

# Developing an intervention toolbox for common health problems in the workplace

Prepared by the **Health and Safety Laboratory**  
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# Developing an intervention toolbox for common health problems in the workplace

**Dr Nick Kendall and Professor Kim Burton**

Kendall Burton Consulting

30 Queen Street

Huddersfield HD1 25P

**Dr Jennifer Lunt and Dr Nadine Mellor**

Health and Safety Laboratory

Harpur Hill, Buxton

Derbyshire SK17 9JN

**Professor Kevin Daniels**

University of East Anglia

Norwich Research Park, Norwich

Norfolk NR4 7TJ

The Management Standards (MS) approach is a key component of the HSE's 'stress toolbox.' It was developed to reduce the levels of work-related stress reported/experienced by working people in Britain. Although a study by Cox et al, 2009 identified a number of weaknesses and limitations in the current version of the Management Standards, research suggested that there were good prospects for correcting these and building on them to evolve a more generic toolbox.

The aim of the project was to look at the feasibility of developing a toolbox for the management of common health problems in the workplace. Reliable and valid evidence identifies the two most common health problems at work as musculoskeletal disorders and psychological ill-health (stress, anxiety and depression). It was anticipated that the tool could bring together work on work-related stress (ie Management Standards) and musculoskeletal disorders (MSDs) and contribute to HSE's specific aim of developing the applicability of the Management Standards to a wider range of health issues in particular, to extend their scope to cover musculoskeletal disorders.

HSE has concluded that it was not possible to develop the simple health and safety toolbox as envisaged, as the 'model' moved into the 'wellbeing' area and away from HSE's specific remit/responsibilities for workplace health-related issues. HSE acknowledges the work of the researchers and believes that others involved in this area of work are better placed to take forward some of the recommendations.

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# 1. EXECUTIVE SUMMARY

## 1.1. AIM

The project brief was to develop the content for an intervention toolbox for common health problems in the workplace - musculoskeletal, mental health and stress complaints. The intention was to develop a prototype toolbox that can be taken forward to (1) minimise the occurrence of work-relevant common health problems (CHPs) and (2) reduce avoidable sickness absence, healthcare use and long-term disability for CHP complaints that inevitably occur in the workplace<sup>1</sup>.

## 1.2. APPROACH

Development of the intervention toolbox was commissioned by the Health and Safety Executive and undertaken by a consortium comprising KendallBurton Consulting, Loughborough University, and the Health and Safety Laboratory. The development process spanned five phases. Phases were designed to attain each of the project's objectives (page 3). The first phase provided the toolbox's evidence base derived from a review of the scientific literature and a stakeholder survey. It gave rise to an underpinning conceptual model for steering subsequent development. The second phase entailed developing a conceptual framework that specified 'what' (content) should go 'where' (structure) and how the toolbox could be implemented. Expert workshops were also undertaken at the outset of phase two to check the project direction. Phase three produced a draft user-centred toolbox based on the conceptual framework comprising information, advice and a suite of tools. In the fourth phase, the draft web-based toolbox was tested for acceptability and usability with a sample of potential end-users, following which a functional prototype was produced.

## 1.3. FINDINGS/OUTCOMES

*Current approaches:* The scientific evidence on the relationship between CHPs and work indicates that prevention approaches using the conventional hazard-risk-control model, and treatment approaches founded on treatment-cure-participate assumptions, have not yielded the hoped-for outcomes. Underlying dose-response assumptions do not readily translate to CHPs. Their subjective and ubiquitous nature significantly undermines the potential for risk control in the workplace to eradicate CHPs. Furthermore, clinical treatments neither fully alleviate all symptoms nor prevent further episodes. What this means in practice is that current health and safety regulation and guidance, including the Management Standards for Work-Related Stress, although useful for their specific purposes, are not sufficient for managing the workplace consequences of CHPs, and that simply adapting them would be a suboptimal approach. The evidence indicates that this supplementary approach should be more effective than adaptations to existing material. Consequently this new approach represents an *addition* to rather than a *change* to current approaches such as the Management Standards.

*Conceptual model:* The underlying principle for this toolbox recognises that the relationship between employment and health is considered to be close, enduring and multidimensional. A

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<sup>1</sup> All key terms used in this document are outlined in the section Definitions and Glossary. The term 'complaint' is preferred over 'symptoms' due to it being more inclusive of the subjective nature of symptom onset, interpretation, and behavioural responses. Complaint denotes the point at which CHP symptoms are reported. Work-relevance has been used on the basis that CHP symptoms affect and are affected by the workplace irrespective of whether work related factors contributed to their onset.

novel conceptual model was developed to support the toolbox, which was based on this principle and was underpinned by a biopsychosocial approach. A key feature is that it combines evidence both from primary prevention approaches and the delivery of healthcare. This allows direct focus on the interface between work and health, and opens up a new zone of opportunity for proactive initiatives in the workplace. Its primary intent is to facilitate an approach that enables people with CHP complaints to maintain work participation, measured by ability to stay at work or return speedily after absence, thus sustaining productive activity.

The conceptual model spans three key areas: Good work; Good Jobs; Supportive Workplaces. The ability to provide and have 'Good work' stems mostly from actions at the socio-political level through enabling legislation and suitable policy frameworks (e.g. the Management Standards). Work that is both 'good' and safe has become an expected minimum standard in modern societies, but, although necessary, this approach is not sufficient to ensure the health and well-being of workers. To do so requires additional interventions at different levels.

The toolbox therefore focuses on helping line managers, and senior management, to provide Good Jobs for when people are well, and Supportive Workplaces for when they are ill or injured. The core principle is that a Good Job will reduce the likelihood that symptoms of CHPs will be expressed at work, while a Supportive Workplace will enable those who are struggling with health at work to more readily maintain work participation.

Good Jobs are characterised by: balanced demands and a safe work environment; effective and helpful line management; working practices and feedback that lead workers to feel they are valued and respected members of staff; opportunities to use and develop skills; endorsement and opportunities for workers to solve their own problems; encouragement to help workers make their own work better; and, opportunities for social interaction.

Supportive Workplaces are characterised by: commitment from senior management; early provision of factual information and advice; fostering early reporting of work-relevant health problems; keeping in touch; adopting a can-do approach; engaging the person in identifying obstacles to work participation and making a work plan; assessing the job and offering temporary modified work if needed (just to ease the path to usual work); liaising with healthcare practitioners if necessary (using a confidentiality waiver); allowing graduated return to work plans; and, monitoring progress so the plan can be appropriately revised if there are any setbacks.

Good Jobs differ from Supportive Workplaces in a number of ways. Creating Good Jobs is intended as a proactive process applied mainly to groups of workers. The emphasis is on directing coping at demands and resilience, with the intention of reducing the work-relevance of CHPs. Creating Supportive Workplaces provides 'just in time' response for individual workers starting to struggle with CHP symptoms at work. The emphasis is on providing an environment where workers can cope with symptoms, so that unnecessary healthcare, sickness absence and disability can be avoided. The aspiration to Good Jobs and delivering a Supportive Workplace should run in tandem.

*User experience:* The intervention toolbox is named the *Health ↔ Work Toolbox* to convey the interdependency between health and work, and the transferability of its content to a range of health at work issues. The key audience is line managers, backed up by senior management buy-in, since they are pivotal in shaping working conditions. Nonetheless, it has also been designed to appeal to a range of players so that they can direct line managers toward it. Toolbox users will initially encounter content under 'Knowledge', intended to encourage their 'buy-in' (and this includes the business, moral and legal case), deepen their knowledge of the nature CHPs, and prompt them to undertake preparatory activities such as learning about and assessing health



and work culture. The content provided under ‘Good Jobs’ and ‘Supportive Workplaces’ broadly splits into knowledge and tools. Two main groups of tools are provided: those to enable ‘identification’ (Good Jobs or Supportive Workplaces) and a suite of tools to provide solutions and aid their implementation. There are succinct lists of ‘Actions’ for the three key areas: Knowledge, Good Jobs, and Supportive Workplaces. These are linked to concise explanations of *what* to do and *how* to do it. Mechanisms are built in to facilitate organisational learning and review both for Good Jobs and Supportive Workplaces.

*Process:* Being web-based, the toolbox has the benefit of hyperlinks. It has a simple logical structure, and is set out so that no single part is contingent on another part having already been accessed. The only exception to this is that implementing targeted actions is always expected to follow ‘identification’ of what can be done to help provide Good Jobs and Supportive Workplaces.

The majority of the process for identifying obstacles is in the form of guided questioning. This process is quite different from assessment of symptoms, and deliberately avoids confounding obstacle identification with the subjectivity of CHP symptoms. Identification of Good Jobs rests largely on asking about job characteristics. Identification of Supportive Workplaces is based on self-report by workers, or others noticing an individual struggling, or a mixture of both: this is followed by proactive discussion between worker and line manager to identify obstacles to staying at or returning to work.

The toolbox content is provided in three layers of complexity. This allows for variations in the user’s time, skill level, interest and resources. Essential information and actions are uppermost in the structure. Narrative devices such as principles and important ideas are provided throughout to anchor understanding of key values and messages. Case studies are provided as exemplars to facilitate application across settings through the use of underlying principles.

#### **1.4. IMPLICATIONS**

The *Health ↔ Work Toolbox* approach differs from existing approaches, including the Management Standards, for a number of reasons: positioned between conventional risk management and healthcare, it is a supplementary approach; it also emphasises positive factors over and above the prevention of harm; it uses a combination of proactive and responsive elements; it encourages dual responsibility for health between the employer and employee; and, it has scope in enabling people with less than perfect health to remain productive and at work. As such, it provides a ‘comprehensive resource to enable line managers more effectively to tackle the challenges created by work-relevant CHPs.

The expert and end-user feedback, albeit from a relatively small sample, was positive and endorsed the overall direction and approach. There were no significant negative comments, though most respondents expressed a desire for improved design and navigability that future development should take into account. Further professional development around the presentation fell outside of the project scope, but the present results suggest that end users would be receptive to a toolbox of this type.

In principle, the *Health ↔ Work Toolbox* holds considerable potential to augment existing primary prevention strategies and healthcare delivery, thus providing a more comprehensive approach to constraining sickness absence. However, more work will be needed to determine its overall effectiveness during application.

## 2. INTRODUCTION

The following introduction summarises current knowledge about Common Health Problems. More detailed supporting information is provided in the appendices.

### 2.1. WHAT ARE COMMON HEALTH PROBLEMS?

Common health problems (CHPs) refer to health complaints that occur most frequently across the population. They include musculoskeletal, mental health and stress<sup>2</sup> complaints. The main contribution to long-term sickness absence and work disability comes not from serious injury or disease, but from CHPs. Collectively CHPs account for most loss of productivity, sickness absence, suffering, care-seeking and health-related benefit claims (e.g. Waddell & Burton, 2004). Self-reported survey data indicates that an estimated 7.6 million working days were lost to musculoskeletal disorders whilst 10.8 million were lost to stress in Great Britain in 2010/11 (HSE, 2011a). These figures account for 70% overall of the lost days attributed to health and safety at work issues (HSE, 2011b).

### 2.2. CHALLENGES POSED BY COMMON HEALTH PROBLEMS

CHPs are characterised by recurrent symptoms of variable frequency and severity, which tend to co-exist. For example, mental health problems and musculoskeletal pain can occur at the same time. CHPs involve the report of one or more symptoms, yet in most instances there is limited objective evidence of injury, disease or impairment (Waddell & Burton, 2004; Waddell, Burton, & Kendall, 2008).

CHPs have a multi-factorial aetiology, and are influenced by both work and non-work factors. For example, musculoskeletal symptoms may be experienced at work or not, or may be influenced by certain work activities and not others. Similarly, stress symptoms may be experienced at work and also at home to varying degrees. Mental health problems (e.g. anxiety, depression) can arise from diverse sources, many of which are unrelated to work, but they are experienced by workers and non-workers alike (Foresight Project, 2008). Evidence for exclusive occupational causation of most CHPs is contentious, inconsistent or lacking. While work may not directly or solely cause the majority of episodes of CHPs, disadvantageous aspects of job design lead to symptoms being more pronounced and bothersome, and may temporarily reduce the person's ability to work. In this sense, CHPs can manifest as *work-relevant* complaints. That is, health complaints which, irrespective of cause (work or non-work), are experienced at the workplace to a greater or lesser extent, and which in turn impact on the performance of a worker (Waddell & Burton, 2004).

The ubiquity and subjective nature of CHPs, along with frequently co-existing symptoms and complaints, pose a major challenge for CHPs' accurate identification and treatment. Nevertheless, the successful management of CHPs should be achievable, and long-term problems are not inevitable. In occupational terms, the consequences are more important than any (assumed) pathology: With the right support, most people can remain active and stay at work or achieve early and sustained return from sickness absence (Waddell & Aylward, 2010; Seymour & Grove, 2005). Defining and effectively delivering that 'right support' has proved a substantial challenge (Waddell et al, 2008).

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<sup>2</sup> In this report the term 'stress' is used to describe the subjective experience of 'feeling stressed'. It is recognised that 'stress' lacks case definition, is not a diagnosis per se, and current taxonomies do not contain clinical criteria.

The inability to reliably and validly differentiate those people with CHPs from those without them is a major obstacle to efforts aimed at preventing and managing them effectively (Talmage, 2010).

### **2.3. CURRENT APPROACHES FOR MANAGING COMMON HEALTH PROBLEMS**

Current approaches to reduce the incidence and prevalence of CHPs appear to be less than exhaustive, given the significant number of CHPs reported at the workplace. Some of this may be due to the complexity and subjectivity of CHPs that give rise to the challenges outlined above. However, over recent years a clear paradox has arisen. Sickness absence and work-relevant disability attributable to CHPs has risen despite a reduction in physical work demands, uptake of approaches aimed at primary prevention, and improved access to healthcare (Waddell & Burton, 2004).

Current preventive approaches of ill health at work, such as the Management Standards for Work-Related Stress, focus on elimination or reduction of known causative agents (risk factors). These approaches are most effective when there is a demonstrable link between exposure and outcome. However, the evidence indicates that for CHPs this link is confounded by multiple factors and often accompanied with small effect sizes (e.g. Fergusson et al, 2006, Semmer, 2006). In this context, preventive interventions can lack relevance, be untimely, and inadequately address the gamut of factors that precipitate symptom onset or complaint.

People with CHPs may need healthcare to control symptoms, but healthcare interventions alone seldom influence occupational outcomes. There is reason to conclude that over-reliance on healthcare can itself have negative consequences by encouraging effects such as passivity and dependence rather than active participation and responsibility.

### **2.4. CASE FOR A NEW APPROACH**

There is need for an integrated approach that facilitates timely, relevant and practical identification and management of CHPs in order to minimise both their occurrence and impact. If one of these outcomes cannot be achieved effectively in any given instance (e.g. occurrence) then we must focus on the other, and vice-versa. Leaving occurrence and impact disconnected may be sub-optimal for managing the work-relevance of CHPs. A new approach should draw on a biopsychosocial rather than a simple biomedical perspective of health. Through recognising health outcomes as the function of the interplay between biological, psychological and social variables, this model enables the subjective nature of CHPs to be more clearly understood (Burton et al, 2008, Lunt et al, 2007). Furthermore, a new approach should aim to get all the players onside and acting consistently, to stimulate managers to provide Good Jobs and encourage the workplace to be accommodating and supportive for people with work-relevant CHPs. The approach will also need to encourage a positive work-health culture, and to enable workers to cope with reasonable job demands both when they are well and when they are not.

An important target is enabling people with CHPs to stay at work, or return to work in a sustainable manner. The aspiration is reduction of work-relevant CHPs, leading to fewer cases requiring healthcare or prolonged sickness absence, and a minimal number progressing to long-term disability. A new approach to CHPs management needs to encourage progress toward workplaces that enable people to flourish when they are well and to be supported when they are ill or injured.

The stimulus for developing a conceptual model that integrates a focus on both minimising the occurrence of CHPs and their impact was derived from a statement espoused by noted occupational medicine theorist Nortin Hadler in 1997. Hadler stated that 'work should be comfortable when we are well and accommodating when we are ill or injured'. This concept

was understood to refer to work with an agreeable quality (comfortable) in a workplace where key people are responsive (accommodating). These aspects of work have been separately investigated with respect to CHPs, but to date those findings have not been combined to underpin relevant interventions.

It was recognised that the terms ‘comfortable’ and ‘accommodating’ may hold some ambiguity to the general public and people in the workplace. While they are used in this technical report to reflect the foundation for the development of the conceptual model, they are replaced in the Toolbox with terms better suited to its intended environment: comfortable jobs become Good Jobs and accommodating workplaces become Supportive Workplaces.

## **2.5. RESEARCH OBJECTIVES**

The overall aim of this project was to develop an Intervention Toolbox for managing CHPs at the workplace, which complements current policy and regulation but fills the gaps in existing guidance and advice. The objectives of the research were to:

1. Identify factors specific to each of the main CHPs and factors shared between the main CHPs that contribute to the:

- (a) Development of CHPs, i.e. the onset of symptoms
- (b) Reporting or complaint of CHPs as a problem, especially in the workplace or to a clinician (since this leads to time off work)
- (c) Persistence of CHPs, with the greater emphasis on behavioural outcomes (especially withdrawal from participation in productive activity) rather than symptoms.

2. Provide a conceptual understanding for important relationships between the main CHPs (with respect to comorbidity and co-occurrence), and the relationship between symptoms and level of function (focusing especially on participation in work).

3. Investigate if and how the Management Standards for work-related stress need to be adapted to accommodate factors implicated in the development and persistence of CHPs. This will include consideration of wider organisational variables as well as work and health-related individual factors.

4. Establish if and how HSE’s risk assessment approach could be adapted so that it captures factors relevant to the development and persistence of CHPs.

5. Determine what alternative approaches would be relevant that encompass a positive model of well-being as well as the deficit model of stress and all biopsychosocial levels. Consider how these approaches might be adapted to sit alongside the Management Standards in an integrated framework. In particular, the potential role of BPS model and the Psychosocial Flags Framework will be determined.

6. As part of an integrated framework, develop:

- (a) Parsimonious explanatory model (one model or a set of inter-linked theories) that conveys how CHPs are developed and maintained. This will inform the content of the assessment component of the framework.
- (b) Process/procedure for assessing CHPs, involving workers and identifying relevant solutions and their cost-benefits. This will inform the process that will underpin the framework.
- (c) Suite of solutions (including interventions) for addressing assessment outcomes that minimises occurrence of CHPs, associated sickness absence, and supports staying and returning to work.

7. Test the framework's feasibility and usability credentials on a representative sample of end users and intermediaries (e.g. inspectors, lawyers etc) who would also be using the framework.

