Injury & Disability Schemes Seminar
Insights and Outcomes
10-12 November 2019 • QT Canberra

"You'll be fine – you've only sprained your brain": Practical Steps Toward Normalization of Expectations and Improvement of Treatment for Emotional Harm

Prepared by Robert Aurbach and Les Kertay

Presented to the Actuaries Institute
Injury and Disability Schemes Seminar
10-12 November 2019

Institute of Actuaries of Australia
ABN 69 000 423 656
Level 2, 50 Carrington Street, Sydney NSW Australia 2000
t +61 (0) 2 9239 6100 **f** +61 (0) 2 9239 6170
e actuaries@actuaries.asn.au **w** www.actuaries.asn.au

"You'll be fine – you've only sprained your brain": Practical Steps Toward Normalization of Expectations and Improvement of Treatment for Emotional Harm

Robert Aurbach and Les Kertay

Abstract

We think and talk about mental health conditions differently than we do about physical conditions, with negative consequences for workers and the system. Because of those differences, both treaters and workers have developed expectations and practices concerning mental health conditions which contribute to poor outcomes. We can do better by changing language, insisting on diagnostic rigor, insisting on appropriate care and patient education, and regular monitoring of the care given. The role of the General Practitioner in the diagnosis of mental health concerns is discussed.

The changes to implement this approach are relatively simple, and can be accomplished either directly, through legislation and regulation, or indirectly, through the payer's power to withhold payment until satisfied that the claimant is getting appropriate and effective services.

Keywords: Robert Aurbach, Les Kertay, mental Health, language associated with mental health, expectations, differential diagnosis, effective treatment, treatment monitoring

You sprain your knee at work and your GP gives you a medical release for a few days at home to rest. You're not unduly concerned, and you either have or easily can get what you need to know about your condition, what to do about it, and what to expect in the normal course of healing. Your boss isn't particularly worried about your ability to come back to work, and no attorney approaches you with an offer to get you "maximum justice."

Or maybe you're involved in a minor, but upsetting, incident at work. The harm, if you can call it that, is the kind that most people encounter from time to time – perhaps you became privy to the opinion of some co-workers, and the opinion isn't complimentary. You can't stop thinking about it, and you take a few days off work. You've heard media advertisements about anxiety and depression, and when you're still distressed you get concerned about the nature of your reaction and go see your GP. At the appointment, your GP gives you a self-reporting test that shows that, sure enough, you've reported symptoms of low mood, trouble concentrating, preoccupation, and being unmotivated. Your GP diagnoses depression, prescribes a medication, and gives you a few more days off work. You don't know much about your diagnosis, but it sounds bad, and you start to worry even more. When you ask your GP about prognosis, he can't tell you much because he's not well trained in mental health conditions. You sit at home, isolated from your daily routine, your work friends and whatever sense of fulfillment that you get from work.

Instead of effective treatment, the GP prescribed time off from work, which creates separation from normal support and routine and allows you more time to ruminate and develop fears about your ability to go back to work. As more time passes, you and your employer become concerned about your future capacity to handle the pressures of the job. Lawyer advertising, taken together with emotional separation from the comfort of work routine leads you to engage an attorney and file a claim. Now you're in the disability or workers' compensation system.

The claim is immediately met with suspicion, evaluation by unsympathetic specialists and delay. In the subsequent conflict between your employer, the insurer, a mental health specialist (who opines that the transient reaction to a minor work incident has long since dissipated), you, your attorney, and your GP, become emotionally committed to the GPs diagnosis and for the benefits for which you may now qualify. Over time, secondary mental health symptoms develop and you feel unable to return to your former employment. The claim becomes prolonged and costly.

The harm in both of these cases – the knee sprain and the disturbing interaction with co-workers - is roughly equivalent to what many of us experienced on a school playground. The difference in the results is not based upon the nature of the harm or the length or difficulty of recovery. Instead, the way we speak about mental health conditions, diagnose them, and treat them is different than with physical injuries. The expectations we set, for the patient, the employer, the treaters and the insurer differ from physical injuries. In the majority of cases (excepting mental health conditions that are chronic, major, or severe) the result of these differences is an elevated probability that our systems will medicalize a simple condition (psychological distress), leading to inappropriate responses from all involved and predictably poor outcomes.

It doesn't have to be this way. A few changes that are within practical reach can make significant improvements in the majority of these cases that have become complex, difficult and very expensive. [1]

How we talk makes a difference

We have words that we use with regard to musculoskeletal injuries that carry significant positive – or at least not very negative - connotations. If you have a bruise, a sprain or a strain, the expectation is that the injury will heal relatively quickly, that the recovery will be complete and uneventful. No one expects lasting serious consequences of the injury. The same is true of inflammation and soreness. While disagreeable, the vast majority of cases will resolve with time, movement and, perhaps, a bit of Panadol. "Twisted" joints, "rolled" ankles, "corked" muscles and "jammed" fingers are other common examples.

For these terms there is an accompanying societal expectation of complete recovery within a reasonable length of time. The person experiencing the injury probably doesn't worry about long term consequences, and neither does the employer. Co-workers don't behave differently to the injured person, absent other circumstances. In fact, many people who are injured regard such a diagnosis as "good news" as compared to more serious alternatives. One has only to look at the media reporting of injuries after a weekend of sport competition to see numerous examples.

There are corresponding words to describe common mental health conditions experienced as a result of workplace incidents. Someone might be miserable or blue because of feeling that they are in a job that has no prospects for advancement, uncomfortable or out of sorts with a change in routine or internal processes, or irritated or tense around a co-worker who is perceived as trying to advance their career at the expense of others. But the general medical community doesn't use these words. They use terms like "depression", "anxiety", or "adjustment disorder" to describe these conditions. The psychiatric/psychological communities use even more ominous sounding language like "major depressive disorder," "adjustment disorder with mixed anxiety and depressed mood," or "generalized

[1] It must be noted that the comments that follow are not intended to apply to mental health conditions appropriately diagnosed as chronic, major or severe. Fortunately, these cases make up a small minority of those presenting for compensation arising from workplace injury. This discussion is also intended as being limited to a discussion of the current Australian experience. Other countries, it will be seen, deal with mental health conditions differently.

anxiety disorder." In either case, the impact on the patient, without ameliorating education, is troubling.

