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

## *Implementation and Dissemination Plan*

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**Citation**

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# 1. Background

In Australia, over 7500 claims for work-related mental health conditions such as stress disorders, anxiety disorders, adjustment disorders and or depression[1] are awarded to workers each year. Often for these workers, recovery is slow, with workers who have a work-related mental health condition taking up to three times longer to return to work compared with workers with a musculoskeletal injury[1]. Patients with work-related mental health injuries are also at an increased risk of developing deleterious physical conditions such as high blood pressure, cholesterol, smoking and pain-related problems, as well as social challenges including work-family conflict[2-5].

Most patients with a work-related injury will visit their general practitioner (GP) throughout their claim and recovery process[6]. However, GPs both in Australia and internationally have reported difficulties with treating and managing patients who are considering applying for a claim or who are receiving compensation for a work-related injury[7, 8]. For patients with work-related mental health conditions, the difficulties reported by GPs are exacerbated[9].

In Australia, GPs primarily are responsible for overseeing the clinical care of workers with mental health conditions. In addition to providing clinical care, GPs are tasked with authorising return to work or an absence from work in workers with work-related mental health conditions. In performing this dual role, GPs resume the roles of both a clinician and a gatekeeper to compensation. Contending with these contrasting responsibilities, GPs report uncertainty and hesitation in managing treatment for these patients[10].

The "*Clinical practice guideline for the diagnosis and management of work-related mental health conditions in general practice*" (The guideline) has been developed to assist GPs to improve their diagnosis and management of patients who have work-related mental health conditions. This implementation and dissemination plan outlines factors that are likely to influence implementation, and provides actions to address these factors.

In developing this implementation and dissemination plan the project Guideline Implementation Working Group utilised the Guideline Implementation Planning Checklist[11], which describes a twelve-step approach for planning and preparing for guideline implementation.

## A. Objective

In this implementation and dissemination plan we describe separate plans for dissemination of the guideline and for the implementation of key recommendations within the guideline. We have considered aspects of implementation that are relevant to the targeted end-users of the guideline as well as other key stakeholders and health care contexts in which the guideline is likely to be used.

Our aims in this dissemination and implementation plan are to:

- Describe a multi-faceted and efficient strategy to raise awareness about the guideline
- Describe a plan for implementation that results in the sustainable application of guideline recommendations in practice
- Describe criteria by which success of the implementation plan can be determined.

## B. Target audiences

### *i. Primary audience*

The "*Clinical guidelines for the diagnosis and management of work-related mental health conditions in general practice*" are created primarily for Australian GPs and GP registrars. As such, they must be applicable to GPs and GP registrars in all Australian jurisdictions, and be fit for use by metropolitan, rural and remote GPs and GP registrars.

### *ii. Secondary audience*

Caring for patients with work-related mental health conditions requires a system-wide approach. Important stakeholders who may benefit from utilising the guideline include:

- Workers and their families

- General practice membership organisations
- Occupational therapists
- Rehabilitation professional bodies
- Primary Health Networks
- Compensation systems
- Collaborating clinicians such as psychiatrists, psychologists, occupational physicians, physiotherapists
- Other mental health and allied health professionals
- Employers and employer groups
- Employee groups and unions
- Policy regulators
- Superannuation insurers

See Appendix A for a full list of key stakeholders.

## 2. Dissemination

The strategy for disseminating the guideline serves two purposes. First, it will raise awareness of the guideline and its recommendations. Secondly, the mode through which the guideline (and key messages) is disseminated is likely to influence whether the information is accepted and retained by GPs.

For the most effective and cost-efficient way to raise awareness of the recommendations included in the guideline the following approaches are recommended[12]:

- Approaches that utilise locations where GPs might search for advice
- Approaches that reach the broader community, including current and future consumers of this guideline
- Peer-reviewed publications in reputed scientific and/or medical journals
- Conferences and public forums
- Approaches that raise awareness prior to publically launching the guideline

Details of activities that pertain to each of these approaches is detailed in Box 1.

