

It is important to note that the Reference List below is not an exhaustive list of resources reviewed, but is a demonstration of the breadth of evidence-based research utilised in the development of these guidelines.

1. https://www.aacbt.org.au/resources/what-is-cbt/
2. https://contextualscience.org/ACT_Randomized_Controlled_Trials
3. https://www.monash.edu/medicine/spahc/general-practice/engagement/clinical-guidelines
4. https://www.nhmrc.gov.au/guidelinesforguidelines/develop/identifying-evidence
5. https://www.odgbymcg.com/treatment/psychodynamic_psychotherapy
6. https://www.odgbymcg.com/treatment/tDCS
7. https://www.odgbymcg.com/treatment/schema_therapy
8. https://www.odgbymcg.com/treatment/mindfulness_therapy
9. https://www.odgbymcg.com/treatment/EMDR
10. https://www.odgbymcg.com/treatment/DBT
11. https://www.odgbymcg.com/treatment/CBT
12. https://www.odgbymcg.com/treatment/ACT
13. https://www.phoenixaustralia.org/resources/our-research-publications/
14. https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/ranzcp-anxiety-clinical-practice-guidelines.aspx
15. https://www.ranzcp.org/publications/guidelines-and-resources-for-practice/ptsd-practice-guidelines
16. https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/mood-disorders-cpg.aspx
17. https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/electroconvulsive-therapy-(ect)
18. https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/repetitive-transcranial-magnetic-stimulation
19. https://www.ranzcp.org/files/resources/college_statements/clinical_memoranda/cm-transcranial-direct-current-stimulation-(tdcs).aspx
20. https://www.ranzcp.org/files/resources/college_statements/clinical_memoranda/cm-deep-brain-stimulation-v1-0-march-2018.aspx
21. https://www.ranzcp.org/files/resources/college_statements/clinician/cpg/ranzcp-anxiety-clinical-practice-guidelines.aspx
22. https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/psychotherapy-conducted-by-psychiatrists
23. https://www.ranzcp.org/files/resources/college_statements/clinical_memoranda/cm-use-of-ketamine-for-treatment-resistant-depress.aspx
24. https://www.sane.org/mental-health-and-illness/facts-and-guides/dialectical-behaviour-therapy-dbt
25. https://www.sciencedirect.com/science/article/pii/S2212144720301940
26. https://www.who.int/classifications/icf/whodasii/en/
27. https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20626.