For these technical or quasi-technical terms, the accompanying societal expectations are not positive. Persons hearing such a diagnosis are unlikely to understand that there is difference between a transient situational reaction and a serious, recurring or chronic mental health condition. They often do not understand that "disorders" describe a range from mild and short-lived conditions to much more serious ailments. They have no clear expectations regarding prognosis and many will assume the worst. The person labeled with a mental health diagnosis may experience isolation as employers, co-workers and even family members regard them as being different from the way they were, and worry about possible unpredictable behaviour. No one takes such a diagnosis as "good news" because there is not a well–defined "worse" that the diagnosis could have been. The possible exception to the "good news" verdict is the attorneys who actively solicit claims of psychological injury because they are profitable.

Perhaps most insidious is the afflicted person's expectations concerning recovery. There has been a substantial effort by organizations such as Black Dog and Beyond Blue to destigmatize mental health conditions and make seeking treatment a more accepted behavior. The advertising around such well-intentioned public information campaigns makes little distinction between chronic, major or severe conditions and transient mild situational conditions that are part of everyday life. The result of this public attention tends to be medicalization (which will be discussed below) and very unclear expectations concerning recovery. In the absence of good information, many people will assume that they are experiencing a long-term condition. With those sorts of expectations, it is predictable that some people will experience durations far in excess of that which would be predicted from the mental health condition alone.

There are other factors that further exacerbate the reactions of some people to psychological harm. As noted above, legitimate organizations spend millions in advertising for the purpose of destigmatizing mental health conditions and making treatment of them more acceptable. While this is useful work, the import of some of the statistics and implications of such public service campaigns are unintended. The oft-quoted statistic that 1 in 4 Australians will experience depression each year fails to explain that depressive disorders range from transient and mild situational reactions to major, chronic and disabling. Importantly, there is a significant difference between the incidence of "feeling blue and down in the dumps," as compared to the incidence of Major Depressive Disorder. By failing to take this difference into account, in combination with the widespread use of self-reporting instruments, such as the DASS ("Depression Anxiety, Stress Scale"), people are left to form their own impression concerning their prognosis. Predictably, some people will assume that they fall on the more serious portion of the spectrum, based on their

perception of their own misery. Moreover, the more ominous the label, the more likely the individual is to feel their condition is worse than it really is.

Add to this effect the recent emphasis on emotional reaction from mainstream Australian media outlets, and the message that we "ought" to become unwell when subjected to any sort of shock is complete. Any broadcast news is rife with examples of interviewers or commentators pairing bad things happening and strong emotional reactions. "Terror", "horror", "devastated", overwhelmed" "shocked", "distraught", "shattered" and similar terms find their way into descriptions and questions, and the "How did you feel when ___?" question has become ubiquitous in interviews. The clear inference from the public media is that emotional harm is to be expected from events that are unwanted and out of the ordinary. Unfortunately, there is no distinction drawn between minor, transient emotional disruptions and the major, serious or chronic mental health conditions that can lead to disability.

The language of mental health professionals

Like most professionals, specialists in mental health are both facilitated by, and hamstrung by, the diagnostic language they are given. The clinical judgement he or she develops out of a personalized understanding of their patient must be translated into the diagnostic labeling required by insurers and other payors. In the workers compensation system, that labeling is constrained to the 5th edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5).

The DSM-5 was designed by committees of experts in their specific arenas of interest and research. Their efforts have been met with limited praise, and substantial criticism. The bulk of that criticism is directed at the expansion of many diagnostic categories to include more people. Post-Traumatic Stress Disorder (PTSD), for example, no longer requires that the presumed precipitating event be outside the range of usual experience, or even that it be directly experienced by the individual. It has been argued that the expanded definitions have led to including many individuals under a diagnostic label that presumes trauma, and resulting lasting impairment, in situations that would otherwise have been considered part of distressing, but normal, experiences that are part of everyday life. Similarly, the diagnosis of Major Depressive Disorder previously excluded grief, meaning that an individual grieving the loss of a loved one would not be labeled as pathological. In DSM-5, that exclusion was removed. On the plus side, that means that health payors are more likely to cover the cost of antidepressant medication that might be helpful to someone who is suffering from extreme grief reactions. However, on the negative side, those who are experience a normal part of life are labeled with a pathological condition)[i]. Perhaps most importantly, the application of those diagnostic labels to the workers compensation system is a poor fit in many cases, over-pathologizes

normal work-related experience, and confuses the average person who encounters psychiatric jargon that they don't understand.

The best use of diagnostic terminology is to allow professionals to communicate with one another. Inevitably, professional jargon – in this case diagnostic labels – becomes shorthand for complex ideas. In an ideal world, a mental health professional will understand that the diagnostic label "Major Depressive Disorder, recurrent mild, with agitated distress", means that the individual has met at least 10 diagnostic criteria, plus two specifiers, each of which in turn has additional criteria. The label also means to a professional that it is quite treatable with medication, psychotherapy, or a combination, and has an excellent prognosis. Unfortunately, the world is not an ideal place, and often even among mental health professionals, there is disagreement over the specific diagnosis [ii]. Among non-mental health providers, the reliability with which diagnostic criteria are made is even lower, and is often made on the basis of a score on a screening tool (e.g., the PHQ-9), and often are made without distinguishing severity, labeling the entire range simply as "depression." To the patient, the label for this eminently treatable condition sounds much more ominous than is necessary, and it contributes to a new anxiety: "I have a terrible psychiatric condition" vs. "I'm having an episode of low mood that is very likely to get better on its own, or with minimal treatment."

The combination of jargon with diagnostic imprecision also increases the likelihood of "fad diagnoses." Bipolar II Disorder, ADHD, and Autism Spectrum Disorder have, all legitimate diagnoses when criteria are applied with rigor, have become the mental health equivalent of repetitive motion injuries, diagnosed all too often in the place of common ill feelings that are likely to resolve and unlikely to cause significant impairment. In the workers compensation system, PTSD in particular is all too often applied to general distress over an upsetting event, because the diagnostic criteria are loosely applied. The problem, of course, is that PTSD sounds much worse that "distress over an upsetting event," and much more likely to be perceived as a source of functional impairment. Unfortunately, the professional jargon does not lend itself to perceptions of minor upsets that require little or no treatment and are expected to resolve, in the same way that a "rolled ankle" is less threatening than a "grade I sprain."

Is there a better way?

