The Australasian Faculty of

Occupational & Environmental Medicine

Realising the health benefits of work – An evidence update

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Introduction

In 2010, the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) released the *Realising the Health Benefits of Work* Position Statement, followed by the *Consensus Statement* in 2011. The companion position statements, *What is Good Work?* and *Improving Workforce Health and Workplace Productivity* were released in 2013. Since its publication, subsequent evidence reiterates that work is good for optimising people's health and wellbeing; and work absence due to illness or injury is not. This evidence update not only reinforces this concept, it also documents emerging evidence demonstrating the growing effect that a lack of 'good' work has on mental health. It highlights the need for an emphasis on promoting recovery at work practices, which require better integration between health services and employers.

The nature of the workforce has changed over time as we now work in a predominantly knowledge-based economy with more sedentary work and less physical labour. The globalisation of labour markets is changing the way we work and the conditions in which we work.[1] Absenteeism and more recently presenteeism – lost productivity that occurs when employees come to work but perform below par due to illness – is on the rise due to growing numbers of employees developing mental illness.[2]

There is a greater imperative for employers and health professionals alike to consider an employee's *productivity* rather than his or her disease and focusing on the psychosocial issues that arise in the workplace. The quality of work (i.e. participating in *good work*)[3] and the level of control an employee has in his or her working environment are two significant factors which should be considered when treating injury and illness. The World Health Organisation 2008 Report notes that high job demand, low control and effort-reward imbalance are risk factors for developing mental and physical ill-health. [4]

The current evidence continues to reflect the importance of applying a biopsychosocial paradigm to understanding and treating injury and disease in a workplace setting. Given the biomedical, psychological and social factors that contribute to health, successful return to work (RTW) practices require good communication and collaboration amongst all stakeholders including employees, employers, General Practitioners (GPs), allied health professionals, unions and insurers.[5]

Return-to-work practices

Current RTW certification practices amongst GPs

The National Return to Work Survey 2014 revealed the Returned to Work Rate was 87 per cent for injured Australian workers, a three per cent increase from 2011/2012 and 88 per cent for injured New Zealand workers. [6] Early integrated and interdisciplinary intervention programs utilising a return to work coordinator have shown to be successful in improving return to work rates compared to

[1] Black, C. Health Benefits of Work: Implications for New Zealand Presentation (1st April 2015)
[2] Op. cit. (Black, 2015)
[3] What is Good Work? Position Statement October 2013. The Royal Australasian College of Physicians and the Australasian Faculty of Occupational and Environmental Medicine.
[4] World Health Organisation (WHO) Closing the gap in a generation. Health equity through action on the social determinants of health (2008).
[5] Wainwright, E., Wainwright, D., Keogh, E & Eccleston, C (2013) Return to work with chronic pain: employers' and employees' views. Occupational Medicine. Vol 63: 501-506
[6] National Return to Work Survey 2014 – Headline Measures Report (The Social Research Centre on behalf of Safe Work Australia) (Accessed on 1/10/2014)

conventional workers' compensation case management.[7] The treatment program achieved a RTW rate of 14 per cent in three months. Effective cardiac rehabilitation programs in which depression and anxiety are addressed and tailored to the specific work setting of the myocardial infarction (MI) patient can improve RTW rates in an MI patient.[8] Even in the absence of a diagnosed medical illness, poor mental health is linked to delayed RTW, increased sickness absence and reduced work productivity.[9]

For the years 2003-2010, GPs in Victoria, Australia provided sickness certificates for workers compensation claimants for musculoskeletal injuries and diseases (40.2per cent), back pain and strains (16.4 per cent) and other traumatic injuries (15.6 per cent). [10] For initial medical certificates, the highest proportion of unfit-for-work certificates was issued to workers with mental health conditions (MHCs). The median duration of unfit-for-work certificates issued by GPs to patients with MHCs is longer than in patients with musculoskeletal injuries and diseases, back pain and other traumatic injuries. In the same pool of data, the rate of unfit-for-work certification (6.35 per 1000 workers) was significantly higher than the rate of certification for alternative duties (1.95 per 1000 workers).