## **2.6. OVERALL APPROACH**

To meet the project's objectives the toolbox development spanned five phases (see Table 1). A multiphasic approach permitted logical progression from establishing the evidence base through to production of a usability-tested, evidence-based and user-centred toolbox. Doing so allows the rationale underpinning the structure and content of the final toolbox to be traced back to the evidence. The phases were as follows:

- Phase 1: Evidence synthesis of the current scientific evidence base, establish stakeholder needs, and produce a conceptual model. This would provide the foundations for subsequent toolbox development.
- Phase 2: Production of an evidence-based conceptual framework on which to 'hang' tools.
- Phase 3: Production of a draft user-centred intervention toolbox.
- Phase 4: Usability testing of the draft toolbox.
- Phase 5: Toolbox refinement in light of usability testing and report preparation.

A consortium comprising KendallBurton Consulting, Loughborough University, and the Health and Safety Laboratory developed the toolbox. The consortium regularly met face-to-face and via tele-meetings to progress the phases. Stakeholder engagement and end-user consultation was built into key stages of the project. Customer consultation occurred at key project milestones. The consortium is referred to as the research team hereon.

## **2.7. CAVEATS**

A paper-based toolbox was originally envisaged. However, during project development a web-based version using all the advantages of hyperlinking was identified as more suitable for capturing and communicating the toolbox layout and structure, and for providing easy access to the tools. A full-scale impact evaluation and development of a professionally designed web-based toolbox fell outside the scope of this project. Consequently the toolbox design requires refining and evaluating prior to its implementation.

To maximise the practicality of the toolbox, it focuses on minimising and managing 'complaints' rather than 'symptoms'. This was decided on the basis that complaints represent the point at which CHP symptoms are reported. Complaints are considered more inclusive of the subjectivity surrounding CHPs because they incorporate coping and behavioural responses. CHPs symptoms are deliberately framed as '*work-relevant*' so that that the toolbox takes account of the direct or indirect impact that symptoms can have upon work, and work upon symptoms, irrespective of whether the causes of CHP symptoms were due to work. Introducing the concept of work-relevance also helps to distinguish symptoms that impact on work ability from those everyday symptoms with which people cope.

**Table 1: Approach Summary**

	<i>Aim</i>		<i>Method</i>		<i>Output</i>
<b>Phase 1</b>	Generate the toolbox's evidence base.	Best evidence synthesis	<ul style="list-style-type: none"> <li>Literature Review (best evidence synthesis)</li> <li>Stakeholder workshops (x2) on CHP needs &amp; problems</li> </ul>	<ul style="list-style-type: none"> <li>Best evidence synthesis literature review (Appendix 1)</li> <li>Conceptual model (Appendix 1)</li> <li>Project definitions (Appendix 1)</li> <li>Stakeholder feedback (Appendix 2)</li> </ul>	
<b>Phase 2</b>	Develop an evidence based framework to 'hang tools on'	Consensus driven decision making & action	<ul style="list-style-type: none"> <li>Workshops (x2) (expert &amp; end-user)</li> <li>Team meetings</li> <li>Mapping content onto the literature review</li> </ul>	<ul style="list-style-type: none"> <li>Conceptual Framework encompassing (Appendix 3):</li> <li>Workshop summary (Appendix 4)</li> </ul>	
<b>Phase 3</b>	Develop a draft user-centred intervention toolbox	Consensus driven decision making & action		<ul style="list-style-type: none"> <li>Draft tool-box (print and web versions)</li> </ul>	
<b>Phase 4</b>	Usability test the toolbox	End-user survey	<ul style="list-style-type: none"> <li>Electronic survey</li> <li>Telephone interviews</li> </ul>	<ul style="list-style-type: none"> <li>Usability testing feedback (Appendix 5)</li> </ul>	
<b>Phase 5</b>	Toolbox refinement and production of final report	Feedback assimilation		<ul style="list-style-type: none"> <li>Toolbox prototype (web-version) (Appendix 6).</li> </ul>	



### 3. PHASE ONE: EVIDENCE SYNTHESIS

#### 3.1. EVIDENCE REVIEW: METHOD

##### 3.1.1. Aim

A literature review was conducted to generate the evidence-based foundations of the toolbox. A conceptual model was also produced during the literature review to highlight levels of intervention and position relative to current approaches. Research questions addressed by the review are outlined in Table 2. The literature review encompassed two main activities. First, the research team’s existing knowledge for each of the topics listed in Table 2 was consolidated. Secondly, all knowledge gaps identified became a search topic. These predominately related to the generic issues outlined in Table 2. Full details of the review method and findings are provided in Appendix 1.

**Table 2:** Research Questions for the Literature Review

<i>Topic Area</i>	<i>Research Question</i>
For each work-relevant common health complaint (stress, musculoskeletal disorders, mental health)	<ul style="list-style-type: none"> <li>• What is the <i>nature</i> of the (work-relevant CHP complaint)?</li> <li>• What are effective work-relevant <i>interventions</i> for (work-relevant CHP complaint)?</li> <li>• How can work-relevant interventions for (work-relevant CHP complaint) be implemented effectively?</li> <li>• What does a Good Job look like?</li> <li>• What does a Supportive Workplace look like?</li> <li>• How are different work-relevant CHP complaints related?</li> </ul>
Generic issues	<ul style="list-style-type: none"> <li>• How do existing conceptual models explain the nature of work-relevant CHP complaints and how can these be improved?</li> <li>• How are and should CHP complaints be assessed?</li> </ul>

##### 3.1.2. Design

A ‘best evidence synthesis’ was used. The overall review method followed well-established principles for using literature reviews, meta-analyses, and conceptual papers (e.g., Waddell & Burton, 2004; Waddell & Burton 2006; Fergusson et al. 2006; Richardson & Rothstein, 2008; Rick et al, 2002). The conceptual model arising from the literature review was arrived at through a series project team discussions and consensus based decision-making.

##### 3.1.3. Search Strategy

Wherever possible, the primary source of evidence comprised existing high quality reviews. When these were not available, appropriate individual studies and articles were sought. To reflect current knowledge, articles published between January 2000 and September 2010 were eligible for inclusion. A comprehensive and systematic literature search was conducted using multiple sources covering electronic databases, internet searches and hand searches.



## **3.2. EVIDENCE REVIEW: KEY FINDINGS**

Appendix 1 contains a detailed report of the literature review and best evidence synthesis. An overview is provided here, with a summary in Box 1.

### **3.2.1. Nature of CHPs**

CHPs incur considerable cost to employees, employers and organisations. Collectively they account for most productivity loss, sickness absence, suffering, care-seeking and health-related benefit claims. CHPs also result in significant suffering to individuals and their families. CHPs are characterised by symptoms rather than disease or damage. They can be work-relevant. This means the person may have difficulty performing their usual activities for a period of time, irrespective of the causes. In most cases there is limited objective evidence of injury or disease cogently related to the work exposures. However, the experience of symptoms at work often encourages the false belief that work is mainly or wholly responsible. This is one example of important beliefs that serve as myths needing to be challenged.

Symptoms tend to be recurrent and CHPs can be described as having an untidy pattern of episodes with variable frequency, severity, and impact. Furthermore, multiple symptoms frequently coexist, both within and between the main categories (e.g. musculoskeletal, mental health and stress complaints). However, coexisting symptoms does not necessarily imply a common genesis.

A biopsychosocial approach is widely considered as optimal to underpin initiatives such as an intervention toolbox to reduce the impact of CHPs in the workplace. This perspective outlines the contribution and roles of cognitions, affect, behaviours and their interactions. It has led to the development of effective treatment paradigms, e.g. for fear-avoidance cycles.

CHP complaints are capable of leading to disabling consequences, but with the right support, opportunities and encouragement, people with CHPs do usually maintain (or return to) their usual level of participation in activity and work, and usually do not seek healthcare.

The subjective nature and ubiquity of symptoms makes it difficult to differentiate on objective or clinical grounds between those who complain and seek help and those with the same problems who do not. Therefore a 'case' should not be determined simply in terms of the presence of symptoms, but rather by the extent to which the symptoms are sufficiently bothersome to trigger one or more of the following: a complaint (reporting); care-seeking; a struggle to be active; a struggle to attend work.

### **3.2.2. Current Approaches**

Conventional approaches for managing CHPs to date concern either risk management or delivery of healthcare. The evidence indicates that these approaches can be effective for serious occupational injury and disease, but they are less than optimal for CHPs. This conclusion is underscored by the observation sickness absence attributed to CHPs have not reduced as expected since the launch of the Management Standards. In part this may be because the Management Standards (HSE, 2012) focused on stressors arising from the immediate work environment and placed less emphasis on individual the level than the biopsychosocial approach.

Risk management assumes that risks and hazards are known and understood; that they can be accurately identified in practice; and that, once they have been identified they can be prevented or controlled. The ubiquitous and subjective nature of CHPs, their gradual onset, varying

patterns of patterns of frequency, difficulties in isolating causes, and absence of a dose response relationship mean that CHPs cannot totally be prevented through changes in work practices.

Likewise healthcare based on the biomedical model predicts a dose response relationship between *treatment* → *cure* → *return to activity and work*. However, this may exacerbate disability through iatrogenic<sup>3</sup> processes. The focus for managing CHPs needs to shift from primary prevention and treatment to managing the consequences and responses to CHP symptoms in such a way that unnecessary use of healthcare and sickness absence is avoided. The focus on who has responsibility for CHP management should shift from either being seen as exclusively either employees or managers to one of dual responsibility. The drawbacks of current approaches are summarised in Figure 1.

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<sup>3</sup> *Adverse treatment outcomes caused by treatment or diagnostic activities.*

□

### *The Nature of CHPs*

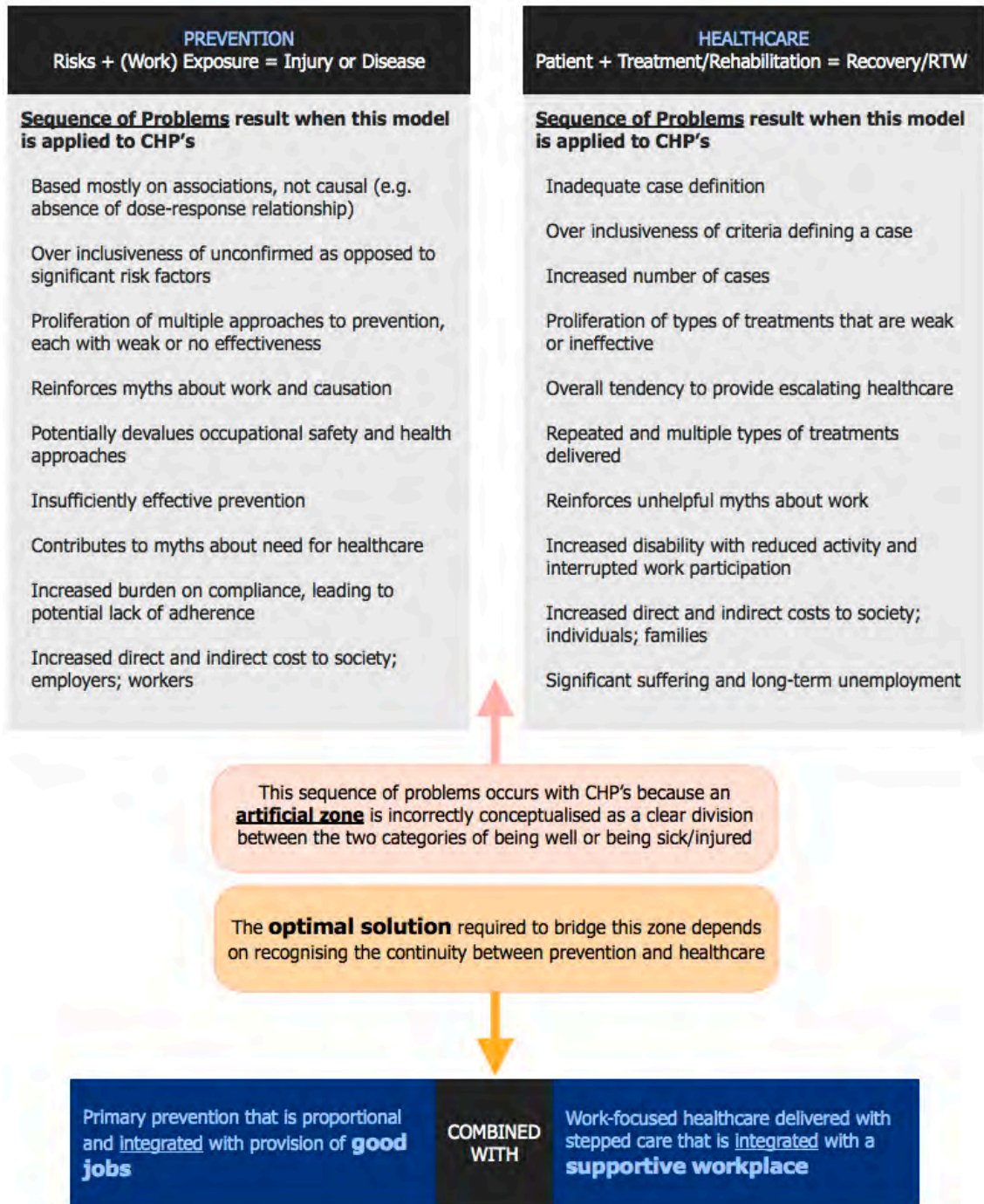
- CHPs are extremely common across the population, and not confined to working age.
- CHPs tend to display an untidy recurrent pattern across the life course with variable periodicity and severity: multiple symptoms and complaints frequently coexist.
- CHPs in the workplace extract enormous societal, commercial, and personal costs, yet the adverse consequences can usually be avoided through relatively low-cost workplace interventions.
- Most episodes of CHPs do settle without healthcare or sickness absence. Some episodes persist: sickness absence is driven more by psychosocial issues than severe illness or injury.
- CHP symptoms often coexist, both within and between CHP categories, but this does not necessarily mean a common genesis
- The biopsychosocial approach helps explain subjective aspects of CHPs such as the role of myths in withdrawal from usual activities and variation in symptom interpretation, response and reporting. It accounts for multifaceted influences upon CHP symptoms.

### *Current Approaches*

- Attempts to control physical and psychological stressors in the workplace have not managed to reduce the incidence and prevalence of CHPs, or their substantial occupational impact. The commonly identified risk factors generally have small and inconsistent causal effects, yet they are related to the work-relevance of symptoms.
- Though job stressors may directly generate some episodes, the potential for further preventive impact from the hazard-risk-control approach seems small.
- Control of subjective symptoms through healthcare may be needed, but typical healthcare interventions do not address occupational outcomes. Furthermore, they can be detrimental by encouraging passivity and dependence (iatrogenic disability).
- Between conventional prevention and typical healthcare lies a 'zone of lost opportunity' – this zone has not so far been considered as a viable locus of intervention but may be more appropriate because of the progression and development of the work-relevance of CHPs.

### *Implications for CHP management*

- While work may not directly cause the majority of episodes of CHPs, the experience is frequently **work-relevant** so that aspects of the job can make symptoms more pronounced and more bothersome. Equally symptoms can make usual work difficult or even impossible.
- Subjective symptoms are the predominant complaint. This makes diagnostic criteria unreliable, and defining a 'case' is very problematic. In occupational terms for CHPs, a case can best be defined as an episode where the symptoms are sufficiently bothersome to trigger one or more of the following: a complaint (reporting); care-seeking; a struggle to be active; a struggle to attend work.
- The 'zone of lost opportunity' can be permeated with more effective workplace interventions that focus on preventing where possible but also on managing the consequences of CHPs without recourse to avoidable healthcare or sickness absence. Doing so would mean people with CHP symptoms can **stay at work** and stay productive but require that managing CHPs effectively is perceived as the **dual responsibility** of employees and managers.



**Figure 1.** The major problems with using a simple model for occupational health and safety and the delivery of healthcare interventions and rehabilitation for CHPs, together with optimal solutions

### 3.2.3. Conceptual Model for a New Approach

The conceptual model developed indicates the scope of the toolbox content, in terms what levels of intervention it covers and the boundaries between these areas. It also indicates the position of the toolbox in relation to other national interventions and provision relating to health at work. Key messages concerning the conceptual model are provided in Box 2.

### 3.2.4. Levels of Intervention

Conventional risk-management and healthcare approaches may be necessary but are not sufficient for tackling work-relevant CHPs. Developing a new supplementary approach (see Figure 2) requires understanding that the complex relationship between work and health is fundamental to devising effective interventions and for complementing key government strategies. This involves a number of important concepts that are related, yet distinct: occupational safety, good work, comfortable jobs, and accommodating workplaces. Work is generally good for physical and mental health and well-being (Waddell & Burton 2006). Furthermore, participation in work can be therapeutic for people with all types of common health problems (Waddell et al. 2008). The important proviso is that it depends on the nature and quality of work, and on social context. The constituents of ‘good work’, ‘comfortable jobs’ (called Good Jobs for the user-centred toolbox) and ‘accommodating workplaces’ (called Supportive Workplaces for the user-centred toolbox) necessarily depend on occupational safety as a prerequisite but involve much more as well.



**Figure 2.** Relationships and intervention levels for good work, Good Jobs, and Supportive Workplaces

*Good Work:* Work that is both ‘good’ and safe has become an expected minimum standard in industrialised societies, but it is not sufficient to fully ensure the health and well-being of workers. Provision of ‘good work’ (which necessitates occupational safety) is primarily fostered at the level of the society, through enabling legislation and suitable policy frameworks. Being

without work is rarely good for one's health, but while 'good work' is linked to positive health outcomes, jobs that are 'not good work' (e.g. insecure, low-paid and lack of protection from stressors and danger) may make people ill. The toolbox is not intended to operate at this level. Good work is taken as a given. Effective CHP management additionally requires jobs to be 'comfortable' when people are functioning well, and for workplaces to be 'accommodating' when people are struggle with CHP complaints.

*Comfortable Jobs:* The provision and experience of a comfortable job derives in the main from the systems and processes that exist in the workplace, including work organisation and the quality of management. All the features required for 'good work' may be in place, yet the job may not be one that prevents harm or promotes health. Clearly, many jobs retain some aspects that may be considered unpleasant or uncomfortable, and this cannot practicably be avoided. The nature of a job is likely to influence a person's sense of job satisfaction, either for better or worse. Job satisfaction can also reciprocally influence the perception of whether a job is comfortable or not. Highly satisfied workers may exhibit higher resilience in coping with less comfortable aspects. The perception of what is 'comfortable' is subjective and varies between individuals. A comfortable job is characterised by the following:

- *Outcomes:* Reduces the likelihood of complaints (about symptoms, the job, and the organisation), and may (in principle) reduce the incidence of episodes of complaints (both physical and mental).
- *Aspiration:* Fosters job satisfaction, resilience and well-being: it increases the probability for workers to progress towards personal goals and values that will give them satisfaction or to engage in activities they find intrinsically enjoyable. Consequently, a comfortable job represents an aspirational set of working conditions.
- *Builds on good work:* Goes beyond safety, and the need to prevent harms.
- *Coping with unavoidable risk.* Minimises discomfort (both perceived and actual) and takes account of physical and psychosocial comfort/needs.
- *Proactivity.* Usually involves delivery of proactive strategies and coping responses that become relevant at the point when work demands start to tax (see Figure 3)
- *Target:* Comfortable jobs aimed at the whole group of workers but may involve consideration of aspects of a job at the individual level.
- *Perception:* Is subjective, and varies between individuals and across time.