If the technical language of the DSM-5 lends itself to pathologizing and anxiety, especially as applied to symptoms experienced in relation to workplace events, is there a good alternative? One option is to substitute the language of the International Classification of Diseases (ICD), currently in its 10th or 11th edition, depending on where you are in the world. There is some suggestion of benefit, especially when using the ICD-11. When applied to individuals who have

experienced a potentially traumatic event that meets the definition of a "criterion A event," there is reasonable concordance between the DSM-5 and the ICD-11, both of which yield fewer diagnoses than ICD-10 criteria.[iii] However, when applied to relatives or others not directly affected, DSM-5 yields higher prevalence than does ICD-11[iv]

Importantly, the way in which the ICD-11 narrows the definition is by removing criteria that are most likely to overlap with other, less severe and less-ominous-sounding conditions. There are, of course, arguments on both sides of the issue. On one side of the argument are those who argue that broader criteria allows for easier access to treatment for individuals who might be impacted by distressing events. On the other side of the issue is the subject of this paper: when diagnostic labels are applied too liberally, we risk pathologizing normal behavior. Within workers compensation systems, where compensation often hinges on how severe a diagnosis sounds, we believe there is very good reason to argue for higher thresholds.

Things get worse when criteria are applied imprecisely. Primary care providers, as mentioned earlier, typically apply the loose terms "depression" or "anxiety" in place of technical more complex, but more precise, definitions. The concern here is the "depression" and "anxiety" are symptoms, not conditions. Everyone feels blue from time to time, and we often describe those blue feelings as "depression." The problem is that primary care providers are much more likely to medicalize and treat "depression" than they would do so for "feeling blue." The same can be said for "anxiety" and "feeling a bit apprehensive" or "feeling tense".

General discomfort with emotional distress on the part of both individuals and their doctors; media attention to the "horrors" of mental illness; and the language we use, results in a tendency to pathologize everyday experiences, creating a perfect storm of medicalization. Because we lack the mental health equivalent of "a rolled ankle," we end up treating psychiatric illness where it isn't, and mix up minor psychological distress with serious mental illness. Further, in workers compensation, we often end up paying for, and keeping employees out of work for, normal human experience. This can, because of the effects of isolation, catastrophizing and the changed perceptions of others, lead to true mental illness. Moreover, this same situation sometimes keeps us from recognizing more significant or complex problems leading to inappropriate under-treatment.

If you think you can, or can't, you're right

Henry Ford is quoted as observing that "If you think you can, or think you can't, you're right". The empirical basis for the observation is well-established. There is a

substantial literature describing the impact of expectations on the outcomes of injury and illness.[v] [vi] Expectations for recovery have been associated with return to work rates and cost of claims.[vii] There is even evidence that the way that we talk about injury can have statistically significant impact on the clinical outcomes of treatment. [viii]

It seems clear that we are setting poor expectations about mental health and reactions to emotionally distressing events in contemporary Australian society, with several adverse consequences, including increased probability of poor worker outcomes[ix]. As we ruminate about a mental health condition we focus on the symptoms and begin to believe that the condition is disabling. With continued focus on symptoms, we develop a binary view of recovery; either the symptoms are completely alleviated or still ongoing, and we associate ongoing symptoms with disability. The result is excessive recovery duration, which in turn increases the probability that the person experiencing the condition will learn the "sick" role[x]. In short, the more we focus on symptoms, the more likely it is that we become habituated in the role of a disabled person.

With excessive recovery duration also comes social isolation, which is itself an adverse emotional event. To the extent that the condition is viewed as threatening, a "fight or flight" reaction may create social behavior that increases the social isolation and results in differential treatment from claims administration personnel.[xi] Prolonged exposure to the hormonal changes from this reaction can have serious adverse health effects.[xii] Finally, this cycle acts as its own anxiety disorder; the longer we are out of work, the more anxious we become about our ability to return to work. Because we tend to avoid things that make us anxious, we tend to stay out longer. The cycle becomes self-perpetuating.

Getting either the medical or media communities to change the way they are discussing mental health presents significant challenges. The media have responded to the tone of their broadcast journalism in the past. As recently as 2015, the language in broadcast journalism was far more focused upon words like "victim" and "victimization" than the current focus on mental health conditions. Similarly, in response to perceptions that the media was focused upon the negative, there has been an open refocusing on more positive content in at least one major outlet. Still, it is unclear whether the message that change is needed can effectively be communicated from outside the journalism community.

It also seems unlikely that we will get the medical and psychological/psychiatric community to reconsider their language. There are too many entrenched opinions, some driven by good intentions for patient care, others driven by research interests, and still others driven by financial incentives. In addition, mental health diagnoses are poorly understood outside mental health practitioners and are even less understood by those without at least general medical knowledge. Insurer

expectations that specialist practitioners utilize DSM-5 classifications also contribute to an environment where change is difficult.

There are some potential solutions. One potentially helpful move would be to make a change from using DSM-5 in the workers compensation system and put the ICD-11 in its place. For some of the most problematic diagnoses in the system, the tighter definitions are less likely to lend themselves to over-diagnosis within the context of a compensation system. This approach would require legislation, and a case for making the change will be challenging.

A second possible change is educating claims professionals and treating providers within the workers compensation system about the importance of using the least pathologizing language that still appropriately characterizes the worker's situation. Simply training those on the front lines of the system to say "I imagine that might have been upsetting" in place of "how traumatic!" will go a long way to creating a different set of expectations for the worker, and for providers. Such client-friendly language may seem unusual and awkward at first, but as those within the system become more educated about mental health, and the difference between serious mental illness and normal human upset, it is possible to create a shift in outcomes.

Righting the course: Steps to better outcomes

In addition to changing the way that we talk about mental health problems, there are other practical solutions that, if adopted, can contribute to better outcomes in mental health conditions within the workers compensation system. Broadly, these involve ensuring accurate diagnosis; better educating patients and reassuring them that outcomes are likely to be positive; insisting on appropriate treatment; and periodically evaluating both diagnosis and treatment, adjusting course as needed. These steps are outlined in the following sections.

Differential diagnosis of mental health conditions

It is no secret that mental health diagnosis is problematic in Australia. The problem partially stems from a lack of understanding of the appropriate process of diagnosis.