Role of Employers

Successful RTW practices such as the 'fit note' require positive and unthreatening communication between line managers/employers and employees. In a qualitative study conducted by Wainwright and colleagues, employers and employees mentioned they appreciated being flexible about the guidance that exists on how to keep in contact when an employee is on sick leave. This is an aspect of managing sickness absence which often causes concern and is particularly challenging for employers who manage employees with chronic illness. [11] Both stakeholders reported the 'fit note' would assist behaviour change. Employers focused on its positive language and favoured the 'fit note's' format, which they considered encourages conversation between stakeholders. Likewise, employees preferred the 'fit note's' format compared to the sick note because it helped RTW negotiations for the following reasons:

1. being considered in terms of fitness was beneficial to how participants saw their capacity;
2. the 'fit note' summarised more detailed conversations between employees and GPs; and
3. these activities were symbolic of the care that had been put into these negotiations.[12]

Role of General Practitioners

The current literature reveals there are conflicting views amongst GPs about their role in enabling employees to return to work after sustaining an injury and disease. Some GPs assert that their role was to provide support and management of health-related issues only and managing long-term worklessness lay outside of their role.[13] The ability of a workplace to accommodate an injured worker may influence GP certification behaviour. Workplace accommodations are often not in place

[7] Hamer, H., Gandhi, R., Wong, S and Mahomed N.N (2013) Predicting return to work following treatment of chronic pain disorder. Occupational Medicine: Vol 63, 253-259
[8] de Jonge, P, PhD., Zuidersma, M, PhD and Bultmann, U, PhD. The presence of a depressive episode predicts lower return to work rate after myocardial infarction. General Hospital Psychiatry 2014; Vol 36, 363-367
[9] Ibid.
[10] Collie, A., Ruseckaite, R., Brijnath, B., Kosny, A. A and Mazza, D (2013) Sickness certification of workers compensation claimants by General Practitioners in Victoria, 2003-2010. Medical Journal of Australia. Vol 199 (7): 480-483
[11] Op. cit. (Wainwright et al. 2013)
[12] Ibid.
[13] Cohen, D., Marfell, N., Webb, K., Robling, M & Aylward, M (2010) Managing long-term worklessness in primary care: a focus group study. Journal of Occupational Medicine. Vol 60: 121-126

to facilitate the RTW process.[14] Four key factors have been identified which influence GPs in their attitude to managing RTW issues:

1. doctor-patient relationships;
2. patient advocacy;
3. pressure on consultation time; and
4. limited occupational health expertise.[15]

Role of GPs in managing mental health conditions

GPs are considered the gatekeepers of mental health care and are responsible for initial treatment, appropriate referral and sickness certification.[16] Employees with mental ill-health are one of the highest risk groups for long-term sickness absence and presenteeism.[17] Therefore, GPs are required to be competent in addressing work and sickness issues because:

1. most people with a mental health condition are likely to seek treatment from their GP;
2. employees with MHCs are 30-50 per cent more likely to take sick leave; and
3. GPs are responsible for certifying sickness.

Several studies have reported GPs shortcomings in identifying patients' complaints as mental health issues. The GP recognition rate for general anxiety disorder is only 30 per cent and is between 55 per cent and 75 per cent for major depressive disorders.[18] It is essential that GPs have the current knowledge and skills to recognise and address mental illness - the OECD Report 2015 references only a small numbers of countries providing training of this nature in the general GP training curriculum.

In particular, the current literature consistently cites confusion amongst GPs about when a worker with a mental health condition should resume work. GPs are uncertain about the kind of alternate duties to recommend and faced the additional challenge of balancing the claimant's privacy with communication about health issues with the employer.[19]

Mental health

Employment and mental health

Poor mental health is prevalent and costly in terms of lost productivity. The current literature reports that good quality employment is good for improving mental health. Work is a powerful determinant of health, and thus, re-entering the workforce can aid recovery and shorten the duration of treatment.[20] There is an urgent need to improve vocational rehabilitation interventions for mental health conditions. Promising approaches include healthcare which incorporates a focus on return to work, workplaces that are accommodating and non-discriminating, and early intervention to support workers to stay in work.[21] Strong evidence indicates that employment can decrease risk of