*Accommodating Workplaces:* Accommodation takes place principally at the individual level. The requirement for, and type of, workplace accommodation is necessarily tailored to the needs of the individual, although its availability invariably depends on workplace policy. The worker-line manager relationship appears key to making it happen effectively. An accommodating workplace is characterised by the following:

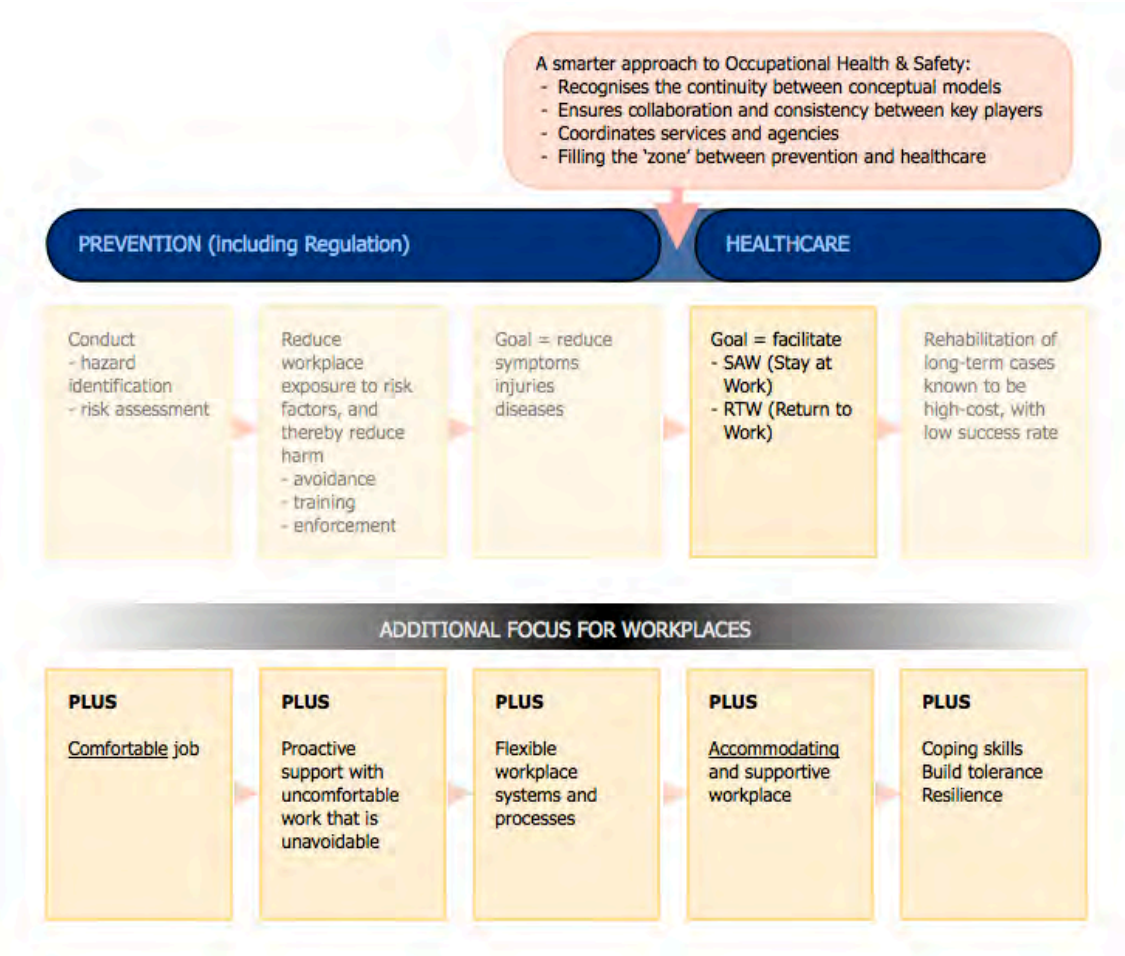
- *Outcomes:* Reduces lost productivity and sickness absence.
- *Struggling:* Is flexible enough to allow and offer temporary helpful individual-level changes when a workers experiencing common health problems, and is having short-

term difficulty with coping. It becomes essential once individuals start to struggle with CHP complaints at work (see Figure 3).

- *Noticing*: Is contingent to the responsiveness of line managers and other in noticing struggling individuals.
- *Temporary changes*: Can offer changes in a variety of domains tailored for the individual worker: work organisation, job tasks, job demands, etc. Allows worker to achieve an acceptable work-life balance.
- *Coping with symptoms*: Enables individuals to perceive themselves as in control of their symptoms
- *Outside influences*: Has some measure of flexibility to accommodate the impact on work from life events outside of work.
- *Fairness*: Is perceived as fair practice by colleagues.
- *Runs* in tandem with comfortable jobs

### **3.2.5. Supplementary Position**

The model is an evolutionary solution, containing novel concepts. It is intended to supplement, not replace, current approaches initiated at a national level. As denoted in Figure 3, it is positioned between primary prevention and healthcare. It recognises that there is no sharp artificial division between the concepts of being healthy/uninjured, versus being sick/injured; and that this is especially true for symptoms of CHPs. Therefore, the toolbox aims to facilitate work participation whether or not people are sick or injured, by bridging the gap between preventive interventions and healthcare provision.



**Figure 3.** Comprehensive OH&S Model recognises additional focuses for workplaces



- - The conceptual model represents the theoretical foundations of the toolbox. It spans all layers of the biopsychosocial model. Good work applies to the societal level. Good (comfortable) jobs applies to the organisation and job level. Supportive (accommodating) workplaces applies to the individual level
  - The nature of work is important: ‘good work’ is good for health and well-being. Good work entails numerous social structures as well as fundamental precursors including safety of workers. Good work may be necessary, but it is not a sufficient condition to control work-relevant CHPs. The quality of the job is important. A Good Job is a comfortable job in a supportive work environment, where the workplace accommodates people struggling with work-relevant CHPs. Good management is the key to comfortable jobs and accommodating workplaces. Creating Good Jobs and Supportive Workplaces formed the focus of the toolbox.
  - The conceptual model is positioned between current primary prevention and healthcare. It fills a ‘zone of lost opportunity’ in enabling people with CHP symptoms to stay at work. Consequently, the toolbox supplements several current approaches and does not replicate existing primary preventive or healthcare approaches. These will be assumed as already in place.
  - Good Jobs differ conceptually from Supportive Workplaces as follows:

	<i>Good Jobs</i>	<i>Supportive Workplaces</i>
<i>Who for?</i>	Groups	Individuals
<i>When (most applicable)?</i>	Continual	When individuals start to struggle with CHP symptoms
<i>Coping target</i>	Focuses on demands and resilience	Focuses on symptoms
<i>Changes</i>	Ongoing	Temporary
<i>Style</i>	Proactive and aspirational	Reactive
<i>Outcomes of interest</i>	Reduced CHP complaints/ ‘caseness’	Reduced sickness absence lost productivity & long-term disability

### **Box 2: Key Messages for the Conceptual Model**

## **3.3. STAKEHOLDER SURVEY: METHOD**

### **3.3.1. Aim**

A stakeholder survey was undertaken to obtain experts’ and potential end-users’ views on the challenges posed by managing CHPs and any improvements necessary for improving current guidance. Full details of the method are provided in Appendix 2. Key messages are provided in Box 3.

### **3.3.2. Design**

A small-scale survey was performed using an electronic survey asking a mixture of open and closed questions. Views were sought on: the extent to which CHPs were considered a problem; potential difficulties in preventing CHPs; potential difficulties in managing CHPs; sources of

advice/guidance; improvements needed for current advice/guidance; characteristics of useful advice/guidance; characteristics of poor advice/guidance and background information (age, gender, role, company type, industry sector etc.).

### **3.3.3. Questionnaire Development**

Questionnaire development was iterative. An initial draft agreed with project team was piloted on five potential end users and then agreed with the HSE customer.

### **3.3.4. Procedure and Sample**

Experts were defined as those with specialised knowledge of CHPs, either through contributions to relevant research, policy development and policy implementation, or through professional and specialised work around CHPs (e.g., medical practitioners specialising in CHPs, insurers, legal advisors). End users were defined as those people responsible for or involved in service implementation and delivery, and included HR professionals and general managers. A web-based version of the questionnaire was administered to 110 experts and 4334 end users (These were sampled from an HSL marketing database of experts and the HSE MINT database). Participants were given two weeks to respond to the survey. In total, 218 end users and 28 experts responded. Open questions were analysed using template analysis. Predominantly descriptive statistics were produced for the closed questions. Inter-rater agreements were conducted for 15 end users and 14 experts, and indicated consistency in how responses were coded.

### **3.3.5. Stakeholder Findings**

Findings are based on 218 end users and 28 experts, giving a response rate for each category of 5% and 25% respectively. Further details are available in Appendix 2. A summary of key messages is provided in Box 3.

### **3.3.6. Perception of CHPs as a problem**

Differences between end users and experts emerged on the extent to which CHPs were judged to be a problem. End users considered CHPs to be moderate problem. Experts considered CHPs to be a significant problem especially in relation to absence they cause from the workplace.

Participants from the smallest companies considered CHPs to be even less of a problem. Participants from sectors with higher physical work demands considered CHPs to be less of a problem than participants from sectors with lower physical demands. This may be because musculoskeletal problems might be more straightforward to deal with. Most participants considered stress and mental health as the most difficult CHPs to deal with, and cited the complexity of CHPs as the reason why CHPs are difficult to manage.

### **3.3.7. Managing and preventing CHPs**

Experts generally thought that CHPs are best prevented through job/organisational redesign (including manager training) and person-focused interventions may be integrated with job/organisational redesign. End users were more likely to think that CHPs are best prevented through person-focused interventions, personal training and manager support for individuals, compared to other forms of intervention.

Participants from smaller organisations and from physical demanding sectors were more likely to favour person-focused approaches than other approaches. However, sizeable minorities of end users also mentioned job/organisational redesign and information provision as effective means of prevention. Many participants indicated the need to take into account individual differences, beliefs and coping abilities in interventions.

### 3.3.8. Advice and guidance

There were a range of views expressed in the survey on CHPs that might need to be addressed in advice and guidance to ensure credibility across a range of stakeholders. First, advice and guidance may need to acknowledge that some people view CHPs as a cultural/societal problem that may not easily be tractable. In contrast, advice and guidance may also need to acknowledge the view held by some that CHPs are not really a problem at all or at least not a problem that organisations should have to deal with. Advice and guidance may need to recognise CHPs complexity and recognise the need to focus prevention and management at multiple levels (personal, manager, job, organisation) through integrated and consultative interventions. Advice and guidance may also need to portray the beneficial aspects of work.

In general, experts and end users in the sample felt that good advice and guidance should be:

- a) Actionable, including information that is concrete and focused on specific problems, with clear advice on actions yet flexible enough to allow tailoring of actions to specific circumstances – specificity of actions may be particularly useful for those in larger organisations;
  - b) Enticing, including a focus on user requirements and expressed in straightforward, evidence-based language by credible sources that are perceived to be neutral, and using visual media where appropriate;
  - c) Easily accessible and pointing end users to good advice rather than poor advice;
  - d) Supported, especially through the use of flexible media and with follow-ups such as training.
- 
- Expert and end-users differ in their perceptions of the challenges posed by work-relevant CHPs. This may be a function of the accuracy of underlying knowledge.
  - Stakeholders consider multi-level interventions as necessary for tackling CHP complaints.
  - According to stakeholders, good advice and guidance is actionable, enticing, easily accessible, and supported by flexible media and follow-ups.

**Box 3:** Key messages from the stakeholder survey.

## 4. PHASE TWO: DEVELOPMENT OF THE CONCEPTUAL FRAMEWORK

### 4.1. WORKSHOPS: METHOD

#### 4.1.1. Aim

Expert workshops were undertaken at the beginning of phase two to obtain early feedback on the project's direction, with regard to the interpretation of the literature, ideas for the shape of the toolbox, the conceptual model and factors to consider in developing the toolbox. Full details of the method are provided in Appendix 3

#### 4.1.2. Sample

Two one-day long workshops were convened, one with experts from outside of HSE (n = 6) (academics, organisational consultants, medical practitioners and expert end users) followed by one with HSE experts (n = 4) (staff with expertise or special interests in aspects of CHPs).

#### 4.1.3. Procedure

Prior to the workshops, participants were sent a summary of the literature review outlining the overall approach and definitions of major concepts of relevance to the project, plus a briefing document explaining the purpose of the workshop and asking participants to consider a range of questions before the workshop. These questions are listed in Box 4.

- - *Is the overall evidence synthesis comprehensive?*
  - *Does the proposed framework facilitate a new approach to CHPs?*
  - *Has this, or other, approach been used elsewhere?*
  - *Are there any interventions that might help to prevent onset of CHPs and/or associated symptoms, which are not already included in standard approaches?*
  - *What can be done to make jobs more comfortable?*
  - *How can struggling workers be identified?*
  - *How can we avoid over-identifying less significant problems?*
  - *What can be done to improve coping with work-relevant symptoms?*
  - *How can resilience be built to deal with unavoidable aspects of work that are unpleasant or uncomfortable?*
  - *What type of plan is required in the workplace, and who needs to be involved?*
  - *What role is there for problem-solving approaches?*
  - *Are there any specific workplace interventions that are reasonably practicable, feasible and effective?*
  - *What can be done to facilitate accommodating workplaces?*

#### **Box 4: Briefing Questions for the Expert Workshops**

The workshops started with a presentation of key findings from the literature including a description of the conceptual model. Questions were taken as the workshops proceeded, and open-ended debates on key issues in toolbox development related to an indication framework, identifying relevant solutions and implementing solutions. Issues debated concerned: good practice; fit for purpose tools; obstacles and enablers; assessment/identification, solution and implementation. Notes from the workshop were summarised and key themes identified and circulated to project team members for agreement.

## 4.2. WORKSHOP: KEY FINDINGS

Overall, findings from the workshops indicated that experts had a mostly favourable opinion of the project team's emerging interpretation of the literature and the conceptual underpinnings of the toolbox, as outlined in the literature review. They however, raised a number of issues, which they think the toolbox should address and these are briefly outlined below. Further details are available in Appendix 3:

- Individual differences in the prevention and accommodation of CHPs should be taken into account through regular line management meetings and development appraisal processes.
- The toolbox should focus on preventing and managing work-relevant CHPs and not represent medically based interventions in the toolbox.
- The word 'comfortable' should not appear in the toolbox, as it might imply work that is too easy and lowered motivation. An alternative term is needed.
- The toolbox needs to take into account line managers' competencies if managers are expected to take a role in CHP assessment and intervention. It needs also to have a means of dealing with line managers if they are problematic (e.g., bullying behaviour is attributed as a cause of CHPs).
- The toolbox should not encourage presenteeism.
- It would be useful if senior management commitment to preventing and managing CHPs could be included in the toolbox, as senior management commitment seems to be a crucial element of implementing interventions.
- It is important to take into account normative beliefs in the population concerning CHPs and their relation to work.
- Management of expectations is needed to create realistic perceptions over the amount of effort required and pace of change.
- It may be necessary to account for background reporting trends (e.g. generated by increased media attention) and reporting cycles stemming from economic shift patterns, seasonal effects, symptom frequency and duration.
- Efforts are needed to discourage unnecessary reporting of CHP complaints generated by raised awareness of CHPs.

Most of the suggestions from experts reinforced the project team's interpretation of the literature and wherever possible these suggestions were integrated in the design of the final toolbox or recommendations for its implementation. In line with experts' view suggesting the role of normative beliefs for effective management of CHPs, we conducted a further literature search. This uncovered few relevant studies on normative beliefs (see Box 5 for key messages).

- - Expert views generally affirmed the interpretation of literature and direction taken by the conceptual module.
  - The toolbox should allow for alternative courses of action where relationships with line manager are too poor for them to be used as the main agent of change.
  - The potential for background reporting trends and population normative beliefs to skew CHP symptom reporting was not verified by formal evidence.
  - The toolbox should avoid prompting presenteeism and reporting of CHP symptoms that might not otherwise have become a case.
  - User-centred alternatives should be produced for technical terms.

### **Box 5: Key Messages from the Expert Workshop**

## **4.3. CONCEPTUAL FRAMEWORK: METHOD**

### **4.3.1. Aim**

Framework development entailed specifying ‘what’ (content) should go in the toolbox, and ‘where’ (structure) based on the conceptual model produced by phase one. Emphasis was placed on identifying the range of potentially relevant ‘tools’ that also mapped onto phase one findings. The conceptual framework would subsequently provide a resource for developing the user-centred version in phase three. Full details of the method are provided in Appendix 4.

### **4.3.2. Design**

Decisions for driving the frameworks’ development were based on structured team discussions, consensus driven decision-making and action identification. Several lengthy meetings were held either face to face or via teleconference. Agenda’s were agreed at the beginning of meetings. Team members then independently worked on actions allocated to them at team meetings.

### **4.3.3. Procedure**

Framework development progressed through the following stages:

1. *Basic Structure*: Firstly, based on the conceptual model, the research team agreed a basic structure for *organising toolbox content* that also indicated *how* it should be implemented.
2. *Intervention criteria*: Secondly, the research team used phase one and expert workshop findings to describe what ‘comfortable job’ and ‘accommodating workplaces’ might look like. Factors from phase one were selected that could characterise and also distinguish comfortable jobs from accommodating workplaces. Factors were then grouped according to similarity in meaning ultimately arriving at three core themes. These would provide the criteria that solutions for creating comfortable jobs or accommodating workplaces would need to fill.
3. *Toolbox components*. Thirdly, the ‘components’ or ‘steps’ that the toolbox would need to contain in order for it to get used and be used appropriately were agreed. Components provided a means of grouping different types of toolbox content according to the function that content would serve. For example, content relevant to getting potential ‘buy-in’ by users differed from content necessary for helping the end user prepare for using interventions.
4. *Identifying a range of relevant interventions*. A suite of potentially relevant interventions or strategies was then generated from the literature that could be grouped according to each component’s function. These were produced for all organisational layers ranging from the individual to the organisational level to ensure systematic coverage of all aspects of the biopsychosocial model.
5. *Producing modules*. Components were then compressed into self-contained modules. Module content, and the relationship between different modules were then specified in more detail.