The term "symptom" is used to denote the things that the patient perceives and describes. Put it another way, it is what the patient complains about. Symptoms are important as clues that the practitioner should use to find a correct diagnosis, but they are never enough for proper diagnosis in themselves. Anyone who watched the medical drama "House" will appreciate that the symptoms can be fluid and

changeable depending on a wide variety of other factors. Most people have experienced the same thing with respect to their own mental health symptoms from time to time. It is common for the observations of a friend or partner to be useful to us in recognizing that we are in a low mood, are tense or are unusually reactive. We don't always pay attention to how we feel, and we sometimes engage in incorrect assumptions about the causes of our feelings.

The difficulty is that the standard practice in Australia is to use a tool for the inventory of the patient's symptoms and use the symptom label as the diagnosis. Typically, a person complaining of anxiety or depression will be presented with a self-reporting tool designed to rate symptom severity and properly used to track patient perceptions of the change in symptoms over time. From those tools a "diagnosis" is rendered, despite the fact that they were never intended to be used in that manner. The DASS is the most frequently seen instrument in Australia and is utterly transparent in its intent. When questioned, workers' compensation conference attendees regard the test as one which a reasonably intelligent year five student could manipulate to make themselves look either well or unwell at will.

"Clinical signs" are the objective observations of a professional trained specifically to consider the various circumstances under which symptoms may be experienced. Most often in physical medicine these are specific physical examination protocols or specific tests for indicators of the condition. "House" aficionados will recall the batteries of tests that were used to either confirm or eliminate possible diagnoses that were suggested by the symptoms. In mental health there are objective and validated tests that can be used to narrow down the field of possible diagnoses. The Psychological Assessments Australia website currently lists 74 separate tests that may be used for this purpose.[xiii] There is also a very important role for the trained observer. Here though, the training is specialized. We know from common experience that some people "read" personal characteristics better than others. When looking at mental health conditions, that "special" ability is further honed by knowledge about what specific behaviours are commonly associated with specific mental health conditions.

The comparison of clinical signs and reported symptoms is necessary to understand what is truly happening. Their use in narrowing in upon a "differential diagnosis" is the accepted process in physical medicine as well as TV drama. No one would accept a diagnosis of a serious heart condition based upon reported chest pain without tests that might confirm the diagnosis or lead to the discovery of a problem that was hidden or a complicating factor. In mental health, the comparison of signs and symptoms to arrive at a differential diagnosis is no less important. Often hidden problems or complicating factors are present that, if untreated, will result in little progress or even a worsened condition. Symptom magnification may also be disclosed by the process.

A "mental health condition" is a construct, based upon the definitions agreed upon by professionals in the field. It distinguishes between a transient or situational response to the environment, and a continuing mental health problem. It is correct for major mental health advocacy groups to suggest that depression and anxiety are experienced by one in four Australians each year. They are referring to the experience of symptoms, but probably not to mental health conditions. Mental health conditions are defined not only by the symptoms experienced, but also by the effect of the symptoms on the ability to perform the necessary functions of everyday living and by their duration or the frequency of their expression. Only when symptoms, duration and effect are present can a mental health condition be said to occur.

Even when a diagnosis is confirmed, mental health conditions describe a range of severity, from conditions that have minimal impact upon life functions or occur infrequently to profoundly disabling conditions. Saying that someone has "depression" or "anxiety" is not a diagnosis and does not describe the impact, duration or effective treatment of their experience. Proper clinical definitions of mental health conditions provide information that is critical in understanding the nature of the problem and the available treatments. Moreover, since researchers utilize the same classification scheme, research of the effectiveness of treatments can only be correctly applied by understanding a proper differential diagnosis of the nature and severity of the mental health condition.

Rigorous diagnosis requires the comparison of clinical signs to the patient's reported symptoms, but there are problems in achieving this goal. Foremost is training of General Practitioners (henceforth "GPs") in the diagnosis process with regard to psychological health. A "level one" Australian GP is only required to have 6 - 7 hours of formal training in mental health and a Level 2 certification can be obtained with as little as 18 hours in total of training.[xiv] This level of training is insufficient to give sufficient background in recognition of clinical signs and the Royal Australian College of General Practitioners Mental Health Training Standards do not specifically address the recognition of clinical signs relating to mental health conditions or specifically address the process of comparing the signs to reported symptoms.

GPs are generally not trained in the administration or interpretation of paper and pencil tests that can be very useful in providing a range of objective clinical signs to compare to symptoms. Personality inventories such as the Minnesota Multiphasic Personality Inventory ("MMPI") are well validated instruments that will disclose the presence of additional diagnostic risk factors not reported by the patient. They can help distinguish between situation specific transient reactions and more global mental health conditions, and can disclose factors that may impact on the treatment protocol. Several instruments, including the MMPI have validated scales for symptom exaggeration and other indications that the reported symptoms may not be entirely reliable.

It's not just that GPs are untrained in the observation and cataloguing of specific clinical signs that distinguish mental health conditions that can present with similar outward symptoms. The essence of the observation of clinical signs is that the observations must be objective. It is sometimes said that GPs "know their patients better" than a specialist that has been called in. That is often true, and the observation is the best argument for limiting GP participation in the diagnostic process. What the GP has more intimate knowledge of is the longitudinal history of what their patient tells them. With the "knowledge" of the patient comes the probability that the GP will be influenced by a laundry list of factors. The desire to keep a good clinical relationship and with it the continuing business of the patient and their family may influence the GP to over-weigh the reported symptoms. GPs sometimes suggest that if they do not treat the complaint the patient will simply seek a different doctor who will. Opinions arising from prior complaints or treatment may cause a perceptual bias that influences the interpretation of objective observations. Even knowledge of the patient over time (and with it the ability to observe a change from the "usual" presentation of the patient) presents the possibility that the current symptoms will be over-weighted, leading to the inability to distinguish a transient situational reaction for a more serious continuing condition. The proper place for such observations may be in clinical referral notes, where they can lay a meaningful baseline for a differential diagnosis to utilize.

Political and social realities may make it difficult or impossible to legislate the requirement that a specialist be required to render a mental health diagnosis. An article in the Sydney Morning Herald dated 19 September, 2019[xv] reported that the Royal College of General Practitioners had laid before Parliament a paper ("Health of the Nation 2019") [xvi]that noted, among other things that data from the last three years indicated that GPs were seeing patients for "anxiety and depression" more frequently than any other ailment category, and that GPs were only allowed to charge Medicare for a 20 minute consultation for treatment of these cases. The first observation should be obvious – the general population has responded to the heightened attention to mental health concerns with the assumption that it is a problem that ought to be brought to a GP. [xvii]

The second observation is that GPs feel economic pressure to deal with patients who present with mental health concerns by attempting to diagnose and treat within very limited time allotments. 20 minutes allocated does not allow for the clinical observations necessary for a proper differential diagnosis and treatment. The article quotes a physician complaining that 20 minutes is already insufficient to counsel a patient presenting with serious concerns. The time period is adequate for assessment of the existence of a mental health concern of sufficient seriousness to justify referral to a specially trained practitioner. But as noted above, many GPs do not have that sort of specialized training.