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[14] Op. cit. (Collie et al. 2013)
[15] Op. cit. (Cohen et al. 2010)
[16] OECD Report. Fit Mind, Fit Job. From evidence to practice in mental health and work. http://www.keepeek.com/Digital-Asset-Management/oecd/employment/fit-mind-fit-job_9789264228283-en#page122 (Accessed on 25/3/2015)
[17] Ibid.
[18] Ibid.
[19] Brijnath, B., Mazza, D., Singh, N., Kosny, A., Ruseckaite, R and Collie, A (2014) Mental health claims management and return to work: qualitative insights from Melbourne, Australia. Journal of Occupational Rehabilitation
[20] Op. cit. (OECD Report, 2015)
[21] Waddell, G., Burton, A.K and Kendall, AS N (2013) Vocational Rehabilitation. What works, for whom, and when? https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf (Accessed on 25/3/2015)

depression and improves general mental health. A systematic review conducted by van der Noordt and colleagues found that employment was a significant protective factor for improving general mental health and reducing the risk of depression (Figure 1).[22] Likewise, employment prevents psychiatric morbidity as employed people were shown to have lower psychiatric morbidity scores.

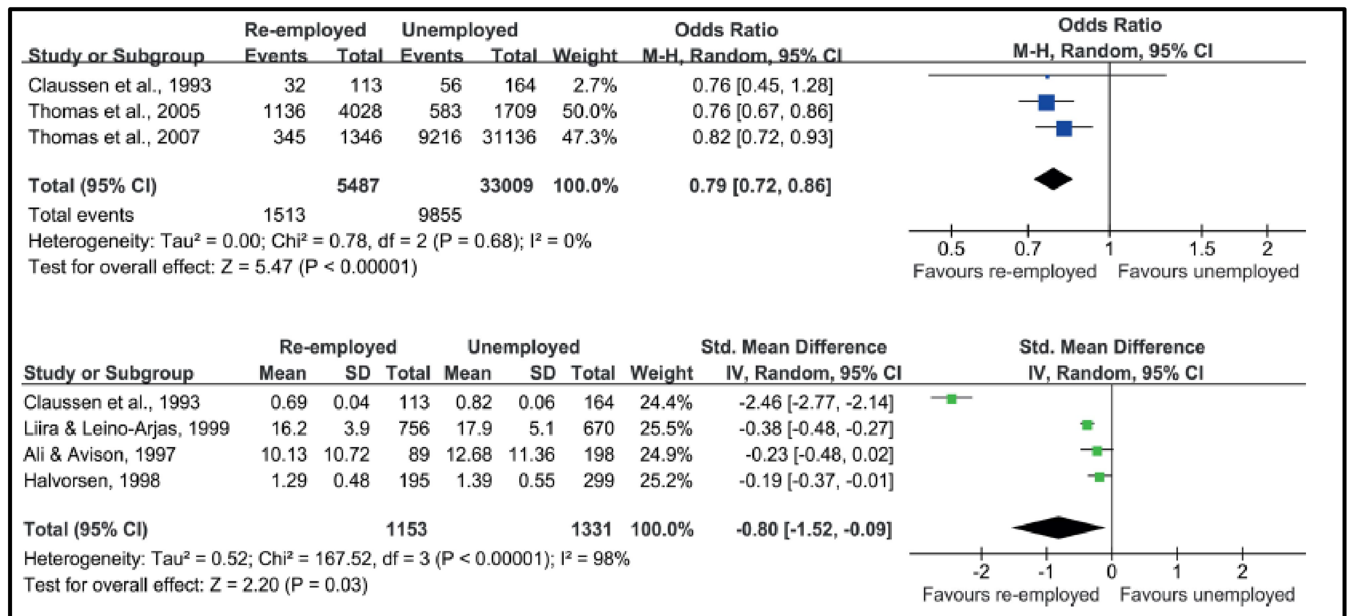

Figure 1: Forest plots show that re-employment reduces the risk of psychological distress and leads to lower psychological distress scores on various scales (Reproduced from van der Noordt et al. 2014).

The effect of 'good work' on mental health outcomes

The AFOEM's companion statement, *What is Good Work?* describes good work as "balancing the interests of individuals, employers and society in order to deliver performance, engagement and fairness." [23] The health benefits of employment are dependent on the quality of the job. Job quality can be defined as whether employees have autonomy, control and task discretion.[24] There are two dimensions to job quality which impact on both health and life expectancy – the conditions of employment (i.e. full-time, part-time and casual work) and the nature of the working environment.[25]

Globalisation has played a considerable role in changing workplace conditions, such as the casualization of the workplace, short-term agency work, outsourcing of tasks by employers to such agencies and the reduction in job security, which has an effect on employee psychological health and job satisfaction.[26] There are two ways in which globalising labour markets have contributed to the rise in psychological illness, burnout and eventual job dissatisfaction amongst employees:

1) employees are more likely to face higher job demands, which results in employees having to deal with the rise in psychological and emotional demands, and conflict in roles; and

[22] van der Noordt, M., IJzelenberg, H., Droomers, M & Proper, I.K (2014) Health effects of employment: a systematic review of prospective studies. Occupational and Environmental Medicine. Vol 17: 730-736
[23] Op. cit. (What is Good Work?, AFOEM 2013)
[24] Coats, D & Lehki, R (2008) 'Good Work': Job quality in a changing economy. The Work Foundation http://www.theworkfoundation.com/assets/docs/publications/197_good_work_final2.pdf (Accessed on 30/6/2015)
[25] Ibid.
[26] Idris, M.A., Dollard, M.F and Winefield, A.H (2011) The effect of globalisation on employee psychological health and job satisfaction in Malaysian workplaces. Journal of Occupational Health. Vol 53: 447-454.

2) highly competitive conditions reduces supervisor and collegial support, as well as employees' sense of decision authority.[27]

The WHO's 2008 Social Determinants of Health Report found studies showing that

1) temporary workers have shorter life expectancies compared to those with permanent roles,
2) poor mental health outcomes are associated with unstable employment arrangements; and
3) employees who believe their work is insecure experience significant detrimental effects on their mental health. [28]

Work relevant stress is costly for employees' health and work productivity. Dollard and colleagues found that from all causes, it costs Australian employers $8 billion per annum due to sickness absence and presenteeism, and $693 million per annum of this is a result of job strain, incivility and bullying in the workplace.[29] The cost of unemployment benefits in contrast is $6.1 billion per annum in the 2010-2011 Financial Year. [30]

Previous studies demonstrate that transitions to poor quality jobs were associated with greater decline in mental health than transitions to unemployment or remaining unemployed.[31] Interestingly, transitions from unemployment to the poorest psychosocial quality jobs were equivalent in effect on employees' mental health as remaining unemployed (Figure 2).[32]

[27] Ibid.
[28] Op. cit. (WHO, 2008)
[29] Dollard, M., Bailey, T., McLinton, S., Richards, P., McTernan, W., Taylor, A., and Bond, S (2012) The Australian Workplace Barometer: report on psychosocial safety climate and worker health in Australia. Safe Work Australia. http://www.safeworkaustralia.gov.au/sites/swa/about/Publications/Documents/748/The-Australian-Workplace-Barometer-report.pdf (Accessed on 19/8/2015)
[30] AIHW (Australian Institute of Health and Welfare) 2013. Australia's Welfare 2013. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544564 (Accessed 27/10/15)
[31] Butterworth, P., Leach, L.S., McManus, S & Stansfeld, S.A (2013) Common mental disorders, unemployment and psychosocial job quality: is a poor job better than no job at all? Psychological Medicine. Vol 43: 1763-1772
[32] Ibid.