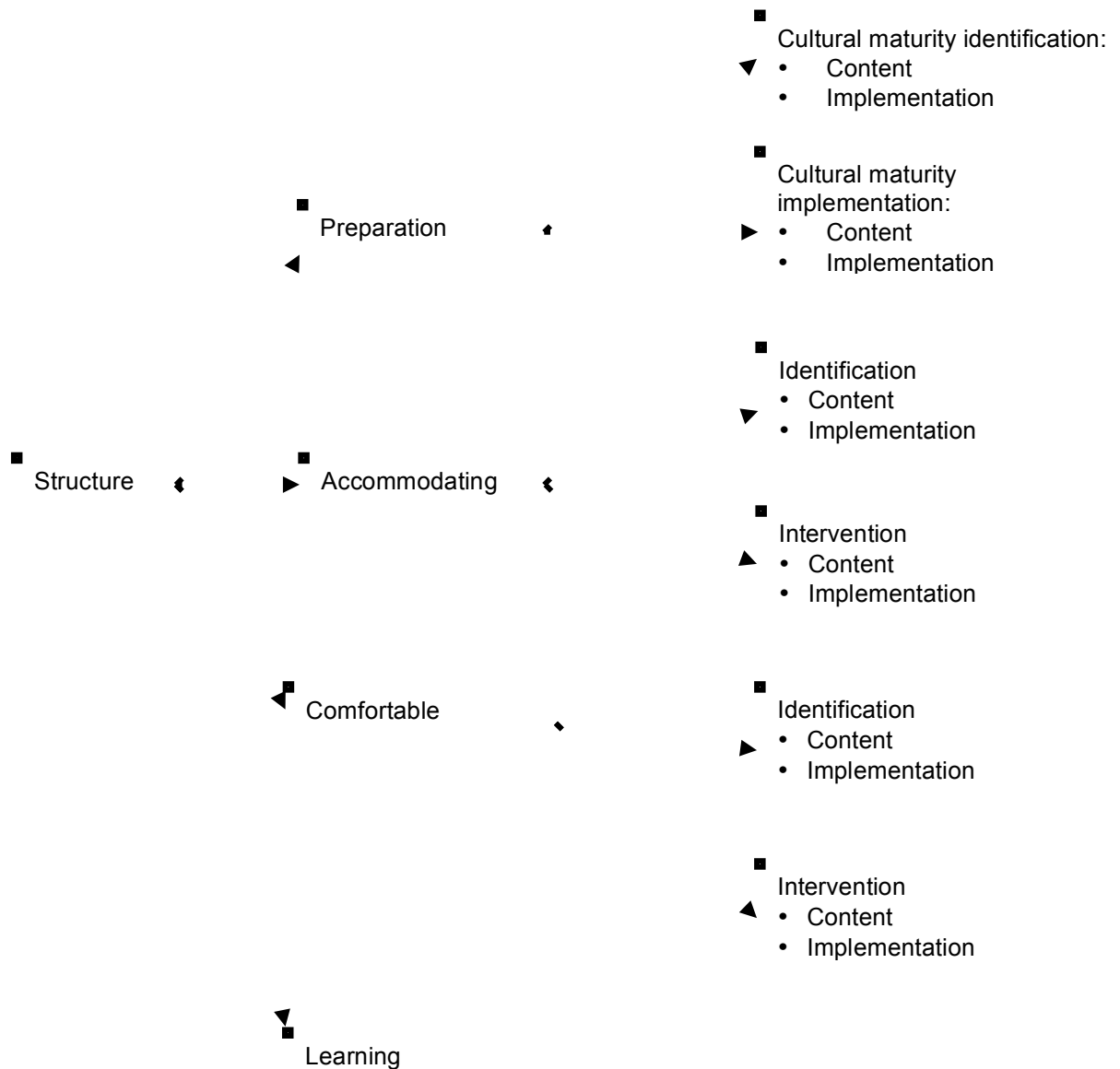
## **4.4. CONCEPTUAL FRAMEWORK: FINDINGS**

The evidence-based framework produced in phase two outlines the structure that would underpin the toolbox, the nature of the content it would contain, and the process by which it should be implemented. In short it would indicate ‘what would go where and why’ as well as ‘how’ the toolbox could be used. Still couched in technical or expert terms so that the alignment with the conceptual model remained clear, producing the framework also helped provide ‘proof of concept’ of the underlying model. Full details of the framework are provided in Appendix 4. Key messages are summarised in Box 6.

### **4.4.1. Basic structure**

The framework’s basic structure is shown in Figure 4 below. At a general level this indicates ‘what goes where and why’. Achieving a reduction in cases (work-relevant episodes) of CHPs would require that the toolbox encompass initial ground work that: gets all the players onside; motivates further toolbox exploration; ensures the necessary resources for using the toolbox are released; and conveys the right kind of knowledge for using the toolbox. This is represented in Figure 4 as ‘preparation’. While the toolbox would need to be attractive to all players, it was determined that line managers would actually have to do the work in making comfortable jobs and accommodating workplaces ‘happen’. Due to their position and role, line managers were deemed to have greatest potential in shaping the working conditions of groups or individuals. Consequently, the toolbox would have to appeal to the needs of line managers in particular. At this stage identifying and improving the organisation’s cultural maturity with respect to health and well-being were considered as potentially useful features of preparation. Actions could then be tailored to whether the underlying culture was best described as minimally compliant with legislation and policy or exceeding basic compliance requirements.

Creating comfortable jobs and accommodating workplaces was recognised as both requiring (a) identification of the extent to which they already exist, which then directs (b) appropriate intervention or action. The term identification was chosen over assessment. This was on the basis that assessment could imply spurious accuracy given the subjective nature of CHP complaints and could be construed by busy managers as too burdensome. Rather it was agreed that identification should comprise guided questions with descriptive anchors that allow enablers and obstacles to full engagement with work to be highlighted. As represented in Figure 4, identification and intervention aspects of the toolbox would each require detail on content and implementation. Following implementation, learning mechanisms would also need to be built into the toolbox to facilitate continued improvement and permit the practices it communicates to become a daily reality of organisational life.



**Figure 4: Toolbox Basic Structure**

#### 4.4.2. Basic content

Separation of preparation, comfortable jobs and accommodating workplaces was initially thought to lend itself to a modular framework.. Each component is distinguished by its role in allowing the module’s purpose to be achieved. As well as modules on comfortable jobs and accommodating workplaces, ‘getting buy in’ was considered most relevant to a module on preparation whereas review and dissemination of lessons learnt aligned to a module on organisational learning. Each module also captures the type of knowledge and interventions considered at this stage as enabling fulfilment of each component. For example, information required for securing buy in could be derived from myth busting messages, and the business, moral and legal cases. As such, deriving the modular structure provided the basis for an



inventory of interventions that would serve as a resource in selecting tools for further development during the next phase.

The range of solutions included in the table were selected on the basis of their meeting Responsive, Acceptable and 'Worth investing criteria' (RAW) derived from the research team's discussions over the phase one factors that could help define comfortable jobs and accommodating workplaces. Namely it was determined that solutions would need to be:

**Responsive:** Is the proposed solution *responsive* to the needs of workers and *flexible* enough to be adapted for specific purposes and contexts.

**Acceptable:** Is the proposed solution *acceptable* to the worker, the manager, co-workers and other relevant stakeholders; *inclusive* in that relevant stakeholders have been consulted; and *fair* to all stakeholders, including the organisation.

**Worth investing in:** Is the proposed solution *consistent* with other organisational policies and practices; is it the solution that gives the best return on *investment*, in that there are no other solutions that are just as effective but easier and/or less costly to implement; and is the intervention *supportive* of workers.

#### **4.4.3. Basic implementation**

In developing comfortable jobs and accommodating workplaces, targeted intervention logically follows identification. Originally, it was also felt that workbooks could be developed to represent module content. These would then be implemented in a certain order to allow tailoring of solutions to the organisation's cultural maturity (see Appendix 4, Figure 2). The order represents identification and improvements in maturity as preceding identification and actions for comfortable jobs that in turn occur just before tackling accommodating workplaces. Worker involvement and problem solving principles would need to be built into identification and intervention stages.

#### **4.4.4. Changes and Adjustments**

In keeping with an iterative and reflexive development process, not all of the ideas developed in this stage were carried forward through into the final toolbox. The main ideas that were later dropped during phase four concerned the modular approach and identification of cultural maturity. While people may think in a linear way, it was felt that people might not use the toolbox in a linear, sequential manner. Consequently, a modular approach was later considered to retain too much dependency on one module being completed before progression to the next. Instead it was decided that it was appropriate for developing comfortable jobs and accommodating workplaces to run in tandem. Inclusion of health cultural maturity was later considered to add excessive complexity. Instead, the final toolbox specifies general actions that senior managers can take forward, without enmeshing these in cultural maturity terms.

The key features of phase two that were retained concerned:

- The basic structure (Figure 4);
- The premise of identification directing action;
- Targeting line managers as users of the toolbox;

- Use of the framework as a resource for guiding what the toolbox would need to cover to ensure due preparation, attainment of comfortable jobs and accommodating workplaces and ongoing learning.
- 
- The conceptual framework outlines the basic structure, content and process by which the toolbox should be implemented. At a general level it guides ‘what goes where and why’ as well as ‘how’ the toolbox should be used.
  - The toolbox will need to appeal to all players, but direct line managers to take the action necessary for creating comfortable jobs and accommodating workplaces.
  - The basic structure recognises that empowering line managers to minimise CHP complaints through sustainable comfortable jobs or the escalation of CHPs through accommodating workplaces also requires initial groundwork and learning mechanisms.
  - Using guided questions to *identify* the extent to which comfortable jobs and accommodating workplaces exist is potentially more appropriate in capturing the subjectivity of CHP complaints than quantitative *assessment*.
  - Identification should direct targeted intervention. Both identification and intervention should draw on worker involvement in problem solving during the identification stages.
  - Toolbox design should allow for ‘organic’ rather than linear use.
  - Toolbox design should enable comfortable jobs and accommodating workplaces to be ever present within organisational life.

**Box 6: Key Messages from developing the conceptual framework**



## 5. PHASE THREE: PRODUCTION OF USER-CENTRED TOOLBOX

### 5.1. PRODUCTION OF USER-CENTRED TOOLBOX: METHOD

#### 5.1.1. Aims

During phase three, the conceptual framework generated from phase two was translated into a user-centred toolbox. This entailed refining the structure and developing specific toolbox content. Emphasis was on producing a toolbox that was both user-friendly but also covered all the necessary 'ingredients' for managing CHPs effectively.

#### 5.1.2. Design

Development followed a similar process to that used in phase two. Decisions for shaping the user-centred version were based on structured team discussions, consensus driven decision-making and action identification. Meetings were held either face to face or via teleconference.

#### 5.1.3. Procedure

Development of the user-centred version of the toolbox was as follows:

- *Review & refinement:* The project team reviewed and refined key project definitions derived from the conceptual model to ensure they were distinct and that all members shared the same viewpoint.
- *Visualising the final deliverable:* The team endeavoured to visualise what a useable toolbox might look like to the end-user in terms of how they would navigate it and use information. This made decisions easier for simplifying the structure, layering information, capturing key messages, securing initial uptake and providing a suitable balance between being sufficiently prescriptive so as to empower, but not so prescriptive as to be insensitive to local circumstances.
- *User-centred terminology:* The team devised user-centred terms for technical terms used during phase 2.
- *Structure:* The structure derived from phase 2 was refined and simplified to create a basic structure for the user-centred version. This was done to enhance usability.
- *Principles:* As a way of capturing the core values and key messages for each main area of the toolbox, the team collectively identified the type of principles that the toolbox would need to convey. These were then fully phrased and agreed by the team.
- *Assessment & Identification:* Building on phase 2 discussions, the team discussed how CHP issues should be identified, and with what questions. These were then translated into simple and usable tools.
- *Solutions:* Phase 2 materials were also used to identify the types of solutions or tools necessary for addressing CHP issues. These were selected on the basis of their:
  - i. Potential simplicity
  - ii. Fit with the notions of Good Jobs and Supportive Workplaces
  - iii. Basis in evidence
  - iv. Added value over and above what is already available.

- *Designing and phrasing content:* Specific tools were allocated to different team members for development. A template was produced to support this process. The main body of the toolbox was initially written as a paper version and then translated into a web-based version. It then went through several iterations and refinement before producing a version ready for usability testing.

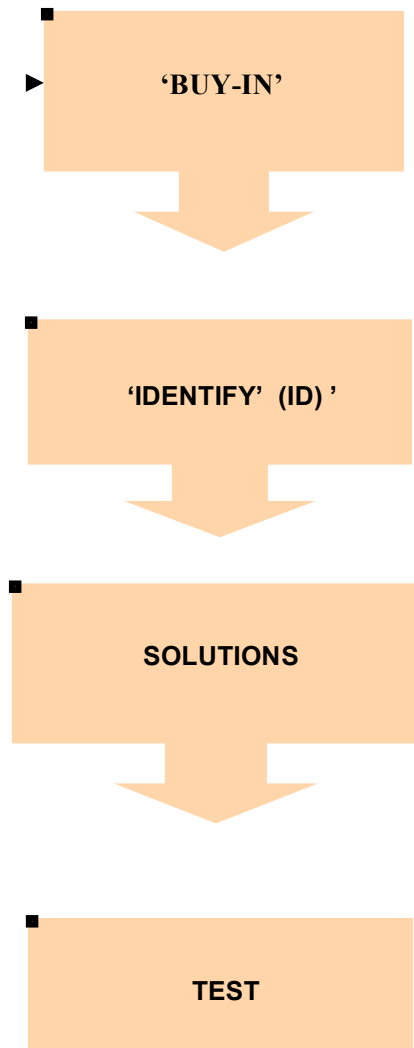
## **5.2. PRODUCTION OF A USER-CENTRED TOOLBOX: FINDINGS**

Based on phase one findings and the research team's experience, translating the conceptual framework into a user-centred toolbox that becomes a habitual and sustainable part of daily organisational life would require that it was (a) useable, had (b) instant appeal and motivated use, and (c) empowered potential end-users. The final web-based toolbox is in Appendix 6. Key messages are summarised in Box 7.

As a way of assuring toolbox usability the research team produced:

- User-centred versions of the underlying structure;
- User-centred alternatives to the terminology;
- Separated and layered the content to provide flexibility in how the toolbox is used, taking into account the time constraints and motivation levels of line managers;
- Principles to capture key messages and core values as well as other narrative devices such as catch phrases and idioms.

*Structure:* To keep the content coherent and manageable, the toolbox assumes fulfilment of basic requirements of health and safety legislation relating to CHPs (e.g. DSE assessments) and use or awareness of relevant primary prevention and healthcare approaches (e.g. the Management Standards, health promotion, standard occupational health provision). In keeping with the conceptual framework from phase two, the basic structure for the user-centred toolbox distinguishes between initial buy-in strategies, identification, solution generation, and testing for improvement. The toolbox incorporates a feedback loop built to ensure continual review and refinement (see Figure 5). This process applies to comfortable jobs and accommodating workplaces. This model also clarifies 'who' does 'what', 'how' and for 'whom' for each aspect of the toolbox. Identification is developed further. For accommodating workplaces, the toolbox is split into initial 'noticing' struggling individuals followed by engagement by the line manager in order to 'identify' obstacles to usual work. Since comfortable jobs necessitates a proactive line management style, identification focuses on the line manager asking their staff whether certain 'enablers' to comfortable jobs are in place.



<b>Good Jobs</b> <b>On</b> – Groups struggling with work <b>Aim</b> – Enable a realistically agreeable Job	<b>Supportive workplaces</b> <b>On</b> – Individuals struggling with symptoms <b>Aim</b> – Enable coping with symptoms & staying at work (S.A.W)	<b>ASSUMPTIONS/PRE-REQUISITES</b>
<ul style="list-style-type: none"> <li>• <b>What?:</b> Aspirational principles (of what comfortable should look and feel like)</li> <li>• <b>By?</b> : All</li> <li>• <b>How?</b> : &gt;Tool&lt;</li> </ul>	<ul style="list-style-type: none"> <li>• <b>What?:</b> Rationale and principles</li> <li>• <b>By?</b> : All</li> <li>• <b>How?</b> &gt;Tool&lt;</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Appropriate cultural enablers (i.e. cultural maturity)</b></li> <li>• <b>Universal primary prevention approaches are used (inc. Management Standards)</b></li> </ul>
<ul style="list-style-type: none"> <li>• <b>What?:</b> Line Manager Observes and Asks</li> <li>• <b>By?</b> Line Manager</li> <li>• <b>How?</b> : &gt;Tool&lt;</li> </ul>	<ul style="list-style-type: none"> <li>• <b>What?:</b> Notice/observe for caseness &amp; ask</li> <li>• <b>By?</b> : All (notice); line manager (ask)</li> <li>• <b>How?</b> : &gt;Tool&lt; (e.g. watchful waiting)</li> </ul>	
<ul style="list-style-type: none"> <li>• <b>What?:</b> Guidance with problem solving examples</li> <li>• <b>By?</b> Line Manager</li> <li>• <b>How?:</b> &gt;Tool&lt;</li> </ul>	<ul style="list-style-type: none"> <li>• <b>What?:</b> (1) ID obstacles; (2) Plan, Act, Do per obstacle</li> <li>• <b>By?</b> : Line manager on worker</li> <li>• <b>How?</b> : &gt;Tool (s) &lt; (do what's needed, when)</li> </ul>	
<ul style="list-style-type: none"> <li>• <b>What?:</b> Question – Would I like to work in their job?</li> <li>• <b>By?:</b> Line Manager</li> <li>• <b>How?:</b> Question</li> </ul>	<ul style="list-style-type: none"> <li>• <b>What?:</b> Question: S.A.W. &amp; productive?</li> <li>• <b>By?</b> : Line manager/HR/duty holder</li> <li>• <b>How?</b> : &gt;Tool&lt;</li> </ul>	

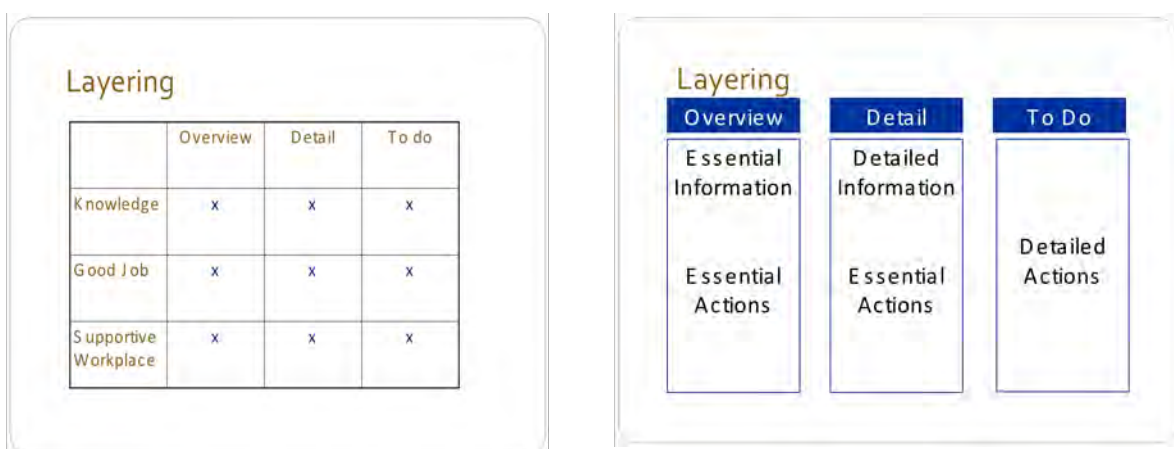
Figure 5: Basic Structure of the Toolkit

*Terminology:* More user-centred alternatives were developed for common health problems, comfortable jobs and accommodating workplaces:

- The term *Health ↔ Work Toolbox* was coined as an alternative to the ‘common health problems’ toolbox on the premise that it communicates the two-way interdependency between health and work effectiveness, namely that health is good for work and work is good for health. Secondly, it is an intentionally inclusive term to allow for potential transferability of the toolbox to other work-relevant health issues besides CHPs.
- ‘*Good Jobs*’ was substituted for comfortable on the basis of it sounding more intuitive, avoiding misinterpretation of the term as implying jobs that are not challenging, motivating, or stretching, and implying that jobs are about a worker’s day to day activities, motivation and engagement with work.
- ‘*Supportive Workplaces*’ substituted ‘accommodating workplaces’ on the basis of it also sounding more intuitive while still locating support in the work context of the struggling employee.
- These terms are used hereon in the remainder of this report.