Several solutions present themselves.

- If GPs are going to be used in the role of primary mental health point of contact in workers' compensation, then the current minimal level of education seems ill-advised. It may be possible, in light of the Health of the Nation report, to convince the College to increase its minimal psychological health education requirements for both new and existing GPs who wish to diagnose and treat mental health concerns. This may indirectly increase the probability of a referral to a specialist.

- Legislative action to prevent GPs from rendering a primary diagnosis in mental health cases for workers' compensation may be too large a change to achieve, but a requirement that GPs undertaking a mental health diagnostic role have undertaken advanced training in mental health awareness, differential diagnosis and evidence-based treatment may be politically possible.

- Legislation of the requirement that objective clinical signs be explicitly considered in any diagnosis of a mental health condition in an injury compensation scheme can be justified as advancing the quality of care provided for such conditions. Such a requirement would reduce the chance that the wrong condition was being treated or that complicated situations were undertreated. The requirement would have the beneficial effect of taking the GP "off the hook" in making a clinical call with which he or she may be uncomfortable. Since GPs can reasonably be predicted to chafe at the additional documentation requirements, this may have a beneficial "channeling" effect of encouraging them to refer to a specialist.

- It may be possible to adjust allowable compensation to provide for higher compensation rates and allowable time allotments for GPs with advanced qualifications in psychological health to engage in mental health treatment, including additional time for diagnosis. Although worker' compensation is not as limited as Medicare in this regard, increased recognition of expertise and time spent may encourage the development of practices and training commensurate with the task. Medicare would also be well advised to consider this option.

- The best legislative/regulatory solution may be to encourage a multidisciplinary approach, with special compensation for cooperation and coordination between the GP and a referral specialist, to see to it that the entire spectrum of needs of the patient is addressed.

There are less politically difficult steps that can be taken to achieve better diagnostic results, albeit with less efficiency. First, it is useful to remember that GPs, like other people, prefer to be paid as soon as possible, with as little additional logistical burden as possible. The payer's "power of the purse strings" creates an option for quick and easy payment in response to a proper differential diagnosis, while a "please explain" letter is offered in response to less robust diagnosis. Workers' compensation systems elsewhere have successfully used such techniques to "channel" medical provider behavior.[xviii] Requests that the GP provide detailed notes of the clinical signs observed and the testing administered during the approval process will put pressure on the GP consider objective evidence and do more than accept what the patient told him or her. The requirement for additional paperwork may also encourage the GP to obtain further training or to refer when it is practical to do so.

Sometimes the offer of a specialist to confirm the GP's diagnosis may be useful, and the opportunity to utilize an independent medical examination (IME) often exists. Many Australian schemes utilize IMEs in this manner, but the questions asked of the examining specialist often call for conclusions and are not directed to require the comparison of signs and symptoms in a meaningful way. It is important to specifically request a differential diagnosis that compares reported symptoms with clinical signs (preferably including objective testing) to obtain an opinion that is likely to be given enough weight by the treating health care provider and, if necessary, the courts.

Appropriate education of patients

Mental health concerns are often associated by the public with grave social problems such as violence, destruction of relationships and careers, homelessness and vulnerability. At the same time, information concerning the normal duration, prognosis, preferred treatment modality and probability of recovery without those dire results is much less known. The combination of these factors leads, all too often, to catastrophizing and fear as a response to a diagnosis. A mental health diagnosis is often assumed by patients to describe a lifetime condition, and the duration of claims for mental health conditions reflects this expectation. Catastrophizing about a "life sentence" diagnosis is strongly associated with poor outcomes [xix].. Unlike a sprain or a strain, minor mental health concerns are often regarded by patients as isolating, disabling and permanent. This contributes to both a sense of loss of internal locus of control and the creation of a "disabled persona", which both have negative impact upon recovery[xx]. Steps to limit that outcome are desirable in preventing unnecessary complication of recovery. The information presented on a slide presented at the 2015 Actuaries Institute Scheme Design conference, giving average durations of various common mental health conditions [xxi]is likely to come as a positive surprise to patients and, often, the practitioners that are attempting to treat them. There is no reason to allow the perpetuation of this harmful ignorance.

There are a number of excellent sources of evidence-based information concerning the treatment and prognosis of mental health conditions. Sources such as "Evidence Based Psychological Interventions in the Treatment of Mental Disorders" (4th Edition, 2018) produced by the Australian Psychological Association, and the ODG evidence based disability guidelines, allow efficient sourcing of information concerning that can prevent catastrophizing and allow informed participation by the patient in the process of determining the treatment approach. Such informed participation has been shown to increase the probability of a positive outcome where it has been studied.[xxii] A brief description of the prognosis and the treatment modality shown by evidence to be most effective with respect to the diagnosis could be mandated by legislation or practice protocols. It would motivate treatment compliance, allow the patient hope and empower them to question if the most effective treatment modality is not being used or if progress is not being made as would normally would be anticipated.[xxiii]

It may be questioned whether giving this sort of information is more harmful than helpful. The impact of "Dr Google" in medical practice dynamics is in two parts. Self-diagnosis via the internet is destructive for the reasons outlined above concerning differential diagnosis and catastrophizing. But post diagnosis information concerning the condition, prognosis and treatment allow the rational participation of the patient in understanding the treatment program, choosing between treatment options, and complying with treatment requirements is not associated with similar risks. A number of workers' compensation jurisdictions already mandate provision of various kinds of information to claimants. Similar requirements are likely to be beneficial with regard to mental health conditions, and may be delivered through the treating professional or the statutory workers' compensation authority.

Compliance can be obtained through legislation or regulation or through a public information campaign that carefully distinguishes between transient situational reactions and ongoing mental health conditions. Alternatively, payment for treatment can be conditioned upon demonstrated compliance with the requirement that the patient be presented with clear, accurate and appropriate information.