*Box 1. A multifaceted approach for dissemination*

**Locations where GPs might search for advice**

- Electronic mail to all practicing GPs in Australia (Month -6 to 1)
- Electronic media such as newsletters from peak GP bodies (Month -6 to 3)
- Relevant magazines such as Australian Doctor, Australian Rural Doctor, Medical Observer, The Conversation, 6-minutes, Croakey blog (Month -6 to 6)
- Electronic GP medical education outlets, such as a "Clinical pearl" through the RACGP Insider newsletter (Month 0-12)
- Electronic libraries and websites of peak bodies such as the RACGP, Safe Work Australia, ACRRM, NHMRC Clinical guidelines portal (Month 0-3)

**Approaches using opinion leaders**

- Webinars or podcasts presented by key opinion leaders in general practice and/or mental health
- Newsletters from peak and/or trusted organisations

**Approaches that reach the broader community, including current and future consumers of the guideline**

- Electronic mail to key stakeholder groups (Appendix A) (month -6 to 2)
- Leverage existing media channels through key stakeholders (Appendix A) (month -6 to 2)
- Newsletters to medical schools and university departments involved in undergraduate teaching (month 0-3)

**Peer-reviewed publications in reputed scientific and/or medical journals**

- Publication in a peer-reviewed journals such as the Medical Journal of Australia or Australian Journal of General Practice (Month 6)
- Requested editorials in international journals

**Conferences and public forums**

- GP19
- ACRRM Annual Conference

**Approaches that raise awareness prior to publically launching the guideline**

- Activities will commence prior to publication of the guideline
- Key messages will highlight the anticipated value of the guideline, synopsis of the clinical questions that will be addressed in the guideline, and overview of the rigorous process undertaken to create the guideline

## C. Cost

*Newsletters and magazines*

Agencies frequently charge a fee for the publication of text and images. These costs vary between agencies.

*Other media channels*

The cost associated with media and publicity arises from fees associated with hosting events, at which media is present. Additional costs will be determined by the staff time required to promote activities through these media channels.

*Publications*

The cost associated with publications is largely determined by the quantity of staff time required to prepare papers for publication. In addition, publication in some open access journals incurs a fee. These may range from $1500-$3000 AUD.

*Conferences*

The cost of conferences includes the cost of registration, travel, accommodation and other incidental costs. The total cost of attending a conference starts at approximately $1000 for local conferences and increases depending on the location and conference registration fees.

*Table 1. Estimated Budget*

| Item | Estimated cost |
|---|---|
| Mailing | |
| Electronic mail to all practicing GPs in Australia | (time of project team) |
| Electronic mail to stakeholder groups (Appendix A) | (time of project team) |
| Publications (newsletters, magazines, journals) | |
| Media such as newsletters (including electronic) from peak GP bodies and trusted organisations e.g. "Clinical Pearl" through the RACGP in Practice newsletter | **Australian Rural Doctor / Australian Doctor:**<br>e-newsletter = $4950<br>(300mm x 250mm comp screen)<br><br>**RACGP:**<br>State Faculty newsletter rates (from $200 to $650 per state for a medium rectangle e-article)<br><br>**In Practice (RACGP newsletter):**<br>$1690 (e-article dimensions 300 x 250 pixels) |