*Content Division and Layering:* The content is divided four main ways: the toolbox home page; knowledge; Good Jobs; and Supportive Workplaces. The home page provides ‘top level’ information on the toolbox’s purpose, why it should be used, who it is aimed at, when it should be used and how it should be used. It comprises the ‘buy-in’ information for all potential players accessing the toolbox that draws on the moral, legal and business case for managing health and work more effectively. ‘Knowledge’ profiles the nature of CHPs together, the challenges CHPs’ pose to the contemporary workplace, preparatory work such as assessing the current *Health ↔ Work Culture*, and information dissemination. The material under ‘Good Jobs’ and ‘Supportive Workplaces’ explains what each means and associated actions for attaining each set of conditions.

The information and guidance provided for each of these divisions is then layered according to: (1) an ‘overview’ comprising essential information; (2) detail, comprising more detailed information and (3) a ‘to do’ layer that provides more detailed instructions for making improvements. Layering in this way should mean that although essential information and actions can readily be accessed and implemented, more detailed guidance is available to the less pressured or more motivated end-user. Figure 6 below summarises how the content was divided and layered. Designing the content in this way allows for flexible use, and helps prevent any one part of the toolbox being contingent on another having been completed.



**Figure 6:** Content Layering

*Narrative devices:* Table 5 lists the principle ‘headlines’ developed for the toolbox that were intended to capture key messages or values. Principles were provided as five key items of knowledge at the overview layer, and were expanded within the ‘detail’ layer.

**Table 3: Toolbox Principles: Summary**

<i>Knowledge</i>	<i>Good Jobs</i>	<i>Supportive Workplaces</i>
<ul style="list-style-type: none"> <li>• Work is usually good for our health and well-being.</li> <li>• Most work is not dangerous</li> <li>• Work may become difficult when we have a health complaint or injury.</li> <li>• Some people struggle to stay at work or get back quickly</li> <li>• Providing Good Jobs that are as comfortable as possible and accommodating workers in a Supportive Workplace when they have health complaints is the way to reduce the burden of health complaints at work</li> </ul>	<ul style="list-style-type: none"> <li>• A good job is not the same as an ideal job. Job satisfaction is important to us all – Good Jobs are satisfying jobs</li> <li>• It’s the simple things that make for Good Jobs</li> <li>• Good Jobs come from good management.</li> <li>• The characteristics of Good Jobs are:               <ul style="list-style-type: none"> <li>- Balanced demands and a safe work environment</li> <li>- Effective and supportive line management</li> <li>- Feeling of being a valued and respected member of a team</li> <li>- Opportunities to use and develop skills</li> <li>- Support and opportunity for workers to solve their own problems</li> <li>- Support to make improvements to the job</li> <li>- Opportunities for social interaction</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• We all get health complaints: mostly they are not caused by work</li> <li>• The reason some people have difficulty coping is mostly not that they have a more serious condition or injury, it’s because they face obstacles</li> <li>• There are 3 things to do: <i>identify</i> obstacles, develop a <i>plan</i> to overcome them, and take the appropriate <i>action</i>.</li> <li>• It is vital to act early, before the obstacles become entrenched.</li> </ul>

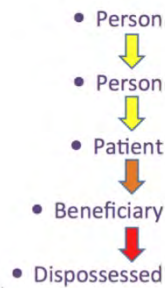
Other narrative devices intended to quickly invoke comprehension include the use of catch phrases and idioms. The language is intentionally first person to enhance its accessibility. Examples are listed below (Figures 7).



## Example Catch Phrases & Idioms

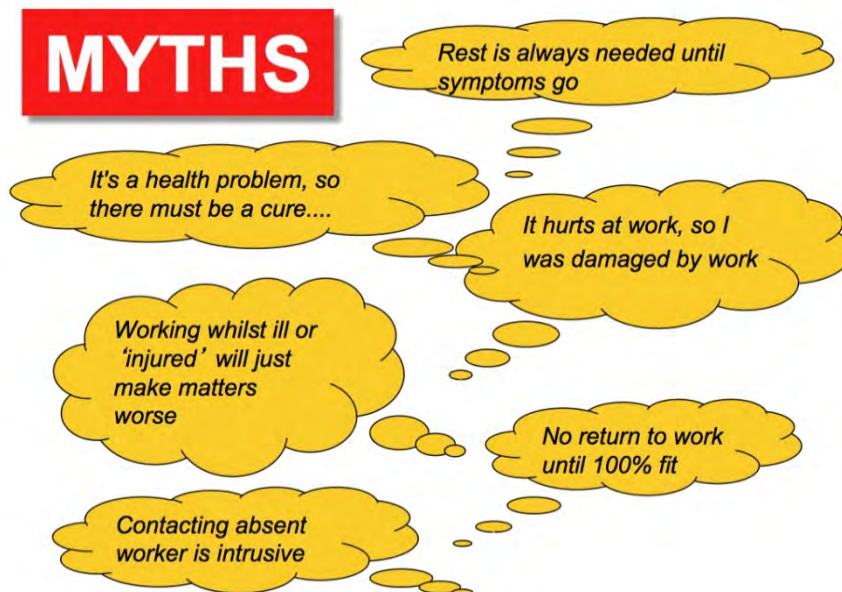
- *Do not let what you can do interfere with what you cannot do* (John Wooden)
- *Do no more on a good day and no less on a good day* (WE Fordyce, personal communication)
- *'You've got to do (some of) it, you ought to do it, and you'll be glad you did'* (the legal case, the moral case, and the business case)
- The **'slide to disaster'**:

- Before symptoms
- At onset of symptoms
- At time of seeking healthcare
- If signed off work
- On failure to recover/participate



(adapted from N Hadler, personal communication)

**Figure 7:** Examples of Narrative Devices



**Figure 8:** Common CHP Myths

### 5.2.1. Motivating Use

Short succinct messages within the home page about the toolbox’s purpose, its target audience, why, when and how it should be used were developed to create instant impact and motivate further exploration. These include using the phrase ‘you’ve got to do (some of it), you ought to do it, and you’ll be glad you did’ to anchor additional information on the business, moral and legal case. ‘Myth busting’ messages have also been included to counter commonly held misconceptions (see Figure 8) about the adverse effects CHP complaint’s have for workability. Throughout the toolbox case studies were been included to enhance understanding and help change attitudes about the detrimental effect that less than perfect health can have on productivity. Tools can be accessed either as part of the instructions under knowledge, Good Jobs or Supportive Workplaces or as a separate ‘resource library’ accessible from all levels. Making the tools easily accessible in this way should enhance the toolbox’s perceived ‘usefulness’ by end-users. Tools are a mixture of checklists, information sheets, action plans and question sets with suggested actions (See Figure 9).



Figure 9: List of Tools within the Resource Library

### 5.2.2. Empowering end-users

Over and above structuring the content to make key ‘know-how’ for managing CHP complaints accessible, all tools and techniques were designed according to ‘who’, ‘when’, ‘where’ and ‘how’ principles. Providing a certain level of prescription in this way should help encourage the

end user to anticipate how the ideas could be implemented. Equally, care was taken to avoid being too prescriptive and consequently losing scope for tailoring actions and solutions to local circumstances. Embedding some of the actions and tools into senior management levels should also help with more sustained use. For this reason a *Health ↔ Work Culture* tool is included to assess senior management beliefs or practices concerning: the interdependency between health and work; associated organisational policies; fair treatment of people with health problems; and the impact of health problems upon productivity. Actions suggested for improving the *Health ↔ Work Culture* that are built into the toolbox include assimilating Good Jobs into line management training; including it as a standing agenda item and involving workers in creating Good Jobs at all organisational levels. Other strategies used for encouraging sustained use concern: encouraging regular review by Senior Management; inclusion of a *Health ↔ Work* questionnaire to gauge understanding of CHP issues; allowing for a gradual build up of work activities as part of Supportive Workplaces; and suggestions for building support networks between colleagues.

- - To make the toolbox user-centred, the term ‘common health problems’ is replaced by *Health ↔ Work* to represent the interdependency between work and health. ‘Good Jobs’ replaces comfortable jobs and ‘Supportive Workplaces’ replaces accommodating workplaces.
  - For Good Jobs, ‘identification’ focuses on the extent to which the enablers of Good Jobs are in place. For Supportive Workplaces, identification splits into noticing a struggling individual followed by identification of obstacles to full participation at work.
  - The toolbox design caters for multiple levels of user and usage and caters for varied motivation, time availability and resource constraints: It separates essential information and actions from more detailed information and instructions. This is done for the three sections ‘knowledge’, ‘Good Jobs’ and ‘Supportive Workplaces’.
  - Principles and other narrative devices such as ‘catch phrases’ and idioms are used to anchor core values and messages.
  - The ‘home page’ intends to engender instant buy-in by using succinct messages to communicate what the toolbox is about, why it should be used, who it is for, when it should be used and how it should be used. These are elaborated through links to other pages.
  - The toolbox design strikes a balance between being sufficiently prescriptive to empower use without being so prescriptive that it becomes insensitive to local circumstances.
  - Review and learning strategies have been built in that should help ensure the toolbox remains a live part of how line managers carry out their job.

**Box 7: Key Messages from Developing the User-Centred Toolbox**

## **6. PHASE FOUR: USABILITY TESTING**

### **6.1. PHASE FOUR: USABILITY TESTING: METHOD**

#### **6.1.1. Aim**

Phase four focused on testing the usability of the draft web-version with a sample of potential end-users. Feedback was mainly on the usefulness, relevance and understanding of content, navigability, and areas from improvement. Full details are provided in Appendix 5.

#### **6.1.2. Design**

A small-scale electronic 10-item survey comprising a mixture of closed and open-ended question was circulated to potential end users. Questions asked whether: the toolbox was easy to follow; its content was understandable; it was perceived as useful in managing CHPs. Views on the toolbox's best aspects and where it required improvement were also obtained. The questionnaire was developed in consultation with HSE and the research team.

#### **6.1.3. Sample and Procedure**

A sample of 20 to 25 experts and potential end-users was sought. This number may have allowed more reliable patterns in usability opinion to be identified, should they exist. Participants were recruited through institutional and personal contacts. Participants were directed to a web site that hosted the toolbox, asked to look through the toolbox as if they were using it for real, and navigate through it. At the same time, participants were also invited to complete a web-based survey asking for their opinions. Twenty-two responses were received (20 via the web-questionnaire; two via email). This represented a response rate of 41%. Email responses were aggregated with the questionnaire feedback. Two questionnaire responses were found to also represent views from others to whom the email was forwarded. Just over half of the response was from line or general managers. Large, medium and small size organisations were represented. Originally it was intended that participants that had consented to be interviewed and had provided uniformly negative responses be followed up with a telephone interview. Since no participants provided uniformly negative comments, two participants that had consented and provided the least favourable views were interviewed. A third participant was interviewed who had provided detailed comments on specific aspects of the toolbox. Qualitative responses were coded using template analysis. Independent coding checks indicated the consistency of the coding.

### **6.2. USABILITY TESTING: FINDINGS**

The usability testing study found that the prototype CHP toolbox was perceived favourably on a number of features. Key messages are provided in Box 8. No clear negative patterns were discovered. The following positive features should be retained or even enhanced for the final version. These features included:

- Easy navigability;
- Links to more detailed and useful information;
- Use of plain English;
- Scientifically accurate and up to date content;
- Thought provoking nature;
- Proactive approach;

- Comprehensive coverage;

The findings also suggest that some respondents were less favourable on certain features. These included:

- Navigability and targeting: clearer links for different kinds of end users (line managers, senior managers, OHS/HR managers, those with problems, those without problems) to ensure speed and accuracy of access to the most appropriate information for different end users.
- Less text and less wordy language;
- Reductions in the amount of detail;
- Use of more graphics and diagrams;
- Incorporation of interactive features;
- Use of video case studies;
- Incorporation of an explicit staged process – potentially laid out as a diagram;

### **6.2.1. Interpretation**

Some comments were generic and shared by a number of participants, and should be taken into account. Some comments were mentioned by only one or two participants and without further investigation were not deemed to warrant major changes at this stage. Potentially helpful improvements implied by at least some participants include:

- The issue of navigability and lay out may be best addressed by mandating a professional designer in subsequent phases of refinement of the toolbox before it goes live on the website.
- Adding a fourth, succinct, top-layer to the toolbox with clear signposts for different end users may collectively address navigability, detail (which some participants said was a positive feature), and comprehensive coverage.
- Using more business friendly language, particularly for Good Jobs, and potentially assimilate the legal and moral case into the business case. Good Jobs may need to be tied less to health, and more to engagement, learning and skills development. The role of leadership, communication and establishing a team/organisational vision in creating Good Jobs may also need to be emphasised to a greater degree
- Signalling clearly that the intention of the toolbox is to help organisations develop healthy and Supportive Workplaces, and not to replace existing good practices in proactive organisations, or to imply that employers are the sole cause/treatment for common health problems.

Although three participants expressed reservations about the notion of ‘Good Jobs’ or at least how Good Jobs were presented, the material related to Supportive Workplaces was generally well received.

- - No uniform patterns of negative feedback emerged from the usability testing.
  - Professional designers will be required for including graphics, improving navigability and interactive options.
  - Consideration should be given to couching Good Jobs less in health terms and more in business terms.
  - Consideration should be given to including a top layer with clear signposts to routes through the toolbox to improve its navigability for different end users.
  - Care to avoid the impression that existing approaches are inherently ineffectual is warranted.

**Box 8: Key Messages from the Usability Testing**



## 7. SUMMARY, IMPLICATIONS AND CONCLUSIONS

A web-based *Health ↔ Work Toolbox* was developed to improve upon current approaches in managing CHPs. The *Health ↔ Work* label captures the interactions between work and health, and allows for transferability across a wide range of common health issues. The conceptual framework underpinning the toolbox can be summarised by answering the following: What does the toolbox do; who is the toolbox for; how should the toolbox work, and how can the toolbox add value?

### 7.1. WHAT DOES THE TOOLBOX DO?

Based on a growing body of evidence demonstrating a commonality in the consequences of different CHP categories (feeling stressed, musculoskeletal problems, and mild to moderate mental health problems), the *Health ↔ Work Toolbox* primarily aims to (1) reduce the impact of CHPs in the workplace by reducing the number of complaints and the proportion that become work-relevant; (2) reduce the proportion of cases escalating to unnecessary and unnecessarily prolonged sickness absence. Thus the toolbox will help people with CHP complaints to stay at work and stay productive, or to return to work sooner after sickness absence. The term ‘complaints’ rather than symptoms allows for the subjective nature of common health problems. Complaint denotes the point at which CHP symptoms are reported, or become a ‘case’. The term work-relevant reflects recognition that the consequences of CHP complaints can affect and be affected by work factors irrespective of CHP origins. Ultimately the toolbox is intended to instil more positive attitudes with respect to health at work that become integral to daily organisational life.

### 7.2. WHO IS THE TOOLBOX FOR?

The toolbox is to be implemented principally at the line manager level of responsibility, be they in a large organisation or a small enterprise. Nonetheless the toolbox’s value is likely to be immediately apparent to whoever accesses it so that they can direct it to line management. It has been designed to have as high a level of appeal as possible for the widest range of key players (e.g. Human Resources and Health and Safety Professionals, Trade Union Representatives, Occupational Health Providers etc.). Options are built in so that other sources of support can be used where the line management relationship prohibits their involvement.

### 7.3. HOW SHOULD THE TOOLBOX WORK?

The central tenets on which the toolbox’s design rests are (1) the aspirational proactive goal of providing jobs that are, so far as is reasonable, agreeable, acceptable and engaging in terms of their physical and mental demands (‘Good Jobs’); (2) the responsive goal of providing a workplace that is supportive of people who do have CHPs that become work-relevant (‘Supportive Workplaces’). Consequently, the toolbox broadly divides in two main ways. The proactive aspect of the toolbox focuses on empowering line managers to create ‘Good Jobs’ so that CHP complaints can be reduced. Not in any sense to be confused with a lax attitude to work, Good Jobs mean work that is generally satisfying and agreeable because it allows workers to function at their best level while being able to pursue personal goals and cope with unavoidable risks and demands. Good Jobs require: balanced demands; competent line management support; a sense of being valued; social networks; skill development opportunities; and, scope to solve problems and improve features of the job independently. The more reactive or ‘just in time’ aspect of the toolbox focuses on empowering line managers to make temporary accommodations for individuals struggling with symptoms and CHP complaints. With the right support, these individuals should be able to stay at work and return to full productivity, without



recourse to unnecessary healthcare use or sickness absence. Providing a Supportive Workplace requires the line manager to work with a struggling individual to overcome personal, workplace and contextual obstacles to usual participation in work. Good Jobs differ from Supportive Workplaces in a number of ways. Good Jobs require that line managers primarily focus on *groups*, whereas providing a Supportive Workplace requires line managers to recognise struggling *individuals*. Good Jobs should foster resilience in coping with unavoidable risks and demands. Supportive Workplaces should enhance ability to cope with work-relevant symptoms. The process of aspiring to providing and having Good Jobs should be a continual activity, although it may become most necessary when demands become challenging. Supportive Workplaces become unnecessary once the struggling individual recovers. This means workplace accommodations (also known as modified work, transitional work arrangements, modified duties etc.) are always temporary and time-limited. In contrast, the development of Good Jobs and the potential to create a Supportive Workplace should be ever present. Combined with ‘good work’, which describes the societal and legislative systems and structures that enable tenets such as safety, fairness, and social capital at work, Good Jobs and Supportive Workplaces makes for an integrated approach to managing health at work based on the biopsychosocial model. Due to good work operating at a more societal level, this toolbox assumes it as a given.