Insist on appropriate and effective treatment

We have addressed the need to *not* treat when there is no mental health condition, and instead a normal manifestation of human distress as it occurs from time to time. Another part of the solution, when a work-relevant mental health condition is present and appropriately diagnosed, is to insist on appropriate and effective treatment.

Requiring a treatment plan is common practice with regard to psychological services, but the strategy has been deployed ineffectively. One common problem is that the treatment plan is not reviewed until extended duration triggers an escalation to a higher level of review, or involvement of a medical professional. In addition, often we don't insist that the provider demonstrate progress toward a goal – ideally improved function even more than symptom relief – before granting extensions to treatment. Even when we consider evaluating the treatment plan, and progress within it, it isn't until the end of the expected duration. Instead, the following steps can make a difference.

Treatment plans should reference an evidence base for efficacy. The American College of Occupational and Environmental Medicine (ACOEM) has published guidelines for evidence-based treatment of mental health in the occupational context[xxiv] , and is currently in the process of revising those guidelines. Importantly, most of the mental health conditions that present in the context of the workplace have well-established treatments based on efficacy research, and many of them have multiple treatments that are known to work. The Australian Psychological Association has similar evidence -based guidelines, referenced above. While it is perhaps unrealistic to expect claims adjudicators to have the skills to evaluate mental health treatment plans, ensuring that treatment plans are reviewed by a qualified mental health professional[xxv] *before* treatment begins is a critical step. If a particular condition does not have a good evidence-based approach, or if something outside the recommended treatment is proposed, the treating provider should be held accountable to offer a clear, and medically reasonable, explanation for the deviation. Experience shows that insisting on evidence and delaying payment and approval if necessary, will help shape provider behavior over time. This is not about delaying treatment for the sake of delay; it is about insisting on the rights of workers to be treated with the most efficient and effective treatments, and the treatments that are most likely to facilitate a return to function. Legislative acknowledgement of that right would help reviewing tribunals to understand the importance of requiring compliance from treaters.

Along these same lines, if a treatment extension is requested, the extension should be reviewed with two key issues in mind. First, it is important to ensure that the treatment actually provided is the treatment outlined in the plan. For example, if the treatment plan is based on work-related cognitive behavioral therapy (w-CBT), then the notes should reflect, and the worker should be able to describe, what emotions and patterns of thinking were discussed in sessions, and how they were connected with work. In addition, both sources should describe "homework" in the form of specific exercises intended to alter deleterious or maladjusted behavior patterns. Holding the provider accountable for providing the evidence-based treatment he or she proposed need not interfere with the therapeutic relationship; in fact, it is a way to ensure that the worker is getting the care that they need in the confines of that relationship.

It also may occur that the provider states that new issues have arisen in the course of treatment. This should automatically trigger two things: a full diagnostic assessment, and an analysis of whether the "new issue" is actually causally connected to work. Good mental health treatment will sometimes lead to insights and emotions that may be appropriate to treat but are unrelated to the workplace event that is compensable under workers compensation. Treating these ancillary issues may (or may not) be good for the client, but regardless should not be an automatic reason to extend treatment indefinitely. Here, too, involving a mental health professional, either within the system or independent from it, can help obtain the best results for the injured worker.

To be sure, this kind of oversight is an expense. However, done appropriately and well, and incorporated into standard claims process and regulatory oversight, the expense of doing things right is substantially less than the financial and human costs of ineffective, inappropriate, and endless care.

It is also worth mentioning that the worker's participation can be used to help get better results. There is rarely a reason to keep diagnoses and treatment goals from the patient. In fact, best clinical practice ensures that the patient is involved in setting, evaluating, and meeting treatment goals. Shared medical decision-making in general, and in mental health treatment in particular, has been shown to be an important part of obtaining compliance with treatment[xxvi]. While the evidence for impact on outcomes is non-conclusive, such studies as have been conducted show better outcomes[xxvii].

Finally, it should be noted that simply labeling a treatment plan with an evidence-based term does not mean that the actual treatment is appropriate or best practice. It is always appropriate to enquire about, and require documentation of, the actual treatment being provided. For example, because "everyone knows" that CBT has a strong evidence base, many providers will label their treatment "CBT" but neither challenge maladaptive thinking nor assign homework, both of which are hallmarks of good CBT. It may also be true that CBT isn't the best treatment for a particular condition. In PTSD, for example, CBT is a known effective treatment, but it is not as effective as prolonged exposure therapy, depending to some extent on patient characteristics. In the end, none of these treatments by themselves are as effective in a workers' compensation setting, as they are when combined with a focus on return-to-work, often with ancillary supportive services designed to facilitate accommodations and graduated return[xxviii].

The need for periodic reassessment

Diagnoses sometimes change over the course of treatment. This happens naturally, as when an underlying depressive disorder emerges in the course of treatment for an adjustment disorder in response to a known stressor. In such a circumstance, one of the things that needs to be addressed is whether the underlying depressive disorder is causally related to the workplace, or is something separate that needs to be addressed in order to overcome a barrier to return to work, or is an unrelated pre-morbid condition. It's also true that the answer to whether the new condition is work-related may be one thing clinically, and another thing from an administrative and legal point of view. In any event, the new diagnosis is an automatic reason to consider the diagnostic formulation, and the treatment plan.

Another way that diagnoses may vary over time is iatrogenic in the DSM system. For example, a distressing event in the workplace may appropriately lead to a diagnosis of adjustment disorder, assuming that actual diagnostic criteria are met. However, with the change in definition found in DSM-5, the initial adjustment disorder may have resolved, but now there is a new adjustment disorder diagnosis, related to being out of work. Theoretically, since being out of work is ongoing, this new adjustment disorder can go on indefinitely, at least until 6 months after the individual returns to work. By contrast, the ICD-11 sets an expectation that an adjustment disorder lasts 6 months or less, regardless of the status of the stressor.

Finally, a new diagnosis may emerge, or morph, when the individual improves with treatment but becomes increasingly anxious about returning to work, as the date approaches. Mental health providers will, not uncommonly, propose delaying return to work until the anxiety subsides. The problem is that avoiding the thing that makes us anxious only reinforces the anxiety. One does not overcome an anxiety disorder without at some point (as early as is reasonable) facing the thing that makes us anxious. That is as true of the fear of returning to work as it is with fear of heights, or spiders, or getting back on the bicycle we fell from. This is not a new anxiety disorder, and should not be treated as such; instead, it should be addressed as a normal human response to change, and the need to try something new. What is needed is support for return-to-work, not avoidance.