| | |
|---|---|
| | *Note: places for Clinical Pearls are not sold, rather determined by the RACGP Quality Care Team*<br><br>**Good Practice (RACGP supplement to AFP newsletter):**<br>$1690 a medium rectangle e-article |
| Relevant magazines (e.g. the Australian doctor, Australian Rural Doctor, The Conversation, 6-minutes, The Medical Observer and Croakey blog | **Australian Rural Doctor / Australian Doctor:**<br>website ad = $190 (half page)<br>A4 print = $8,580<br><br>**The Conversation:**<br>free (Academics can sign up and pitch articles for free)<br><br>**6-minutes:**<br>Website ad (330 x 250 pixels) = $135<br>e-newsletter ad (330 x 250 pixels) = $4950 (ads run in weekly blocks) |
| Publication in a peer-reviewed journal such as the MJA or AFP | **MJA:**<br>Free for articles (no publication costs)<br>Advertising between 0.5 to 1 page = $4300 to $7700<br><br>**AFP:**<br>Free for articles (no publication costs)<br>Advertising between 0.5 to 1 page = $5050 to $7650 |
| Websites and webinars? | |
| Webinars presented by key opinion leaders in general practice and or mental health | $1200 (approximate estimate calculated using the GoToWebinar platform for free and reimbursing key opinion leaders at $200 per hour for their time, for 3 two hour webinars) |
| Leverage existing media channels through key stakeholders (Appendix A) | Zero to minimal costs anticipated<br>(e.g. Dr FeelGood radio channel, *beyondblue* website) |
| Electronic libraries and website of peak bodies such as RACGP and ACRRM | **RACGP:**<br>Website rates are $3450 (30 days) |
| Conferences and public forums | |
| GP19 | $1270 (standard registration for 3 days)<br>$400 (approx. flights)<br>$600 (approx. accommodation costs per person, per night) |
| ACRRM annual conference (Rural Medicine Australia) | $1258 (standard registration for 3 days)<br>$400 (approx. flights)<br>$600 (approx. accommodation costs per person, per night) |
| International conferences (e.g. GIN, EBHC) | $1500 (approx. conference registration)<br>$3000 (approx. accommodation and flights) |

# 3. Issues for consideration in Implementation

The Guideline Development Group has identified recommendations that we feel are most likely to affect change in the health outcomes of patients with work-related mental health conditions, and should be prioritised for implementation, either in as the focus of an implementation strategy, by clinicians in practice, or by research funders. These recommendations are presented in Table 1.

For each guideline recommendation, the Guideline Development Group and Implementation Working Group considered the target audience to whom the recommendation is directed, and the required changes in behaviour and systems that will be necessary in to put the recommendation into practice. Recommendations were evaluated using a process that drew on a range of existing approaches for prioritising recommendations[10, 13-15]. In summary: (1) the Guideline Implementation Working Group listed suggested recommendations in a draft Implementation Plan (2) sought opinions from stakeholders

on these suggested recommendations during the public consultation process; (3) the Guideline Development Group considered these responses as well as any updates to the guideline to determine a final list of recommendations.

The following factors were considered by the Guideline Development Group when considering which recommendations are most likely to affect change in the health outcomes of patients with work-related mental health conditions:

- Highest level of evidence
- Areas of greater gaps between the recommendation/consensus statement and practice
- Easiest wins (fewest and smallest barriers associated with the adoption of a recommendation)
- Level of importance – patient's perspective
    - Quality of life
    - Benefits and harms
- Level of importance – clinician's perspective
    - Patient outcomes
    - GP-patient relationship
    - GP outcomes
- Level of importance – public perspective
    - Public health outcomes
    - Do they address a priority problem for disadvantaged populations?
    - Is there a reason to anticipate different effects of interventions in disadvantaged and privileged populations?
    - What barriers to implementation would there be for disadvantaged populations?
    - How will the impact of the recommendation be assessed for disadvantaged populations?