As far as possible the toolbox has been designed to support flexible, unstructured use. Dependency of any one part of the toolbox on another having been used is kept to a minimum. When navigating the web-based toolbox, the end user will encounter material provided as part of the home page or under knowledge, Good Jobs and Supportive Workplaces pages that:

- (a) At an uppermost level is intended to motivate toolbox use (i.e. obtain buy-in) if they are a line manager or prompt line management to access the toolbox (available on the home page);
- (b) Enhances knowledge of CHP characteristics, challenges for the workplace, and the importance of overcoming these challenges (available on knowledge pages);
- (c) Encourages ground work that can facilitate Good Jobs and Supportive Workplaces. This occurs predominantly at the organisational or cultural level (accessed through knowledge pages);
- (d) Enhances knowledge of what Good Jobs and Supportive Workplaces mean (accessed through Good Jobs and Supportive Workplaces pages);
- (e) Represents tools that enable either identification of the extent to which Good Jobs and Supportive Workplaces are in place, or solutions for addressing any shortfall (available via Good Jobs or Supportive Workplaces pages or as a separate resource library);
- (f) Allows ongoing learning and sustained use (assimilated into Good Jobs or Supportive Workplace pages).

Where linear use does become more necessary is in the generation of solutions that target issues identified as detracting from Good Jobs or Supportive Workplaces. Doing so draws workers into a problem solving process. Identification in the form of guided questioning is preferred over assessment, on the basis that it better caters for the subjectivity surrounding CHP complaints. However, the identification process for Supportive Workplaces differs from Good Jobs with respect to the role of obstacles. Identification splits into two phases for Supportive Workplaces. Line managers must recognise struggling individuals, either directly or through prompting by others, before obstacles can be identified. The proactive nature of Good Jobs means that identification has only one phase: asking whether jobs are good. The end user will also find material layered so that s/he can choose how much detail they wish to draw on.

Essential information and actions are readily accessible so that improvements can be quickly generated where motivation levels, time constraints or lack of resource prevent more involved use. As a result the toolbox should be amenable for use by small and medium enterprises (SMEs).

#### **7.4. HOW CAN THE TOOLBOX ADD VALUE?**

By filling a ‘zone of lost opportunity’ between primary prevention and healthcare, this toolbox provides an evolutionary solution for a much needed improvement in the understanding and management of CHPs. On the premise that the ubiquitous and subjective nature of CHPs makes total prevention and a full enduring recovery an unrealistic goal, this toolbox has been designed to empower employers to help people with CHPs maintain work participation and productivity. In filling this gap, the toolbox therefore supplements current approaches and guidance. Combined with current approaches, the toolbox should provide a more complete solution for managing all aspects of occupational health, inclusive of traditional occupational health problems as well as CHPs. It has been designed to provide a comprehensive resource capturing necessary ‘know-how’ for managing CHPs that targets line managers as opposed to experts. Line management are typically regarded as a bottleneck to enhancing the well-being at work agenda (Black & Frost, 2011).

The toolbox developed in this project is unique, and therefore differs from current approaches such as the Management Standards, because of the following:

- It draws on a positive approach to health and well-being. The concept of Good Jobs extends beyond preventing harm, to instilling resilience and ability to cope with unavoidable demand and discomfort.
- The approach to providing Supportive Workplaces provides comprehensive and practical methods to assist and support those individuals struggling to cope with symptoms at work.
- It combines proactive strategies for reducing CHP complaints with just-in-time strategies for managing complaint escalation.
- It is built on a biopsychosocial approach to health, and differs from previous initiatives by providing a toolbox that is multilevel (c.f. the Management Standards that tend to focus on work stressors located in the immediate work environment).
- The toolbox encourages dual responsibility for health, for example, recognising that a belief that CHPs inevitably and irrevocably reduce workability can be held by the employee, as well as importance of managers in providing temporary accommodations for struggling workers.
- The level of prescription provided by the toolbox should provide end users clarity over how they can implement changes. Lack of implementation detail has been levelled as a criticism of other approaches (Cox et al, 2007; Daniels et al, 2012).
- Much of the content is also applicable to a range of other health at work issues.

#### **7.5. CAVEATS**

The important caveats pertain to toolbox assumptions, method, and final toolbox status.

*Assumptions:* Since this toolbox supplements rather than supercedes other approaches, this toolbox assumes:

- Duty of care obligations for health and safety are as met;

- Primary preventive approaches (e.g. health promotion, occupational health risk management, the Management Standards for stress) are used, or at least known;
- Primary healthcare (or occupational health) is accessed or accessible;
- Good work as in effect due to its basis in a legislative and policy framework.

*Method:* A reflexive, approach has been followed to stimulate the creativity and conceptual thinking necessary for producing a toolbox capable of tackling the challenges around CHPs. Honing development by going from the broad to the specific has led to some ideas being dropped, such as a modular approach and cultural maturity assessment. Other ideas have been reworked and refined in order to produce a versatile and user-centred toolbox with a high level of acceptability and practicality. For this reason, the outputs from the earlier phases do not necessarily capture refinements made later on in the project. The overall design and sequencing of the phases means that the final toolbox can be traced back to the underlying evidence base, thereby enhancing its credibility. The use of regular consultation with experts and potential end-users (i.e. with surveys and workshops) has provided a form of validation for the direction taken. Given the relatively low response rates obtained from the stakeholder survey, those results are not fully representative of either Great Britain end-user or expert populations and need to be interpreted in light of other sources of information (e.g., the literature review). This consultation process was intended to be a straightforward exercise providing additional sources of information to inform next steps. It was not intended to be an extensive study on its own. Similarly, although the sample size used in the usability testing precludes generalisation, the intention was to generate a sample size large enough for exploring the practicality and feasibility of using the toolbox in a variety of workplaces.

*Prototype:* Since producing a professionally designed and presented web-based toolbox falls outside the scope of this project, the final product should necessarily be regarded as a prototype.

## **7.6. NEXT STEPS**

### **7.6.1. Launch**

Further refinement in the presentation and design of the web-based *Health ↔ Work Toolbox* is required before it can be used in everyday settings.

(1) Although usability testing (Appendix 5) indicated a generally favourable reception to content in the toolbox, there is scope for representation of issues and layout to improve acceptance and navigability. Other suggestions for improving the toolbox presentation included the use of more graphics and video case studies for example. Engaging specialists in web-design and multimedia presentation would help with packaging the toolbox. To ensure the integrity of the content and scientific message, it is envisaged web-design and multimedia specialists might ideally work closely with the team that developed the prototype, for the team are most familiar with the underlying scientific literature, content and intent of the toolbox.

(2) The *Health ↔ Work Toolbox* has been designed for ease of use, usually without specialist support, so that the up-take amongst SMEs would be improved over other guidance. With these factors in mind, if the toolbox were to be launched, then sectors having particular problems with CHPs (either occurrence, absence or other disruptions), or sectors with particular productivity problems could be targeted. Furthermore, targeting SMEs is particularly pertinent because productivity in SMEs is seen as fuelling economic growth: investment in practical steps to help SMEs keep staff with CHPs productive may produce greater economic benefits than the same level of investment in other sectors of the economy.

### **7.6.2. Evaluation.**

Formal evaluation of the effectiveness of the toolbox to influence the key outcome variables (i.e. the number of work-relevant CHP complaints, and the amount of sickness absence) is recommended. Ideally this should be completed before full implementation, using suitable research methods. See Appendix 7 for more detailed suggestions on how the toolbox can be evaluated.

### **7.6.3. Conclusions**

The *Health ↔ Work Toolbox* has considerable potential to facilitate the provision of Good Jobs as a way to constrain the onset of work-relevant CHPs, and to enhance the early workplace management of inevitably occurring symptoms as a way to minimise (unnecessary) sickness absence and, consequently, long-term disability.



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## 9. APPENDIX 1

### 9.1. BEST EVIDENCE SYNTHESIS

*This appendix provides a full account of the literature review, data extraction tables, evidence grading, evidence statements, and evidence synthesis.*

#### KEY POINTS

##### PROJECT BACKGROUND

This project is concerned with the control of common health problems (CHPs) at work. CHPs (musculoskeletal, mental health and stress complaints) are characterised by subjective symptoms, and are experienced by nearly everyone at various stages during life: they have substantial impact on workplaces because the symptoms are often *work-relevant*. The three categories of interest are: musculoskeletal complaints, mild/moderate mental health complaints and the symptoms of stress. The project entailed a wide-ranging literature review and evidence synthesis, leading to a conceptual framework underpinning an intervention toolbox.

Acknowledging that CHPs are an unavoidable fact of life, the questions then become, to what extent can they be controlled and how? A key finding from the evidence review is that prevention approaches based on the conventional hazard-risk-control model are suboptimal for CHPs, and have not yielded the hoped-for outcomes. A comprehensive analysis of why this is the case reveals significant conceptual discontinuity between prevention on the one hand and healthcare on the other. Little transfer has occurred between these knowledge areas, resulting in the relevant specialisms operating in silos. This has created a ‘zone of lost opportunity’ between the two, which provides a space for interventions optimised to control CHPs. Arguably, the limited exploitation of this zone to date goes some way to explaining the disappointing outcomes.

The intervention toolbox is designed to permeate this zone with practical evidence-informed resources to be used by key players, with the major focus on line managers. It is built on a solid conceptual basis that recognises the importance of ensuring ‘comfortable jobs’ to minimise the probability of developing and complaining about symptoms of CHPs, and providing an ‘accommodating workplace’ for those with symptoms who are struggling to cope at work<sup>4</sup>. It follows that the interventions must be targeted both at the group and individual levels.

The toolbox includes methods to identify and address salient job features that undermine provision of comfortable jobs and accommodating workplaces. It incorporates existing evidence-based knowledge from the key CHP areas: musculoskeletal (e.g. psychosocial flags framework), mental health, and stress (e.g. Management Standards), with the focus on practicable actions that are continuous, tailored and timely.

##### THE NATURE OF CHPS

- CHPs are extremely common across the population, and not confined to working age.
- CHPs tend to display an untidy recurrent pattern across the life course with variable periodicity and severity: multiple symptoms and complaints frequently coexist.
- CHPs in the workplace extract enormous societal, commercial, and personal costs, yet the adverse consequences can usually be avoided through relatively low-cost workplace interventions.

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<sup>4</sup> As development of the toolbox progressed, the term ‘comfortable jobs’ was replaced with ‘Good Jobs’, recognising that jobs should be configured to be motivating, engaging, and productive, and accommodating workplaces was replaced with the term ‘Supportive Workplaces’. Please see the main report for more details



- Most episodes of CHPs do settle without healthcare or sickness absence. Some episodes persist: sickness absence is driven more by psychosocial issues than severe illness or injury.

### **IMPLICATIONS FOR CHP MANAGEMENT**

- While work may not directly cause the majority of episodes of CHPs, the experience is frequently work-relevant so that aspects of the job can make symptoms more pronounced and more bothersome.
- Subjective symptoms are the predominant complaint. This makes diagnostic criteria unreliable, and defining a 'case' is very problematic. In occupational terms, a case can best be defined as an episode where the symptoms are work-relevant.

### **IMPLICATIONS FOR CURRENT APPROACHES**

- Attempts to control physical and psychological stressors in the workplace have not managed to reduce the incidence and prevalence of CHPs, or their substantial occupational impact. The commonly identified risk factors generally have small and inconsistent causal effects, yet they are strongly related to the work-relevance of symptoms.
- Though job stressors may directly generate some episodes, the potential for further preventive impact from the hazard-risk-control approach seems small.
- Control of subjective symptoms through healthcare may be needed, but typical healthcare interventions do not address occupational outcomes. Furthermore, they can be detrimental by encouraging passivity and dependence (iatrogenic disability).
- Between conventional prevention and typical healthcare lies a 'zone of lost opportunity', one that can be permeated with more effective workplace interventions.

### **DEVELOPING A NEW APPROACH**

- To achieve a reduction in cases (work-relevant episodes) of CHPs, workplace actions optimised for CHPs are crucial - identification and control of psychosocial obstacles to work participation: this sort of intervention is effective for occupational outcomes across the different CHPs.
- The nature of work is important: 'good work' is good for health and well-being. It entails numerous social structures as well as fundamental precursors including safety of workers. Good work may be necessary, but it is not a sufficient condition to control work-relevant CHPs. The quality of the job is important. A good job is a comfortable job in a supportive work environment, where the workplace accommodates people struggling with work-relevant CHPs. Good management is the key to comfortable jobs and accommodating workplaces.
- The toolbox aims to get all the players onside, and stimulate managers to cultivate *Good Jobs* by making them comfortable and the workplace accommodating and *supportive* for people with work-relevant CHPs. It provides the tools needed to create a positive work-health culture, and to construct a comfortable and accommodating work environment, one that enables workers to cope with reasonable job demands both when they are well and when they are not. The aspiration is reduction of work-relevant CHPs, leading to fewer cases requiring healthcare or prolonged sickness absence, and a minimal number progressing to long-term disability.

### **SUPPLEMENTING CURRENT APPROACHES**

The toolbox is an evolutionary solution, containing novel concepts. It is intended to supplement, not replace, current approaches. For example, while the Management Standards may have had little effect on the symptoms of stress in the workplace, it is also apparent that they cannot be

adapted to the control of other CHPs. However, the explicit aim of that approach to define conditions for a high level of health and well-being in the workplace can be incorporated in the toolbox, as can the use of a problem-solving approach.

## **MOVING ON**

Though based on an intellectually sophisticated model and framework, the toolkit itself needs to be intuitively highly attractive if it is to be effective. It needs to present complex ideas in an accessible format, together with a set of tools that is useable across workplaces of varying cultural maturity. To be implemented and effective, the interventions will need to be both practicable and proportional. Control of CHPs in the workplace is a challenge, but one that the evidence indicates is achievable.

## **PREAMBLE**

The main aim of this project is to develop an Intervention Toolbox based on an integrated and evidence-informed framework for managing common health problems (CHPs) at work, which allows practical assessment of relevant features and provides effective solutions for managing them in order, where possible, to minimise both the occurrence and the impact of CHPs<sup>5</sup>. The key target for minimising impact is enabling people with CHPs to stay at work, or return to work in a sustainable manner. The practical output is a detailed ‘intervention toolbox’ for use by people in and around the workplace to implement the framework.

CHPs are the categories of health complaints that occur most frequently across the population, and can readily be work-relevant. Collectively they account for most productivity loss, sickness absence, suffering, care-seeking, and health-related benefit claims. Most CHPs are characterised by their symptoms, which tend to be recurrent describing an untidy pattern of episodes having variable frequency, severity, and impact. Symptoms tend to coexist, both within and between the main categories (musculoskeletal, mental health and stress complaints). In view of their nature, interactions and shared characteristics, a biopsychosocial approach is optimal to underpin an intervention toolbox to reduce the impact of CHPs in the workplace.

An intervention toolbox cannot stand alone. It must sit alongside existing policy and regulation, and should fill the gaps in existing guidance and advice. In order to do that successfully requires a strong conceptual basis to position and underpin the toolbox. The present project develops an evidence-informed conceptual model for tackling common health problems (as distinct from serious injury or illness) at work. It takes as its starting point the notion that *work should be comfortable when we are well and accommodating when we are ill or injured* (Hadler 1997). This concept neatly captures the fact that CHPs are closely associated with work and workability, and that the workplace provides the optimal environment for intervention aimed at reducing work-related injury and ill-health and the number of people drifting into prolonged sickness absence.

## **WORK AND HEALTH**

Understanding the complex relationship between work and health is fundamental to devising effective interventions and to supporting key government strategies (HM Government 2005; HSE 2009b). This involves a number of important concepts that are related, yet distinct: Occupational Safety, Good Work, Comfortable Jobs, and Accommodating Workplaces. Work is generally good for physical and mental health and well-being (Waddell & Burton 2006). Furthermore, participation in work can be therapeutic for people with all types of common health problems (Waddell et al. 2008). The important proviso is that it depends on the nature and quality of work, and on social context. The constituents of ‘good work’, ‘comfortable jobs’ and ‘accommodating workplaces’ necessarily depend on occupational safety as a prerequisite but involve much more as well.

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<sup>5</sup> All key terms used in the project are outlined below in the sections on Project Definitions and Project Glossary

The overall conceptual model developed for this project (see Appendix 1 - Figure 1) goes beyond the notion of safety and ‘good work’, and recognises that what is of particular importance to the individual is the *quality* of their job and workplace.



**Appendix 1 - Figure. 1** Relationships and intervention levels for good work, comfortable jobs, and accommodating workplaces

This model avoids over-simplification and describes the characteristics of work and outlines the cascading relationships between them. This allows focus on the relevant intervention levels. Provision of ‘good work’ (which necessitates occupational safety) is primarily fostered at the level of the society, through enabling legislation and the like. The toolkit under development is not intended to operate at this level. Ensuring ‘comfortable jobs’ (which may incorporate aspects of safety) is a function for the workplace, taking place primarily at the organisational or group level. Provision of ‘accommodating workplaces’ also occurs at the workplace, but the intervention is at the individual level: accommodation is provided by ‘managers’ in response to people with symptoms or health problems who are struggling to stay at work. This model forms the basis for a broader conceptual framework to underpin the Intervention Toolbox for the management of CHPs at work by addressing the ‘comfortable’ and ‘accommodating’ levels.

The following best evidence synthesis sets out how the available evidence drives the conceptual basis for the toolkit. It is underpinned by accompanying Evidence Statements, supplemented with explanatory narrative in each of the sections relating to the three main categories of CHPs (musculoskeletal complaints, mental health complaints and stress complaints). The supporting scientific data, in the form of Evidence Tables, are located after the Evidence Synthesis.

The evidence synthesis provides a comprehensive analysis of several key areas:

- The knowledge base about CHPs that is available from both the occupational health and safety and treatment and rehabilitation fields;
- The dearth of empirical evidence supporting the applicability of the hazard-risk-control model for CHPs;
- The need for a supplementary approach that is optimised for CHPs;
- The conceptual basis for an effective intervention toolbox for CHPs;

- The complex relationship between work and health (including injury), and implications for understanding how CHPs may be controlled in the workplace;

## **METHODS**

### **LITERATURE REVIEW**

The approach taken is a 'best evidence synthesis', combining the available scientific evidence, logical reasoning, evidence-based guidance and examples of best practice (Goldsmith et al. 2007; Silverstein et al. 2005; Slavin 1995). A standard systematic literature review method was unsuitable due to the complex nature of workplace intervention for CHPs and the need for the review to cover a wide range of evidence of different types and quality. A best evidence synthesis provides a more useful base for the conceptual development of the intervention toolbox. It summarises the relevant literature and draws conclusions about the balance of evidence, based on its quality, quantity and consistency, and sets the conclusions in context. This provides the flexibility to tackle heterogeneous evidence and complex socio-medical issues, together with quality assurance. The potential for selection and personal bias is acknowledged, but efforts were made to minimise this, and to lay out the strengths and weaknesses of the evidence and the arguments as explicitly as possible.

The primary source of evidence was existing high quality reviews wherever possible. When these were not available, appropriate individual studies and articles were sought. To reflect current knowledge, articles published between January 2000 and September 2010 were eligible for inclusion. A comprehensive and systematic literature search was conducted using four strategies: (1) electronic database searches; (2) internet searches; (3) hand searches of relevant journals and grey literature; (4) personal databases.

The overall review method followed well-established principles for using literature reviews, meta-analyses, and conceptual papers (e.g., Fergusson et al. 2006; Richardson & Rothstein 2008; Rick et al. 2002; Waddell & Burton 2004; Waddell & Burton 2006); (. A standard evidence grading approach has been adapted for the purposes of the project (see table below).