All of the above are examples of the normal course of treatment, in which diagnostic formulations and treatments change over time. With respect to the workers compensation system, these expected clinical changes create problems in several ways.

One difficulty unique to insurance claims is the status given to the initial assessment. This arises from claims assessment practices held over from property and casualty lines from which workers' compensation insurance historically arose. The difficulty is that mental health is a fluid, constantly changing dynamic for virtually everyone. Fire damage to a home can be assessed and plans made for restoration and repair. A

broken tibia can be set, and within a range of variation, has an expectation with regard to the cost of treatment (hence the prevalence of "global fees" for routine procedures). In contrast the nature and existence of mental health concerns should change with treatment and a static diagnosis is often a sign that the current treatment protocol is ineffective. When the diagnosis goes unexamined for long periods of time, the connection between the interventions provided and recovery may be compromised at the therapeutic and claims administration levels. The result in either case is that the probability that the patient is getting the most efficacious intervention is compromised, and the claim may just keep on going until artificial system limits cut off compensation.

Reassessment of claims is usually done at fixed intervals, often at least partially related to stepdown provisions in the compensation act. This "one size fits all" approach is probably less than optimal for all claimants and is certainly questionable with respect to mental health conditions. Treating mental health inappropriately (especially when the "treatment" is separation from the workplace where a precipitating event occurred) can create secondary complications, such as fears surrounding return to work, that can greatly extend the duration of the claim. Re-assessment should occur when the evidence base predicts that recovery should be near, allowing for transitional planning that will smooth the process. Guidelines for recovery describe populations, and not individuals and the durations offered should be taken in that light. Nonetheless, the current practice of reliance on a fixed period of time before review will result in incorrect timing in most cases. Commercially available expert software that can interface with the claims administration platform can provide more individualized scheduling assistance, generate appropriate correspondence to a re-assessing specialist and assist with post-assessment decision making without relying on claims staff to make independent informed judgments on when a review is appropriate.

Preventing harm

The usual prescription for reducing the incidence of mental health claims involves measures that are designed to reduce the perceived workplace stress felt by the employee. These initiatives have several difficulties associated with them that limit their effectiveness. Workload control is often featured as a strategy, but it has obvious consequences regarding productivity that may make it unattractive to employers. Much of the source of workplace mental health concerns is interpersonal interactions. Not only are they difficult to control, but the very process of ascertaining the nature of the problem is time consuming and creates further stress on the participants. Encouraging peer to peer support can be difficult in competitive environments or certain cultural contexts.

It is sometimes assumed that employees universally desire more pay, more time off and less work load, but provision of those things seldom results in less perceived workplace stress. When asked about work conditions employees will often highlight situations where they have little or no authority to match their responsibility as a major stressor. Similarly, the inability to positively impact the work process and reduce unnecessary processes is often cited as a source of stress and resentment, as is failure to recognize individual accomplishments. This suggests that the reduction of workplace stressors can be approached in a manner that does not have significant negative impact on productivity or create upwards pressure on personnel costs.

Management of workplace stress is a balance between the imperatives of the business and the psychological impacts of the work and workplace culture on the employees. The loss of a sense of personal control is associated with the activation of the sympathetic nervous system and the "fight or flight" response. Being in the "fight or flight" state has serious mental health impacts[xxix]. While showing up at work necessarily implies some level of relinquishment of control on the part of the employee, the degree of loss is often something the employer can impact.

Separation of responsibility for results from the authority necessary to accomplish results creates the kind of loss of control that creates workplace stress. Segmentation of the work, so that processes begun by one employee are transferred to another to continue the process rob the employee of the satisfaction of seeing the job through and create fear of the impact of others in the chain of responsibility on the final outcome. Failure to allow employee input in the design of the processes they implement or otherwise invest in the work process can cause disengagement and stress as well as loss of the opportunity to improve the process. If management does not trust the employees to handle the responsibility implied by an expanded and decentralized role, then that distrust is likely to be perceived and also becomes a stressor.

There are numerous examples of the principle of empowerment of employees having excellent results for both the business and the employee. Discussions involving workers in making their working environment safer while keeping up production are a common feature of safety plans. A highly successful international hotel chain empowers every one of its employees to spend a significant sum to fix guest problems with excellent effect [xxx]Conversely, the insurance and finance sector, which has traditionally been characterized as highly centrally controlled, with high degrees of segmentation of the work and few opportunities for line input on the management of the work has been rated in a recent PwC report as having the highest incidence of mental health concerns in Australia.

Going forward

It has been difficult to measure the true cost of mental health concerns in the workplace, especially if that costing includes the secondary psychological overlay to claims of physical or mental health injury.[xxxi] It is certain that those costs are significant and they may be our largest cost driver. These factors also play a role in the increases in severity of claims that have been observed in this decade.

Steps necessary to change the way that we discuss, diagnose, treat and prevent workplace mental health concerns will not be easy and will require investments of time and money. The costs and human impacts of the present systems of insufficiently controlled claiming and questionable treatment and exclusion of claims must be weighed. But it seems reasonable to assume that mental health concerns, including secondary psychological overlay to the original claim are in play in a significant majority of the claims that fail to resolve and linger in the system for extended periods. They are a factor in a large portion of the 10-15 % of claims that account for 80-90% of claims costs. Spending a little to impact these huge costs is simply good business. Moreover, it has been estimated that the return on investment in effective workplace mental health strategies is $2.30 for every dollar spent.[xxxii]

More importantly, these long-term claims are almost all instances of ruined lives and unnecessary suffering. The steps described will both improve the quality of care and reduce costly unnecessary disability and time away from productive work. Rarely do we get the opportunity to do something that is good both for the bottom line and for the needs of the humans who come to our systems for help.

Endnotes

[i] Francis, A, 2013, Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life, Harper Collins Books

[ii] For instance, the kappa statistic for interrater reliability of Major Depressive Disorders in the DSM-5 field trials was 0.36, which is questionable. See, Regier DA, Narrow WE, Clarke DE, et al., DSM-5 field trials in the United States and Canada, Pert II: Test-retest reliability of selected categorical diagnoses. Am J Psychiatry 2013; 170(1):59-70)

[iii] Kuester A, Kohler K, Ehring T, et al. Comparison of DSM-5 and proposed ICD-11 criteria for PTSD with DSM-IV and ICD-10: Changes in PTSD prevalence in military personnel. Eur J Psychotraumatol. 2017; 8(1): 1386988).