*Table 1. Key recommendations and implications*

| Recommendation/Consensus-based recommendation | Target audience(s) | Implications / Evaluation |
|---|---|---|
| For workers with symptoms of mental health conditions, a GP should use:<br>the Patient Health Questionnaire-9 to assist in making an accurate diagnosis of depression and to assess its severity<br>either the Generalized Anxiety Disorder 7-item or the Depression Anxiety Stress Scales (DASS) to assist in making an accurate diagnosis of an anxiety disorder<br>the PTSD CheckList – Civilian Version to assist in making an accurate diagnosis of PTSD and to assess its severity<br>the Alcohol Use Disorders Identification Test, Severity of Alcohol Dependence Questionnaire, or the Leeds Dependence Questionnaire, to assist in making an accurate diagnosis of an alcohol use disorder, and to assess its severity<br>the Leeds Dependence Questionnaire to assist in making a diagnosis of substance use disorders and to assess their severity.<br>*Strong recommendation FOR (high quality of evidence)* | General practitioners | This recommendation represents a quasi-paradigm shift in how GPs make a diagnosis of a mental health condition.<br><br>The guideline includes copies of each of the recommended instruments to facilitate use in a clinical setting.<br><br>Evaluation: Documentation of the use of the recommended tools during diagnosis |
| Adjustment disorder implies a level of distress greater than would otherwise be expected after a certain event(s). It is sometimes diagnosed when other psychiatric illnesses such as major depression and anxiety have been excluded and is time limited. There are no recommended tools for diagnosing adjustment disorder or assessing its severity in general practice. A GP may consider use of the DASS to assess levels of patient distress and World Health Organization Disability Assessment Schedule 2.0 to assess levels of functional impairment.<br>*Consensus-based recommendation* | | Evaluation: Documentation of the use of the recommended tools during diagnosis |

| Recommendation/Consensus-based recommendation | Target audience(s) | Implications / Evaluation |
|---|---|---|
| On the available evidence, there is no clear support for an intervention in a general practice setting to improve personal recovery or return to work in patients with a work-related mental health condition; therefore, there is an urgent need to promote research in this area.<br><br>*Recommendation for future research.* | Policy makers, researchers, clinicians | Published strategies for facilitating return to work and personal recovery focus largely on clinical treatments. There are, however, policy initiatives and health system initiatives that may be useful in a general practice setting (e.g. e-certification, team care approaches etc.). Further testing of the impact of these on patient outcomes is warranted. |
| A GP should note the presence and severity of comorbidities in their assessments, with a view to considering their implications for treatment planning.<br><br>*Consensus-based recommendation* | General practitioners | Consideration of comorbidities during treatment planning is frequently overlooked. A shift in this clinical approach that considers comorbidities would enable more appropriate patient-centred care and improve outcomes for patients.<br><br>Evaluation: There is documentation of assessments that seek to note the presence and severity of comorbidities. |
| A GP should use telephone and/or face-to-face methods to communicate between a worker, supervisor, healthcare provider(s), union representatives and other disability management stakeholders.<br><br>*Strong recommendation FOR (Moderate quality of evidence)* | General practitioners, workers, employers, union representatives, compensation scheme agents | Open and constructive dialogue between clinicians, injured workers, case managers etc. may improve recovery and return to work by facilitating an understanding of the roles and requirements of each group.<br><br>Evaluation: There is documentation of communications with a workplace and other key people involved in the patient's recovery that focus on the patient's needs and the workplace. |

## Implementation considerations for key recommendations

Implementation of guidelines is influenced by factors-relating to the target audience, the health setting (i.e. other clinicians who are involved in a patient's care), and the health system (i.e. policy makers and industry groups)[16]. A substantial body of research now describes barriers and enablers (albeit enablers are described to a lesser extent) to guideline uptake by health professionals[17]. In addition, many studies have demonstrated interventions that are likely to be effective at improving guideline implementation in varying contexts. For instance, a Cochrane Review of tools used by guideline developers to promote uptake of their guideline concluded that tools that are used as an aid to improve compliance (i.e. domains of applicability, appropriateness and format) are most likely effective at improving adherence to guideline recommendations by health professionals[18]. Other potentially effective interventions include the use of opinion leaders or academic detailing[19, 20]. By considering barriers and/or enablers relevant to a recommendation, it is possible to select and tailor interventions that are most likely to improve implementation of the guideline by health professionals[16].