### Appendix 1 - Table 1 Rating strength of evidence

<i>System for rating the strength of scientific evidence underlying the evidence statements<sup>6</sup></i>		
<i>Evidence Grade</i>		<i>Definition</i>
***	Strong	Generally consistent findings provided by (systematic review(s) of) multiple scientific studies.
**	Moderate	Generally consistent findings provided by (review(s) of) fewer and/or lower quality scientific studies.
*	Weak	Based on a single scientific study, general consensus and guidance, or inconsistent findings provided by (review(s) of) multiple scientific studies.
0	-	No high quality scientific evidence

The process for the review involved six key steps: Defining research questions and working definitions for the project; Literature search and selection; Data extraction; Generate evidence statements; Grade strength of evidence; Conceptual synthesis of evidence. For a conceptual synthesis, some important issues are inappropriate for scientific experiment or a ‘scientific’ answer, but that does not mean that there is ‘no evidence available’. Rather, it can be appropriate to invoke evidence defined on various other criteria (see box below). In appropriate cases this structured approach, which extends beyond consensus, can produce findings that are just as valid as those based on scientific evidence.

### Appendix 1 - Table 2 Criteria used for non-scientific evidence

<i>Criteria used for non-scientific evidence</i>
Background scientific evidence (e.g. epidemiology, indirect or related evidence) Logical reasoning Worthwhile use of resources Direct and indirect evidence on likely benefits Information from stakeholder survey and workshops (see Appendix 2 and Appendix 3)

<sup>6</sup> Burton, A. K., Kendall, N. A. S., Pearce, B. G., Birrell, L. N., & Bainbridge, L. C. (2008). Management of Upper Limb Disorders and the Biopsychosocial Model. London: HSE Books

## **EVIDENCE FINDINGS**

The evidence findings are presented as high-level evidence statements, which are a convenient way of summarising knowledge across the pertinent themes. Each statement is linked to the supporting literature, the details of which are summarised in the separately available evidence tables.

For convenience, and to reflect the way the literature is published, the evidence statements are categorised by common health complaint: musculoskeletal, mental health, and stress.

The statements specific to the health complaint are separated into three main topics to cover [1] the nature of the complaints, including epidemiology associations (risk factors), and clinical aspects, [2] the effective workplace interventions (for various outcomes), and [3] implementation at the workplace (best practice and key players).

In addition, there is a section for generic evidence statements that cut across the three health complaints. This is sub-divided into [1] conceptual models, [2] concurrent complaints, [3] assessment (person; workplace; context), [4] comfortable and accommodating workplaces.

There are numerous important aspects of the main topic areas, such as individual, organisational and contextual levels along with specific focus on work retention or return to work, but further subdividing the evidence statements would add a burdensome level of complexity. So, these aspects are accommodated within the wording of the evidence statements in order to reflect the pertinent substance of the evidence. The evidence is summarised in two ways: the main conclusions are given in bullet lists ahead of the evidence statements, whilst narrative summaries interpret the evidence in the light of the toolbox and its conceptual framework, with reference to additional supporting literature as appropriate.

The evidence tables containing the data extracted from the reviewed articles are organised to match the evidence statements, which identify the specific tables containing the supporting evidence for each statement. Table 1 relates to work-relevant musculoskeletal problems, Table 2 relates to work-relevant mental health problems, Table 3 relates to work-relevant stress, and Table 4 covers generic issues.

### **WORK-RELEVANT MUSCULOSKELETAL COMPLAINTS**

Common musculoskeletal problems are variously referred to in terms of symptoms, injury, or pathology. There is a wide spectrum of classification systems, ranging from specific disorders (diagnoses) to descriptive syndromes (non-specific), as well as a plethora of colloquial labels. Despite considerable international research and regulation, musculoskeletal problems remain a major reason for absence from work on health and injury grounds, with an estimated 11.6 million working days a year being lost in the UK ([www.hse.gov.uk/msd/hsemsd.htm](http://www.hse.gov.uk/msd/hsemsd.htm)).

The main conclusions are:

- Musculoskeletal complaints exhibit high prevalence rates across the life course, and across all segments of the population. Most people will experience numerous episodes, and many will experience coexisting complaints. Whilst the bulk of the science on musculoskeletal complaints comes from the field of back pain, the relationships with

work and the principles of successful intervention are common across the range of complaints involving all body regions and peripheral joints.

- The genesis of musculoskeletal complaints is complex: a mixture of biological, biomechanical and psychosocial factors contribute to the development of symptoms. The decision to report or complain about symptoms and to seek help appears due to a related but different set of factors: psychosocial issues are often prominent. The persistence of disability due to musculoskeletal pain is mostly due to psychosocial factors. These arise from the person, their workplace, and the context in which they function.
- There is limited scope for reducing the incidence of musculoskeletal complaints through primary workplace prevention. This is partly due to the ubiquitous nature of the symptoms and their recurrent pattern, and partly because occupational risk factors have been demonstrated to have generally small to negligible effect sizes. Reducing the likelihood of musculoskeletal complaints becoming work-relevant seems feasible.
- Staying at work, early return to work, and work retention, are key goals for virtually every case. There is considerable scope for controlling work-relevant musculoskeletal complaints in order to help people stay at work or achieve an early return to work whilst still experiencing symptoms.
- Healthcare is not always sought nor needed. Neither medical treatment nor ergonomic workplace interventions alone offer an optimal solution; rather, multimodal interventions involving work-focused healthcare and workplace accommodation are the most effective yet least frequently delivered. Successful management strategies require all the players to be onside and acting in a coordinated fashion; this requires engaging employers and workers to participate.
- The biopsychosocial model applies: biological considerations should not be ignored, but it is psychosocial factors that are important determinants of occupational outcomes. Implementation of interventions that address the full range of psychosocial issues will require a cultural shift in the way the relationship between musculoskeletal complaints and work is conceived and handled. Educational strategies aimed at employers, workers, and the public are likely to be the most useful method to achieve this.
- The best evidence synthesis consistently points to a framework that adopts a problem-solving and support-driven approach aimed at rapid resolution of all obstacles to remaining at or returning to work. The most important emphasis should be on facilitating participation and being productive, with reduced emphasis on what is 'wrong' or who is responsible.

## **EVIDENCE STATEMENTS**

The data extractions from articles supporting the evidence statements in this section are in Tables 1 and 4.

## Nature of complaints

MS-1 \*\*\* Musculoskeletal symptoms are very common across the population, and not confined to working-age people. The experience can be characterised as recurrent spells of varying duration, interval, and intensity. Most episodes are self-limiting and full recovery is anticipated.

Table 1 (Burton et al. 2008; Côté et al. 2008; Waddell et al. 2008)

MS-2 \*\*\* The basic epidemiology and natural presentation of musculoskeletal problems make it very difficult to differentiate everyday experiences from work-induced symptoms. Many musculoskeletal symptoms are perceived as 'work-related', but causation is complex and relationships to purported physical risk factors at work remains, in most instances, unsupported by the epidemiology. Nevertheless, musculoskeletal problems are frequently work-relevant, in that some aspects of the work may be temporarily difficult, painful, or impossible.

Table 1 (Burton et al. 2008; Kendall et al. 2009; Waddell et al. 2008)

MS-3 \*\*\* The various presentations of common musculoskeletal problems (presence of symptoms; reporting of symptoms; attribution to work; sickness absence; prolonged disability; well-being) have different determinants - psychosocial factors arising from the person, their workplace, and the context in which they function predominate. Classification and diagnosis of musculoskeletal problems is particularly problematic. Inconsistent application of diagnostic criteria is widespread in both the clinic and workplace leading to misdiagnosis, incorrect labelling, and repeated delivery of weak or ineffective treatment.

Table 1 (Burton 1997; Burton et al. 2008; Kendall et al. 2009; Waddell & Burton 2000)

MS-4 \*\* Onset of a given episode of musculoskeletal symptoms may be either rapid or gradual. Over half of episodes will not result in care seeking and a minority result in sickness absence. The reason(s) for care seeking and taking sickness absence are complex, being influenced by the beliefs and attitudes of both the person and healthcare providers. Healthcare interventions can control symptoms and disease processes, but healthcare alone does not achieve positive work outcomes. Similarly, workplace interventions alone (e.g. physical ergonomics) do not offer primary prevention, nor do they improve return to work rates.

Table 1 (Miranda et al. 2010; Waddell et al. 2008)

Table 4 (Waddell & Aylward 2010)

## Interventions

MS-5 \*\*\* Preventing the onset of musculoskeletal problems seems infeasible. There is a paradox: while disability due to musculoskeletal problems has increased exponentially, the prevalence of symptoms has remained constant, the quality and provision of healthcare has improved, and the physical demands of work have reduced. There is limited evidence to support purported risk factors, and even those that are well documented have small effect-sizes. This compromises the potential magnitude of preventive interventions.



Table 1 (Bakker et al. 2009; Bell & Burnett 2009; Bigos et al. 2009; Burton et al. 2004; Burton et al. 2008; Clemes et al. 2010; Côté et al. 2008; Driessen et al. 2010; Hadler 1997; Kennedy et al. 2010; Martimo et al. 2008; Rivilis et al. 2008; Roffey et al. 2010a; Roffey et al. 2010b; Roffey et al. 2010c; Roffey et al. 2010d; Roffey et al. 2010e; Tullar et al. 2010; Waddell & Burton 2004; Wai et al. 2010a; Wai et al. 2010b; Wai et al. 2010c; Williams et al. 2010)

MS-6 \*\*\* Risk identification is the current cornerstone of attempts to prevent musculoskeletal problems. The principle is one of hazard identification using some form of risk assessment based on agreed criteria. This approach rests on a sequence of assumptions: that hazards are known and significant; that they can be accurately identified in practice; that they can be eliminated, or reduced, and that this will yield a subsequent reduction in cases. Attempts to control physical hazards using ergonomics or training alone have failed to influence the prevalence or consequences of the common musculoskeletal problems experienced at work.

Table 1 (da Costa & Vieira 2010; Driessen et al. 2010; Marras et al. 2009; van den Berg et al. 2009; van Rijn et al. 2009a; van Rijn et al. 2009b; van Rijn et al. 2010; Waersted et al. 2010)

MS-7 \*\* Prolonged absence from work is detrimental to health: reducing unnecessary sickness absence is a desirable goal. Although some work may be difficult or impossible for a while for people with musculoskeletal problems, that does not mean work is unsafe: most people can and do stay at work (sometimes using temporary adjustments). However, when job demands cannot be tolerated or suitable adjustments are impossible, a limited period of absence is the appropriate response.

Table 1 (Waddell et al. 2008; Waddell & Burton 2006; Williams et al. 2010)

MS-8 \*\* Effective workplace interventions for work-relevant musculoskeletal problems include: maintaining contact with the workplace; provision of accurate information and advice; a supportive environment to facilitate stay at work and early return to work; access to effective healthcare; temporary workplace accommodations (e.g. changes to workload, organisation, or tasks) with involvement of the worker. When a worker has been off work for any extended period (i.e. a few weeks), it is most effective to provide a combination of work-focused healthcare and an accommodating workplace.

Table 1 (Briand et al. 2008; Burton et al. 2008; Carter & Birrell 2000; Hanson et al. 2006; Iles et al. 2008; Iles et al. 2009; Kendall et al. 2009; Nelson & Hughes 2009; Okunribido 2009; van Oostrom et al. 2009; Waddell et al. 2008; Waddell & Burton 2000)

## **Implementation**

MS-9 \*\* Early intervention is desirable to maintain workability or facilitate timely return to work. Encouraging early reporting of symptoms can facilitate timely intervention, but incautious encouragement has the potential for unhelpful attribution to work.

Conversely, the absence of a reporting system would be a major obstacle to early intervention. Screening tools have limited utility in selecting cases needing specific levels of intervention.

Table 1 (Burton et al. 2008; Hanson et al. 2006; Kendall et al. 2009; Shaw et al. 2009; Waddell et al. 2003; Waddell et al. 2008)

MS-10 \* A biopsychosocial approach to tackling musculoskeletal problems is justified, taking account of the person, the workplace and the context. The principle of identifying obstacles and enablers (to work participation), making a plan, and taking action is a practical means to implementing the approach.

Table 1 (Burton et al. 2008; Kendall et al. 2009; Schultz et al. 2007; Waddell et al. 2008; Waddell & Burton 2004)

MS-11 \*\* The ubiquity and variable nature of musculoskeletal problems suggest that a stepped care approach is appropriate – doing just what’s needed, when it’s needed for whom it’s needed. The number of steps is not fixed but starts with information/advice, followed by increasingly intensive interventions as needed, involving both work-focused healthcare and workplace accommodation.

Table 1 (Burton et al. 2008; Kendall et al. 2009; Waddell et al. 2008)

MS-12 \* Consistency and communication among all the players seems a key factor in successful interventions. This requires commitment from senior management coupled with supportive actions by line managers. Modified work (transitional work arrangements) can facilitate work participation. Case management approaches can be effective, and it is possible for a range of players to act effectively as case managers (e.g. occupational health, HR, and some line managers).

Table 1 (Burton et al. 2008; Hanson et al. 2006; Kendall et al. 2009; Waddell et al. 2008)

## **INTERPRETATION**

MSDs provide an exemplar of scientific study into the relationship between work and common health problems. The topic has been studied extensively over numerous decades and, with the use of increasingly complex investigative methods, the earlier paradigms have had to give way to more sophisticated models and interventions.

Symptoms related to the musculoskeletal system are so ubiquitous that they must be considered to be a typical life experience. Musculoskeletal pain is not restricted to adults: for instance, by adolescence over 50% will have experienced one or more spells of back pain. During the course of a month, two-thirds of people will experience musculoskeletal symptoms, and half of them will have pain at multiple sites: some 15% will report poor work ability with respect to physical or mental work demands. For many people the symptoms will be recurrent, typically experienced as an untidy fluctuating pattern of symptoms of varying severity, site, periodicity, and impact – only a small proportion, yet representing large numbers, will go on to persistent pain and disability.

Musculoskeletal symptoms are a major cause of sickness absence, and account for a substantial proportion of compensation and disability benefit claims. Interestingly, there has been a shift in recent years from people with musculoskeletal problems to people with mental health problems

forming the majority of claimants (Black, 2008), which may be due to factors such as reduced stigma from complaining of mental health symptoms, and possibly greater confidence among GP's to offer a psychological diagnosis.

The progression to persistent pain and disability is more associated with psychosocial factors (obstacles to recovery) rather than underlying pathology. Clinical interventions for musculoskeletal problems tend to be focused on symptom management; those that have been shown to be effective have small effect sizes, and have little impact on the natural history. With few exceptions, the most effective interventions for reducing the undesirable consequences of musculoskeletal problems (persistent symptoms and disability) involve physical challenges to the musculoskeletal system (movement and exercise) as opposed to avoidance and rest. Interventions involving activity and movement are consistently superior to more passive treatments, and seem to have some protective effect. Resistant cases that have progressed to persistent pain and disability require a multidisciplinary approach focusing on psychosocial factors and reactivation. Importantly, clinical intervention alone has little impact on occupational outcomes such as work retention and return to work.

In order to understand and ultimately tackle musculoskeletal problems, it is of fundamental importance to recognise the different presentations across the community: presence of symptoms; reporting of symptoms; attribution to work; objective injury/damage; sickness absence; long-term disability. These presentations have different associations and determinants that require different interventions.

A proportion of musculoskeletal episodes are due to soft tissue disruption or injury of some type, which can be precipitated by physical demands, but the exposures are inconsistent and very difficult to quantify. Indeed, the onset of many episodes cannot be linked to a physical stressor and there is no overt injury. Although attribution to work is commonly assumed by workers, their health professionals and society in general, the epidemiology suggests that it will only be a minority of instances of musculoskeletal problems that are caused directly by some physical insult resulting from work. Recent research indicates that the traditionally proposed biomechanical risk factors related to force, repetition and posture have small and inconsistent effect sizes, and that these influences vary across the presentations (symptoms; injury; sick leave). Indeed, occupational causation has proved difficult to confirm: very few occupations show the level of association between a job and a disorder that is required by the Industrial Injuries Advisory Council (a doubling of risk) for prescription of a specific condition as an industrial injury.

These findings do not deny a relationship between work and musculoskeletal problems, just that in most cases work is unlikely to be primarily causative, and the problem should not readily be characterised as an occupational injury in the absence of definitive evidence. However, many musculoskeletal problems will be *work-relevant*, meaning they are experienced at the workplace (to a greater or lesser extent), and will impact on comfortable performance of the job – the symptoms may be worse or exacerbated whilst working, but that does not imply the work is damaging. The experience of work-relevant symptoms can inadvertently contribute to the belief that work was the primary cause. If the symptoms are repeatedly evident or more pronounced at work, this focuses and reinforces perceptions of an association, and so it appears to the worker that this must have been the cause of their discomfort.

The current cornerstone of attempts to prevent musculoskeletal problems developing through work is hazard identification and control. This approach rests on a sequence of assumptions: that risks and hazards are known and understood; that they can be accurately identified in practice; and that, once they have been identified, they can be eliminated, or at least reduced, and this will yield a subsequent reduction in cases. Unfortunately, the available scientific evidence has failed thus far to provide support for the concept of primary prevention through risk control: it is likely that only a small minority of musculoskeletal problems afflicting workers can actually be prevented. That is not to say that all attempts at primary prevention of

injury should be abandoned, but expectations need to be in flux with reality. Where the magnitude of risk is low (small effect size for the hazard), attempting to control the risk by reducing the exposure can, at best, have only a small impact.

This risk management approach is based on the basic ‘injury’ model, which implies that injury risk is related to exposure to stressors, that continued exposure to stressors is related to more damage/symptoms, and that at some point damage will exceed repair leading to disability. This model, though intuitively attractive, does not adequately explain the phenomenon of musculoskeletal problems. A paradox remains: despite work becoming less physically demanding, along with an improvement in access to healthcare, the prevalence rate of symptoms in the community has remained stable yet there has been a substantial increase in work-related disability over recent decades.

It is fortunate, then, that most people with musculoskeletal complaints do stay at work: the sheer numbers involved mean that most people experiencing work-relevant musculoskeletal symptoms continue at their job (perhaps with temporary accommodation), and they apparently come to no harm. Of course, there will be occasions where some physical exposure at work results in injury, but these are exceedingly difficult to predict with any useful degree of accuracy. Inevitably, there will be cases where the person is not coping, job demands cannot be tolerated or suitable adjustments are impossible, in which case a limited period of absence is the appropriate response. A timely return to work is generally beneficial, even for cases with a specific pathology/diagnosis, - prolonged absence from work (beyond a few weeks) is detrimental to health and well-being (assuming reasonable job quality). The upshot is then to look towards accommodating workers with symptoms within the workplace.