[iv] Hafsted GS, Thorensen S, Wentzel-Larsen T, et al. PTSD or not PTSD? Comparing the proposed ICD-11 and the DSM-5 PTSD criteria among young survivors of the 2011 Norway attacks and their parents. Psychological Med 2017; 47(7):1283-1291).

[v] Cole, D., et al, 2002, prog
Listening to injured workers: how recovery expectations predict outcomes — a prospective study, Canadian Medical Association Journal 166(6)

[vi] Carroll,L, et al, 2009, Recovery in Whiplash-Associated Disorders: DoYou Get WhatYou Expect?, The Journal of Rheumatology 2009; 36:4; doi:10.3899/jrheum.080680

[vii] Victor M, Lau B, Ruud T. Predictors of return to work among patients in treatment for common mental health disorders: a pre-post study. BMC Public Health 2017; 17:736

[viii] Kholsa, A, Turner, JA, Jarvik JG, Gray LA, Kallmes DF Impact of Pain question modifiers on spine augmentation outcome, Radiology 2010 Nov., 257(2): 477-82 Epub 2010 Aug 31

[ix] Iles, RA, et al, 2008, Psychosocial predictors of failure to return to work in non-chronic non-specific low back pain: a systematic review, Occup Environ Med 2008;65:507–517. doi:10.1136/oem.2007.036046

[x] See Brigham, C. and Bennett, H., 2015, "Living Abled and Healthy: Your Guide to Injury and Illness Recovery", Healthy Living Press and Aurbach, R. 2015, "Better Recovery Through Neuroscience", *Proceedings of the 2015 Injury Schemes Seminar, Australian Actuaries Institute,* October 2015. Also available at www.uncommonapproach.com/publications.php.

[xi] Aurbach, R., 2017, "Fighting Fight or Flight", *Proceedings of the Actuaries Institute Injury & Disability Schemes Seminar,* 12-14 November 2017. Also available at www.uncommonapproach.com/publications.php

[xii] "Fighting Fight or Flight", ibid.

[xiii] (https://paa.com.au/category/catalogue-2/adult-mental-health-assessments/?pg=2)

[xiv] Mental health raining Standards 2017-2019. https://www.racgp.org.au/education/education-providers/curriculum/contextual-units/presentations/ps16-psychological-health. See particularly Table 1. Thanks to and Ronald McCoy of the RACGP for assistance in finding this information.

[xv] https://www.smh.com.au/national/depression-anxiety-more-common-than-coughs-colds-in-gp-waiting-rooms-20190918-p52sk0.html

[xvi] https://www.racgp.org.au/FSDEDEV/media/documents/Special%20events/Health-of-the-Nation-2019-Report.pdf

[xvii] Whether that heighted awareness is because of medicalization of everyday emotional ups and downs or because of increased treatment of clinical conditions is a question for which there is insufficient evidence to meaningfully debate.

[xviii] See, for example, the State of Colorado, where the use of medical practice guidelines, enforcement through payment mechanisms, and physician education has reduced disputes about medical treatment in workers' compensation cases to a negligible level, according to Dr. Kathryn Meuller, former Chief Physician for the Colorado Department of Labor and Employment, Workers' Compensation Division.

[xix] Kovacs, F. M., Seco, J., Royuela, A., Corcoll-Reixach, J., & PenaArrebola, A. (2012). The prognostic value of catastrophizing for predicting the clinical evolution of low back pain patients: a study in routine clinical practice within the Spanish National Health Service. Spine Journal, 12(7), 545–555.

[xx] Aurbach, R., 2015, Better Recovery through Neuroscience, ibid.

[xxi] Presentation by Debra Brodowski,Centre for Corporate Health, "The Me in Scheme" slide 5, https://actuaries.asn.au/Library/Events/ACS/2015/P3DebraBrodowski.pdf. The presentation cited the following evidence-based predicted durations for common mental health disorders, given appropriate treatment: Adjustment disorders: 8-12

weeks; Major depression (mild to moderate) 8-12 weeks; Major depression (severe) 6-9 months; anxiety disorders 16 weeks (maximum); PTSD (single incident) 8-12 weeks.

[xxii] Suh, W, and Lee, C., 2010, Impact of shared-decision making on patient satisfaction, Journal of Preventive Medicine and Public Health 43(1), pp 26-34., Hoffmann, T, et.al., 2014, Shared decision making: what do clinicians need to know and why should they bother? Med J Aust; 201 (1): 35-39. || doi: 10.5694/mja14.00002 Published online: 7 July 2014

[xxiii] Verbeek, J, et al, 2004, Patient Expectations of Treatment for Back Pain A Systematic Review of Qualitative and Quantitative Studies, SPINE Volume 29, Number 20, pp 2309–2318

[xxiv] American College of Occupational and Environmental Medicine (ACOEM). ACOEM Practice Guidelines: Workplace Mental Health. Denver, CO: MD Guidelines, 2019.

[xxv] "Expert" computer programs that are capable of doing such reviews in routine cases are also becoming available.

[xxvi] Novella, S., 2013, "Patient Participation in Decision-Making" , Science and Medicine, https://sciencebasedmedicine.org/patient-participation-in-decision-making/

[xxvii] Sanders, AR, 2013, Effects of improved patient participation in primary care on health-related outcomes: a systematic review, Fam Pract. 2013 Aug;30(4):365-78.

[xxviii] Brenninkmeijer, V., 2019, Predicting the Effectiveness of Work-Focused CBT for Common Mental Disorders: The Influence of Baseline Self-Efficacy, Depression and Anxiety, Journal of Occupational Rehabilitation, Volume 29, Issue 1, pp 31–41.

[xxix] Aurbach, R., 2017, "Fighting Fight or Flight", ibid.

[xxx] Michelli, J, "The New Gold Standard 5 Leadership Principles for Creating a Legendary Customer Experience Courtesy of the Ritz-Carlton Hotel Company", 2008, McGraw-Hill, p. 110.

[xxxi] Aurbach, R. 2015, "Your Biggest Unmeasured Cost", Insurance Thought Leadership, Online at: http:llinsurancethoughtleadership.com/your-biggest-unmeasuredcost/#sthash. gs 1 OskUJ.dPbs

[xxxii] "Mental health is good business: PwC", 2014, https://www.accountantsdaily.com.au/news/7424-mental-health-is-good-business-pwc