In the context of mental health conditions, guideline implementation strategies that facilitate shared decision-making approaches between a patient and their clinician are particularly important[21, 22]. Similar themes are also reported for mental health guideline adherence in the compensable injury context, where communication and collaboration between end-users is viewed as a key factor influencing guideline implementation by practitioners[23].

One ongoing criticism of implementation research is that interventions are aimed at clinicians, without also considering the organisational, policy and health care context[17, 24, 25]. Any interventions used to implement this guideline should therefore consider the local health and policy context – which is particularly important for compensable injury where each state and territory in Australia operate within their own legislation[26, 27].

Thus, taking into account current policy and practice and using theoretical foundations and reflecting on existing high-quality evidence, an intervention mapping approach[28, 29] may be applied to formulate suitable interventions to address the implementation considerations described in Table 2.

An intervention mapping approach will involve the following activities:

- A system overview report
- Baseline practice - what are the practices that need intervention?
- Consider, for the key recommendations, what are the main influences on decision-making
- Barriers and enablers analysis using the Theoretical Domains Framework
- Consider what practices will the guideline be targeting for change
- Consider what behaviours make up the practice
- Consider what contextual and health setting aspects might be useful targets for interventions to facilitate change in GP practice
- Use a collaborative approach with stakeholders to design, pilot and test the feasibility of an implementation strategy in numerous contexts
- Full scale implementation and evaluation

# 4. Summary

Implementation of the "*Clinical practice guideline for the diagnosis and management of work-related mental health conditions in general practice*" will be fostered through a multi-faceted implementation and dissemination strategy that delivers useful and usable information to relevant stakeholders, and assists these stakeholders with understanding the information and putting it into practice. Successful implementation of the guideline will be measured by improvements in the clinical care provided in general practice that produces improvements in personal recovery and return to work rates for people with work-related mental health conditions.

