Lecture #4

STRATEGIES TO ENHANCE WORK FUNCTIONING AND WORK REINTEGRATION FOR WORKERS WITH MENTAL HEALTH PROBLEMS

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THE IMPACT OF MENTAL HEALTH PROBLEMS ON WORKPLACES

Workplaces are central to the mental health of workers. Work can promote mental wellbeing by providing individuals with purpose, financial resources and a source of identity. Conversely, work can contribute to the development of mental ill health through poor working conditions and work organization issues[1,2]. It has been estimated that occupational risk factors account for 11% of the major depressive disorders burden in the general population[3]. It is therefore important to support workplaces in their efforts to identify and mitigate occupational risk factors for mental ill health. However, workplaces are faced with the reality that not all mental ill health in workers can be prevented by creating a healthy work environment.

Mental health problems constitute a major occupational health problem. These disorders are highly prevalent and lead to substantial productivity losses. Productivity losses in workers with mental health problems are in part caused by absenteeism, but the costs of presenteeism may be 5-10 times higher[4]. Furthermore, the impact of mental health problems goes beyond the consequences in terms of productivity. Over the last decades, research has been emerging highlighting a broader impact of mental health problems, which can be labeled as work functioning problems. Work functioning refers to the health-related capacity of the individual worker to adequately meet work responsibilities. Capability to meet the physical and psychological requirements of the job (capacity to work), the ability to meet formal and informal work responsibilities (quality of work performance), but also the ability to recover after work is affected by mental health problems.

STRATEGIES TO ENHANCE WORK FUNCTIONING AND PREVENT ABSENTEEISM

Strategies to enhance work functioning and prevent absenteeism can target workers on three levels, the general working population (universal prevention), workers at high risk of developing a mental health problems (selective prevention) and workers with a current mental health problem (indicated prevention). The WHO framework for healthy workplaces is an example of a universal prevention strategy. This framework guides workplaces in creating a working environment that promotes, supports and protects the mental and social wellbeing of workers[5]. Despite the face validity of this strategy, it has been proven difficult to demonstrate the effectiveness of intervention that target the working environment[6].

Selective prevention targets high-risk groups for mental health problems. In the work context, this type of prevention may include targeting specific occupational groups. Occupational groups that pose a higher risk of developing a mental health problem are groups such as healthcare workers, physicians and nurses, police officers, and teachers. Alternatively, it may be worthwhile for workplaces to screen for high level of exposure to unfavorable psychosocial work characteristics. High job demands and low control, high effort-reward imbalance, organizational injustice, and bullying are well-known risk factors for mental ill health among workers.

Another preventive strategy is indicated prevention, which focuses on workers with detectable signs or symptoms of mental health ill health. Indicated prevention usually entails screening for symptoms of mental ill health such as stress, depression or anxiety. But workers could also be screened for work functioning problems due to mental health problems. A preventive strategy in nurses and allied health professional that combined screening with advice by an occupational physician was effective in reducing work functioning problems. Moreover, workers had reduced absenteeism and presenteeism

following this intervention, representing a favourable business case for the employer with the costs of the intervention more than recouped within six months[7].

An alternative approach to indicated prevention is to screen for early indicators of mental ill health in workers. Need for Recovery is such a measure, this construct of accumulating work-induced fatigue is captured with an 11-item questionnaire. Need for Recovery has been shown to be predictive of chronic stress and depressive disorders. An advantage of screening for fatigue after work is that this may be associated with less stigma compared to directly assessing depressive symptoms.

STRATEGIES TO ENHANCE WORK REINTEGRATION

When workers suffer from a mental disorder, two main approaches can be implemented to enhance work reintegration. The first approach is to improve the symptoms of the mental health problem the workers is suffering from. As the symptoms pose barriers to return to work, clinical interventions such as psychotropic medication and psychotherapeutic interventions may help workers return to work. However, symptomatic recovery is often not sufficient for a return-to-work, and work-directed interventions are often needed to facilitate returning to work. Work-directed interventions aim to ameliorate the consequences of mental ill health on the ability to work. Some of these interventions target the work itself, by modifying the job task, addressing the causes of the mental health problem at work such as a conflict or (temporarily) reducing the working hours.

In workers who have been off work for an extended period of time, graded return to work, which aims to gradually build up working hours during the return-to-work process, has been found to be a strategy that enhances work participation[8]. Work-directed interventions can also support the worker in dealing with the consequences of their mental health problem at the workplace, such as enhancing their skills to cope with work situations. A Cochrane review on workers with depressive disorders found that adding a work-directed intervention to a clinical intervention reduces sickness absence[9].

While the contours of interventions that are effective in enhancing return to work in workers with mental ill health are starting to emerge, two relevant aspects of work reintegration should not be overlooked. First, workers who are at higher risk of a late return to work or not reintegrating at all may be identified early on. One promising prognostic factor is return to work self-efficacy, the confidence that the workers has in the outcome of the return-to-work process. This factor has consistently been found to be a predictor of successful return to work.

Higher age is another factor that has been found to be a predictor of late return to work in multiple studies. The effectiveness of tailoring interventions to the level of risk of not returning to work should be explored in research over the years to come. Second, interventions may also differ in their effects on the work functioning after a workers has returned to work. In a sample of workers with depressive disorders and in a sample with mixed diagnoses, workers were found to still be impaired in their work functioning after having returned to work. This also implies that return-to-work should not be considered the end of the work reintegration trajectory, but rather is a phase during which interventions may still be needed. However, the effectiveness of interventions on the phase after return to work are still scarce. One study did find that a problem-solving intervention after return-to-work of workers with common mental disorders (stress, depression and anxiety) helped prevent relapse over a period of twelve months[10].

CONCLUSION

The high impact of mental ill health on workers and workplaces alike warrants the implementation of preventive and reintegration strategies. While researchers around the world continue to develop screening strategies and new interventions, occupational health professionals can direct employing organizations to currently available preventive and reintegration strategies.

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