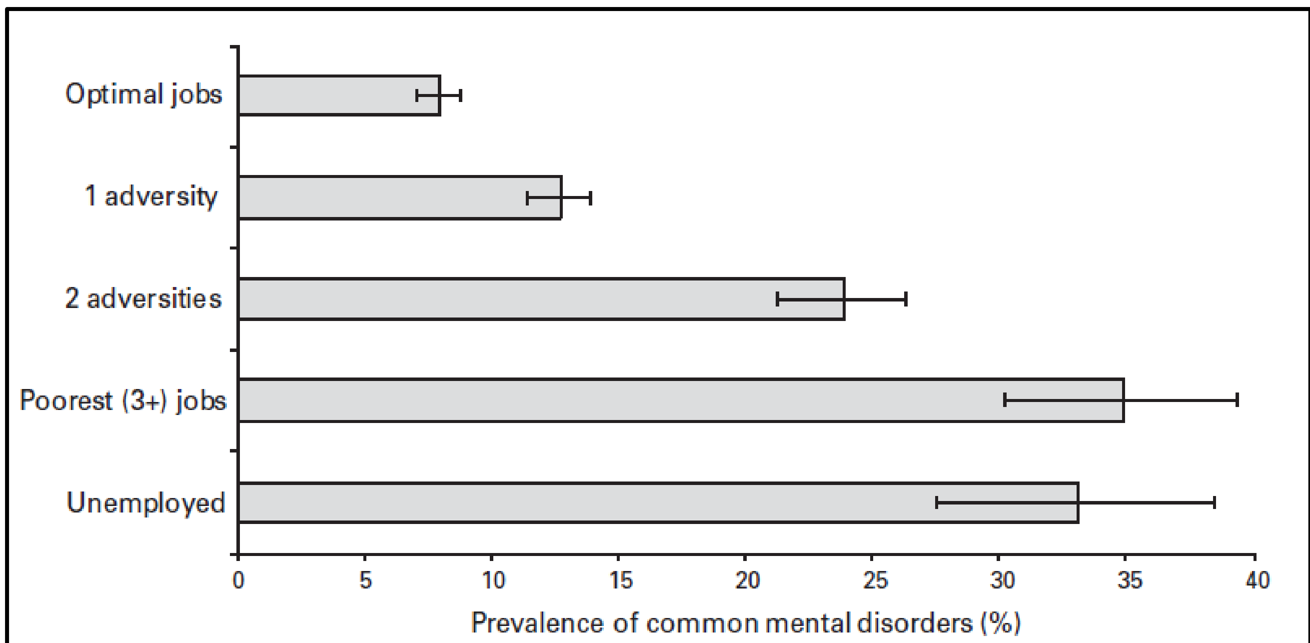

Figure 2: A higher prevalence of common mental disorders was seen amongst employed persons with poor quality jobs (Reproduced from Butterworth, P et al. 2013).

A systematic review conducted by Rueda and colleagues found no evidence of an increase in psychological distress at follow up for continually unemployed participants.[33] The mental health benefits of work are gained from good quality jobs. The poorest quality of work is comparable to unemployment as a risk factor for poor mental health.[34]

Previous Australian studies highlighted a clear linear relationship which exists between job quality and mental health where the number of psychosocial job adversities and levels of depression and anxiety increased. Amongst employed people living with HIV, adverse psychosocial factors such as job insecurity, psychological demands, and decision authority were associated with depressive symptoms.[35]

Role of Employers in managing mental ill-health

The link between treatment for improving mental health and employment is strong, since being in work substantially reduces the duration of treatment. This is especially relevant in providing mental health care.[36] It is worthwhile incorporating employment support into the treatment plan for people suffering from mild to moderate levels of mental illness. The OECD Report (2015) recommends providing mental health training and support for line managers so that they are better equipped to identify mental health problems and address problematic behaviour in employees at an early stage.[37] Implementing this kind of workplace policy leads to less conflict between line managers and

[33] Rueda, S, PhD., Cambers, L, MSW., Wilson, M, PhD., Michael, C, PhD., Rouke, S.B, PhD., Bayoumi, A, MD, MSc., Raboud, J, PhD and John Lavis, PhD. Association of returning to work with better health in working-aged adults: A systematic review. American Journal of Public Health 2012; Vol 102, No. 3
[34] Op. cit. (Butterworth et al, 2013)
[35] Rueda, S., Smith, P., Bekele, T., O'Brien, K., Husbands, W., Li, A., Jose- Boerbridge, M., Mittman, N., Rachlis, A., Conyers, L., Boomer, K.B., Rourke, S.B & ECHO Study Team (2015) Is any job better than no job? Labor market experiences and depressive symptoms in people living with HIV. AIDS Care, 27(7): 907-915.
[36] Op. cit. (OECD Report, 2015)
[37] Op. cit. (OECD Report, 2015)

employees and encourages more effective use of workplace process when line managers use shared decision-making styles.[38]

Concluding remarks

This update of the evidence indicates the importance of the value of 'good' work due to its positive effect on employees' mental health. The increased use of the 'fit note' certificate by GPs may encourage injured employees to return to the workplace, as the evidence supports re-employment as an important component in the rehabilitation process.[39] Guidelines and protocols need to be developed to improve GPs and other health professionals' management of mental health claims.[40] Further training is a step forward to promoting and implementing the use of the 'fit note' certificate. Training should focus on employers and insurance agents communicating effectively, and GPs properly assessing mental health claims and clinical management of mental illness.[41]

[38] Op. cit. (Wainwright et al. 2013)
[39] Pakpoor, J (2015) 'Fit note' is linked to fewer people taking long term sick leave, study finds. BMJ 2015;350:h1024 http://www.bmj.com/content/350/bmj.h1024 (Accessed on 17/3/15)
[40] Op. cit. (Brijnath et al. 2014)
[41] Op. cit. (Brijnath et al. 2014)