# 5. References


1. Safe Work Australia. Work-related mental health disorders profile. Canberra: ACT: Safe Work Australia; 2015.
2. Habibi E, Poorabdian S, M. S. Job strain (demands and control model) as a predictor of cardiovascular risk factors among petrochemical personnel. J Educ Health Promot. 2015;4:16.
3. Saastamoinen P, Laaksonen M, Leino-Arjas P, Lahelma E. Psychosocial risk factors of pain among employees. Eur J Pain. 2009;13(1):102-8.
4. Berset M, Semmer NK, Elfering A, Jacobshagen N, Meier LL. Does stress at work make you gain weight? A two-year longitudinal study. Scand J Work Environ Health. 2011;37(1):45-53.
5. Nohe C, Meier LL, Sonntag K, Michel A. The chicken or the egg? A meta-analysis of panel studies of the relationship between work-family conflict and strain. J Appl Psychol. 2015;100(2):522-36.
6. Dembe AE, Mastroberti MA, Fox SE, Bigelow C, Banks SM. Inpatient hospital care for work-related injuries and illnesses. Am J Ind Med. 2003;44(4):331-42.
7. Mazza D, Brijnath B, Singh N, Kosny A, Ruseckaite R, Collie A. General practitioners and sickness certification for injury in Australia. BMC Fam Pract. 2015;16:100.
8. Anema JR, Jettinghoff K, Houtman I, Schoemaker CG, Buijs PC, van den Berg R. Medical care of employees long-term sick listed due to mental health problems: a cohort study to describe and compare the care of the occupational physician and the general practitioner. J Occup Rehabil. 2006;16(1):41-52.
9. Brijnath B, Mazza D, Singh N, Konsy A, Ruseckaite R, Collie A. Mental Health Claims Management and Return to Work: Qualitative Insights from Melbourne, Australia. J Occup Rehabil. 2014;24(4):766-76.
10. Gagliardi AR, Marshall C, Huckson S, James R, Moore V. Developing a checklist for guideline implementation planning: review and synthesis of guideline development and implementation advice. Implement Sci. 2015;10:19.
11. Schipper K, Bakker M, De Wit M, Ket JCF, Abma TA. Strategies for disseminating recommendations or guidelines to patients: a systematic review. Implement Sci. 2016;11:82.
12. Schipper K, Bakker M, De Wit M, Ket JC, Abma TA. Strategies for disseminating recommendations or guidelines to patients: a systematic review. Implementation science : IS. 2016;11(1):82.
13. Shekelle PG. Developing guidelines. BMJ. 1999;318:563.
14. Martin J, Lal A, Moodie J, Zhu F, Cheng D. Hospital-Based HTA and Know4Go at MEDICI in London, Ontario, Canada., in Hospital-Based Health Technology Assessment. In: Sampietro-Colom L, Martin J, editors. Hospital-Based Health Technology Assessment. Heidelberg: Germany: Adis, Cham; 2017.
15. Johnson K, Tuzzio L, Renz A, Baldwin LM, Parchman M. Decision-to-implement worksheet for evidence-based interventions: from the WWAMI Region Practice and Research Network. J Am Board Fam Med. 2016;29(5):553-62.
16. Fischer F, Lange K, Klose K, Greiner W, Kraemer A. Barriers and strategies in guideline implementation-a scoping review. Healthcare (Basel). 2016;4(3):E36.
17. Gagliardi AR, Alhabib S, Members of the Guidelines International Network Implementation Working Group. Trends in guideline implementation: a scoping systematic review. Implement Sci. 2015;10:54.
18. Flodgren G, HallL AM, Goulding L, Eccles MP, Grimshaw JM, Leng GC, et al. Tools developed and disseminated by guideline producers to promote the uptake of their guidelines. Cochrane Database Syst Rev. 2016(8):CD010669.
19. O'Brien MA, Rogers S, Jamtvedt G, Oxman AD, Odgaard-Jensen J, Kristoffersen DT, et al. Educational outreach visits: effects on professional practice and health care outcomes. Cochrane Database Syst Rev. 2007(4):CD000409.
20. Forsetlund L, Bjørndal A, Rashidian A, Jamtvedt G, O'Brien MA, Wolf F, et al. Continuing education meetings and workshops: effects on professional practice and health care outcomes. Cochrane Database Syst Rev. 2009(2):CD003030.
21. Goldner EM, Jeffries V, Bilsker D, Jenkins E, Menear M, Petermann L. Knowledge translation in mental health: a scoping review. Healthc Policy. 2011;7(2):83–98.
22. Moreno EM, Antonio Moriana J. User involvement in the implementation of clinical guidelines for common mental health disorders: a review and compilation of strategies and resources. Health Res Policy Syst. 2016;14:61.
23. Lugtenberg M, van Beurden KM, Brouwers EP, Terluin B, van Weeghel J, van der Klink JJ, et al. Occupational physicians' perceived barriers and suggested solutions to improve adherence to a guideline on mental health problems: analysis of a peer group training. BMC Health Serv Res. 2016;16:271.

24. Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. Lancet. 2003;362(9391):1225-30.
25. Mazza D, Bairstow P, Buchan H, Chakraborty SP, Van Hecke O, Grech C, et al. Refining a taxonomy for guideline implementation: results of an exercise in abstract classification. Implement Sci. 2013;8:32.
26. Zardo P, Collie A. Type, frequency and purpose of information used to inform public health policy and program decision-making. BMC Public Health. 2015;15:381.
27. Safe Work Australia. Comparison of workers' compensation arrangements in Australia and New Zealand (2017). Canberra: ACT: Safe Work Australia; 2017.
28. Kok G, Gottlieb NH, Peters GJ, Mullen PD, Parcel GS, Ruiter RA, et al. A taxonomy of behaviour change methods: an Intervention Mapping approach. Health Psychol Rev. 2016;10(3):297-312.
29. LK B, Parcel GS, Kok G. Intervention mapping: a process for developing theory- and evidence-based health education programs. Health Educ Behav. 1998;25(5):545-63.

# Appendix A. Key stakeholders

The following organisations and groups of individuals are recognised as having an interest in these guidelines:

- **Professional organisations and associations:**
  - Royal Australian College of General Practitioners
  - Australian College of Rural and Remote Medicine
  - Royal Australian College of Physicians
  - Australasian Faculty of Occupational and Environmental Medicine
  - Royal Australian and New Zealand College of Psychiatrists
  - Australian Psychological Society
  - APS College of Clinical Psychologist
  - Australian Society for Psychological Medicine
  - Occupational Therapy Australia
  - Australian Medical Association
  - Australian General Practice Training
  - GP registrar training associations
  - GP Mental Health Standards Collaboration
  - Mental Health Professionals Network
  - Australian College of Nursing
  - Australian Rehabilitation Providers Association
  - Australian College of Physiotherapists
  - Northern Clinical School Rehabilitation Studies Unit, University of Sydney
  - The Pharmaceutical Benefits Scheme
  - The Medical Services Advisory Committee
  - The Therapeutic Goods Administration
  - The Australian Association for Academic Primary Care
  - The Federation of Ethnic Communities' Councils of Australia
  - Australian Rehabilitation Providers Association
  - Australasian Rehabilitation Nurses' Association
  - Rehabilitation Counselling Association of Australia
  - Australian Society of Rehabilitation Counsellors
  - Australian Nursing and Midwifery Federation
- **Mental health organisations:**
  - Mental Health Council of Australia
  - Mental Health Australia
  - Mental Health Foundation Australia
  - National Mental Health Commission
  - Mental Health Forum
  - HeadsUp.org.au
  - beyondblue
  - headspace
  - SANE Australia
  - Blackdog Institute
- **Aboriginal and Torres Strait Islander representative organisations:**
  - Indigenous Health Division of the Australian Government
  - Department of Health
  - Lowitja Institute
  - Australian Indigenous Health*InfoNet*
  - National Aboriginal Community Controlled Health Organisation
  - Aboriginal Health & Medical Research Council of New South Wales
  - Aboriginal Health Council of Western Australia
  - Queensland Aboriginal and Islander Health Council
  - Victorian Aboriginal Community Controlled Health Organisation
  - Aboriginal Medical Services Alliance Northern Territory
  - Aboriginal Health Council of South Australia Inc.
  - Tasmanian Aboriginal Corporation
  - Winnunga Nimmityjah Aboriginal Health Service
  - RACGP Aboriginal and Torres Strait Islander Health
- **Care organisations:**
  - National Mental Health Consumer and Carer Forum
  - Health Issues Centre
  - Consumers Health Forum Australia
  - Mind Australia
- **Employer/Employee/legal groups:**
  - The Australian Council of Trade Unions
  - The Australian Chamber of Commerce and Industry
  - The Australian Industry Group
  - Mentally Healthy Workplace Alliance
  - Union groups
  - The Actuaries Institute
  - Law Council of Australia
  - Department of Veterans Affairs (DVA)
  - UnionsACT

- **Regulatory groups / Worker's compensation authorities:**
  - Department of Jobs and Small Business
  - SafeWorkAustralia
  - Comcare
  - NT WorkSafe
  - Workplace Health and Safety Queensland
  - State Insurance Regulation Authority
  - iCare
  - Return to WorkSA
  - WorkSafe WA
  - SafeWork NSW
  - WorkSafe ACT
  - WorkSafe Victoria
  - WorkSafe Tasmania
  - SafeWork SA
- **Institute for Safety, Compensation and Recovery Research**
- **Departments of General Practice:**
  - Monash University
  - Bond University
  - The Australian National University
  - Deakin University
  - Flinders University
  - Griffiths University
  - James Cook University
  - The University of Adelaide
  - The University of Melbourne
  - The University of New South Wales
  - The University of Newcastle
  - The University of Notre Dame Australia
  - The University of Queensland
  - The University of Sydney
  - The University of Tasmania
  - The University of Western Australia
  - The University of Western Sydney
  - The University of Wollongong