An alternative to the largely unhelpful injury model is the biopsychosocial model; this has gained widespread acceptance and both explains the musculoskeletal phenomenon and points to wider-ranging targets for intervention. There is a developing appreciation, and increasing evidence, that alternative approaches that focus on tackling the consequences of work-relevant musculoskeletal problems (presence of symptoms; reporting of symptoms; attribution to work; sickness absence; prolonged disability; well-being) will contribute to lowering the levels of sickness absence and disability. The range of effective workplace interventions includes: maintaining contact between the absent worker and the workplace; provision of accurate, consistent and pertinent information and advice; provision of a supportive environment to facilitate staying at work and early return to work; enabling access to effective healthcare; implementation of temporary workplace accommodations (with involvement of the worker). The type of clinical treatment, when needed, depends on the nature of the health problem, but it should have a work focus and avoid ill-considered attribution to work.

The very nature of musculoskeletal problems (their ubiquity and inherent variability and inconsistent association with work) points to a stepped care approach for managing the consequences - delivering just what is needed, when it is needed, to whom it is needed. Most people self-manage most episodes of musculoskeletal symptoms, and they continue at work or return rapidly with little, if any, additional help. It is, then, a reasonable assumption that, for these people, their work and workplace is relatively undemanding and free of obstacles – comfortable work. However, for other people there are inherent obstacles that impede their return and they need help to maintain work participation. Because screening for those likely to struggle is imprecise, it follows that a stepped approach is more efficient: the longer the period of absence the more intense the intervention – only those who do not respond to earlier (less intensive interventions) require and receive the more intensive intervention. The initial stage may simply comprise accurate information and advice, focused on myth busting and practical tips. When a worker has been off work for any extended period (i.e. a week or two), it is likely healthcare will be involved. Healthcare alone is insufficient to secure desired occupational outcomes – it is necessary to provide a combination of work-focused healthcare and an accommodating workplace (Waddell et al 2008).

To maintain workability or facilitate timely return to work, early workplace identification of cases and obstacles is needed. Incautious encouragement to report trivial symptoms risks unhelpful attribution, but procedures for early reporting of work-relevant symptoms will be helpful if followed by appropriate response. Whilst all the players should be involved in identifying any obstacles along with planning and implementing problem-solving actions, it is the workplace (probably the line manager) that holds the key to making the workplace accommodating (modified work) so that the worker can continue at work whilst recovering. It is also the line manager, perhaps along with the personnel department, who will need to interpret and implement the medical advice on the recently introduced fit note. Case management approaches can be effective, but they do not need to be applied by a professional case manager – a range of players in the workplace (including line managers) can learn to effectively apply the principles.

In summary, accepting the importance of job retention and early return to work, tackling musculoskeletal problems is likely to require workplaces that are both comfortable and accommodating, with specific reference to identifying and addressing psychosocial obstacles. Although the evidence is limited, these approaches may well minimise the incidence of cases of work-relevant symptoms. The fundamental question of what makes a workplace comfortable and accommodating, how best those attributes can be achieved, and what tools are required by whom are discussed in the Generic section of the report.

## WORK-RELEVANT MENTAL HEALTH COMPLAINTS

Common mental health problems have become the predominant health problem of working age in the UK, and they are now the main reason cited for absence from work on health grounds. As for the other CHPs, they are referred to using a wide variety of terminology that ranges from descriptive to diagnostic. There are standard diagnostic criteria for anxiety and depression (DSM-IVR, ICD-10). It is not clear how widely used these are for sick certification.

When symptoms of anxiety or depression coexist with other common health problems (e.g. musculoskeletal pain) there is a tendency for those symptoms to be perceived as worse and there is the potential for more exaggerated responses (Kessler et al. 2003; Mental Health Foundation 2009).

‘Stress’ is not a diagnosable psychiatric/psychological disorder (except for Acute Stress Disorder in the DSM-IVR, or Acute Stress Reaction in ICD-10 which is considered the precursor to Post-Traumatic Stress Disorder, PTSD). It is a term in wide current use, and is therefore considered in a separate section. However, there is considerable overlap with this section on mental health.

The main conclusions are:

- A large minority of the population experiences mental health symptoms, with about 1 in 6 having them at any point in time. A much smaller proportion of people seek healthcare.
- The most common mental health problems are anxiety and depression, although these may not meet diagnostic criteria. They are now reported more frequently than any other CHP and have become the predominant health problem, and reason for sickness absence, for people of working age in the UK. This has occurred despite there being no evidence underlying prevalence rates have changed.
- The impact of mental health complaints varies widely. When they coexist with other health problems those other symptoms are often perceived as much worse.
- There are widespread and over-simplified beliefs that work often causes mental health symptoms, despite lack of evidence for a direct relationship.
- There is no direct evidence that work-relevant mental health symptoms can be prevented through top-down changes to work design to the point that there is no or even minimal incidence in the working population, nor their progression halted; this also holds true for diagnosable psychological disorders.
- Making jobs comfortable from a mental health point of view involves a mixture of trying to eliminate or reduce workplace stressors (e.g., managing the amount of psychological burden workers are under), along with trying to help people identify and become aware of stressors and how to deal with them effectively. However, some people with mental health symptoms do find work hard to tolerate and need temporary workplace adjustments or short spells of sickness absence.
- Mental health symptoms can be ameliorated with effective healthcare in many cases (using either medication, psychological therapy, or both). This does not by itself yield occupational outcomes. Staying at, or returning to, work is a vital outcome indicator.

This suggests the need to provide targeted workplace support over and above standard healthcare services. Additionally, because of the potential for mental symptoms themselves to become obstacles, there is a need to ensure appropriate intervention strategies are offered upon returning to work. This largely involves provision of an accommodating workplace.

- It seems that interventions aimed at reducing the probability of mental health symptoms and their impact should ideally be delivered at multiple levels (but only when necessary and appropriate): at both the organisation and the individual levels.

## **EVIDENCE STATEMENTS**

The data extractions from articles supporting the evidence statements in this section are in Tables 2, 3, and 4.

### **Nature of complaints**

MH-1           \*\*\*       Mental health symptoms are common. At any point in time, about a third of the working age population have some mental symptoms (e.g. fatigue, irritability, or worry), about 17% would meet diagnostic criteria for a mental illness, but only 6% seek healthcare. The spectrum of mental health symptoms have the propensity to interfere to a greater or lesser extent with a wide range of functioning including interpersonal, domestic, leisure activity, and work. There is wide individual variation of the impact of symptoms.

Table 2: (Lelliott et al. 2008; Martin et al. 2009; Seymour & Grove 2005; Waddell et al. 2008; Waddell & Burton 2004)

Table 4: (Seymour 2010)

MH-2           \*\*         The most common mental illnesses are depression and anxiety or a combination of the two. The incidence and prevalence are not changing in the working age population. However, there has clearly been a change in the diagnostic and sick certification rates. This indicates that more people report symptoms than before, and this may be a reflection of reduced stigma in reporting mental health symptoms. The course of common mental health problems can be brief and self-limiting, recurrent, or persistent. Onset may occur gradually or rapidly, and may range from mild to severe.

Table 2: (Martin et al. 2009; Seymour & Grove 2005; Waddell et al. 2008; Waddell & Burton 2006)

MH-3           \*\*         The basis of mental health symptoms and disorders is multifactorial with biological, psychological, social, developmental, and situational aspects. People complaining of mental health symptoms may not meet diagnostic criteria, but these may still be significant. For example, the experience of 'psychological strain' is considered an intermediate state from which physical and mental health symptoms can arise through a diathesis-stress process.

Table 2: (Michie & Williams 2003; Seymour & Grove 2005; Waddell et al. 2008)

Table 4: (NICE 2009; Seymour 2010)

MH-4           \*\*       The high frequency of common mental health problems makes it difficult to differentiate everyday experiences from work-induced symptoms. Despite this, there is a widespread and simplistic perception that work causes mental illness and stress, but the interactions between work and mental ill health are complex. The rate at which mental health problems are reported does vary by occupation: People in non-manual jobs are more likely to report depression and anxiety than those in manual jobs. The rate is also influenced by the general finding of lower health status among those from lower socioeconomic groups (although this may be influenced by a 'negative selection' process whereby those with poorer health are less successful in the labour market).

Table 2. (Bender & Kennedy 2004; Friedli 2009; Waddell et al. 2008)

Table 4: (NICE 2009; Seymour 2010)

### **Interventions**

MH-5           \*\*       Risk identification is the basis of attempts to prevent health problems. Completely or even largely preventing the onset of common mental health problems seems largely infeasible (as for musculoskeletal problems), although research is very limited. There is evidence of weak positive effects on symptoms of anxiety and depression from workplace-based health promotion interventions, but no effect on composite mental health outcomes.

Table 2. (Couser 2008; Egan et al. 2007; Graveling et al. 2008; Harvey et al. 2006; Krupa 2007; Lamontagne et al. 2007; Martin et al. 2009; Michie & Williams 2003)

MH-6           \*\*\*      Prolonged absence from work is detrimental to health. Common mental health problems are frequently work-relevant in that some aspects of the work may be temporarily difficult or impossible to perform. It is not necessary to be entirely symptom free to stay at or return to work, using temporary workplace accommodations. When job demands cannot be tolerated or suitable adjustments are impossible, a limited period of absence is the appropriate response.

Table 1 (Waddell et al. 2008; Waddell & Burton 2006)

Table 2. (Friedli 2009; Mancuso 1990)

Table 4: (Seymour 2010)

MH-7           \*\*\*      There is strong evidence that various medical and psychological treatments for anxiety and depression can improve symptoms, clinical outcomes and quality of life. There is limited evidence that symptomatic treatments for depression (medication, psychological therapy or a combination of both) in themselves improve occupational outcomes and no clear evidence on the magnitude of any effect. There is no evidence that symptomatic treatment for anxiety disorders (including PTSD) improves work outcomes.

Table 2: (Graveling et al. 2008; Martin et al. 2009; Nieuwenhuijsen et al. 2008; Seymour & Grove 2005; Waddell et al. 2008)



MH-8 \* There is rational argument and some consensus, yet limited evidence, that people with mental health problems require additional help (over and above symptomatic treatment) in order to (return to) work. RTW interventions for mental health issues are: more effective if they are individually targeted; more inclined to fail if they exclude the workplace; and, are more effective where people have a high level of control over their jobs.

Table 2. (Harvey et al. 2006; Kashdan & Rottenberg 2010; MacEachen et al. 2006; Michie & Williams 2003; Nieuwenhuijsen et al. 2008; Schneider 2003; Seymour & Grove 2005; van Oostrom et al. 2009; Waddell et al. 2008)

Table 4: (Seymour 2010)

MH-9 \*\*\* There is general consensus that organisation-level interventions (disability management, improved communication, early contact with absent worker, an agreed rehabilitation plan, flexibility in work organisation and return to work arrangements) are applicable to mental health problems, and limited evidence that they improve work outcomes.

Table 2: (Egan et al. 2009; Graveling et al. 2008; Harvey et al. 2006; Krupa 2007; MacEachen et al. 2006; Michie & Williams 2003)

Table 3: (Bambra et al. 2007)

MH-10 \*\*\* Organisational interventions need to be combined with individual interventions to yield optimal impact on mental health outcomes and increase the likelihood of indirect as well as direct benefits. Multi-level interventions yield optimal impact on individual well-being outcomes over and above that achieved by either in isolation. Interventions may need to be integrated with other organisational processes, be targeted at the work environment and the worker, include a range of interventions including worker training and management training, and allow workers to shape their own environment. Job control and support may be particularly beneficial, if supplemented with appropriate training, for allowing workers to regulate their own experience of work.

Table 2: (Krupa 2007; Lamontagne et al. 2007; MacEachen et al. 2006; Martin et al. 2009; Seymour & Grove 2005)

MH-11 \* Resilience and related concepts including psychological flexibility and sense of coherence offer ways for equipping individuals to cope with workplace adversity and potentially reduce susceptibility to common mental health problems.

Table 2: (Friedli 2009; Kashdan & Rottenberg 2010; Olsson et al. 2009; Varekamp et al. 2006)

Table 4: (Gillespie et al. 2007; Jackson et al. 2007)

## **Implementation**

MH-12 \* There is general consensus the ideal is to create a work and organisational environment that fosters well-being in the hope this may reduce the probability of

development or progression of common mental health problems. This needs to be clarified by further research.

Table 2: (Bender & Kennedy 2004; Michie & Williams 2003; Seymour & Grove 2005; van Oostrom et al. 2009; Varekamp et al. 2006)

Table 3: (Semmer 2008)

Table 4: (Bilsker et al. 2005; Seymour 2010)

MH-13 \* Approaches addressing job characteristics need to be supplemented with 'non-standard' variables such as intrinsic reward, individuals and work teams determining their own job content, and an individual-organisational values/goals match.

Table 3: (Bal & Van Der Velde 2008; Daniels 2011; Hornung et al. 2010; Leana et al. 2009; Topa Cantisano et al. 2008; Zhao et al. 2007)

## INTERPRETATION

Common mental health problems are now the predominant health problem of working age. Despite this the research evidence is mixed in quality and common mental health problems provide a significant conceptual and practical challenge, not least because they illustrate the depth of the complexity of the relationship between work and health. Biopsychosocial analyses seem fruitful, but more research is needed.

The literature on mental health and occupational stress is large and highly variable in quality, and is based on a diverse array of theoretical perspectives. It is often summarised into a simple framework that presents stress as a process with three major conceptual phases that are additionally influenced by personal, social and environmental factors (Harvey et al. 2006). These are “[a] *stressors* that are conceptualised as identifiable, stress-inducing agents that exist in the organisation and job environments, [b] *stress* which is the psychological interpretation and experience of these events by an individual as stressful and [c] *strain* which is a consequence to prolonged or acute stress in the form of behavioural, psychological, physiological and organisational outcomes. From a mental health standpoint, it is psychological strain that might be of greatest interest (e.g., burnout, psychological distress), but it is assumed that other health outcomes may result from or coexist with stress (Behavioural - e.g. alcohol and drug abuse; Organisational - e.g. absenteeism, staff turnover; Physiological - e.g. ulcers)” (p. 3). There are also variables that arise from individuals or their environments that can consequently influence the stress process, and these are referred to as moderators<sup>7</sup> because they can influence the nature of the relationships observed in the stress process. Examples include individual characteristics such as personality and preferred coping styles, or environmental factors such as the support received from others and the culture of the organisation.

Attempts to prevent the development of work-relevant mental health problems rest on a sequence of assumptions (that are similar to those for musculoskeletal problems): Stressors in

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<sup>7</sup> According to the definition established by Barron & Kenny (1986):

- A moderator is a qualitative (e.g., sex, race, class) or quantitative (e.g., level of reward) variable that affects the direction and/or strength of the relation between an independent or predictor variable and a dependent or criterion variable.
- A given variable may be said to function as a mediator to the extent that it accounts for the relation between the predictor and the criterion. For example, mediators explain how external events take on internal psychological significance. Whereas moderator variables specify when certain effects will hold, mediators speak to how or why such effects occur.

the workplace can be identified, eliminated, or reduced; and, that this will reduce the number of cases.

One approach to providing comfortable jobs involves a mixture of trying to eliminate or reduce stressors, along with trying to help people identify and become aware of stressors and how to deal with them effectively. When job demands cannot be tolerated or suitable adjustments are impossible, a limited period of absence is the appropriate response.

There is a general consensus (based on sound theoretical reasons) to promote a number of psychological aspects as a 'buffer' against developing mental health problems. These include well-being, personal resilience, a sense of coherence, psychological flexibility and positively reframing everyday stressors. Psychological flexibility refers to a number of dynamic processes that unfold overtime that concern how a person adapts to demands of fluctuating situations, reconfigures mental resources, shifts perspectives, and balances competing needs (Kashdan & Rottenberg 2010). Personal resilience is described as a strategy for surviving and thriving in the face of workplace adversity (Jackson et al. 2007), and encompasses: good health, sociability, confidence, optimism, hope, social support, problem-solving ability, internal locus of control, appraisal skills, flexibility in goal setting and ability to mobilise resources (Atkinson et al. 2009). Whilst a debate over the extent to which resilience should be regarded as a personality trait is ongoing, others view it as a process that can be developed at any time in the lifespan (Gillespie et al. 2007). Sense of coherence refers to a general tendency to see life as comprehensible, manageable and meaningful (Olsson et al. 2009). Whilst the relationship between each of these related concepts and common health problems are yet to be borne out, each can be regarded as a mental resource that offers protective effects against poor mental and physical health outcomes due to the role of underlying cognitive appraisal processes. Adaptive coping strategies include positive reappraisal, goal directed problem-solving and infusion of ordinary events with meaning (Folkman & Moskowitz 2000). Times of economic downturn and consequent austerity measures can be regarded as conditions of adversity. This is supported by evidence that the mental health of people in jobs with low psychosocial quality (i.e. with those low job control, high job demands and complexity, job insecurity and the perception of unfair pay) is similar to people who are unemployed (Butterworth et al. 2011). It is a reasonable assumption, and logical conclusion therefore, that interventions that target constructs such as these should address multiple levels by tackling individual, group, immediate work environment and organisational characteristics. Pragmatic challenges due to tailoring to individual characteristics can be overcome by tackling patterns that occur at the group level.

A balance needs to be struck between empowering people to take greater control over their health and employers' duty of care obligations. Responsibility should therefore be shared between individuals and employers. This represents a shift from the principles underpinning the Management Standards and recognises that people view their own health as their 'territory'.

Return to work is a vital social indicator of recovery and rehabilitation leading to better health outcomes and quality of life (Mental Health Foundation 2009). However, those with depression or anxiety may return to work with a mixture of residual symptoms and the addition of poor coping skills, low self-esteem, a reliance on medication, poor self-management (e.g. not utilising available workplace support such as occupational health service and counselling), poor working relationships, low motivation and low job satisfaction. This creates the potential for vicious cycles to develop, e.g. low levels of self-efficacy and motivation become obstacles for return to work leading to an unmotivated state (Briand et al. 2007; Labriola et al. 2007). This suggests the need to ensure appropriate intervention strategies are offered upon returning to work, and this largely involves provision of an accommodating workplace.

## WORK-RELEVANT STRESS COMPLAINTS

Stress complaints have become a common health problem. For the purposes of this project stress complaints refer to the subjective experiences of a constellation of complaints that usually include, but are not limited to: physiological features, e.g. headaches, gastric upset; behavioural features, e.g. reduced activity, sickness absence; cognitive features, e.g. worry, being distracted or forgetful; emotional features, e.g. fear, low mood. The person usually associates these complaints with perception of adverse life and/or working conditions and feels unable to cope with them. This may be accompanied by a diminished sense of subjective well-being. This approach transcends ambiguity where the term 'stress' can refer to both cause and consequence<sup>8</sup>. Yet, it is consistent with HSE's formal definition of work related stress as: "The adverse reaction people have to excessive pressures or other types of demand placed on them at work" (see also, Cox 1978).

The actual prevalence rates are difficult to determine. The Labour Force Survey, in 2008/09, estimated that ~415 000 individuals, who worked in the last year, believed that they were experiencing work-related stress at a level that was making them ill. The 2009 Psychosocial Working Conditions survey indicated that almost 17% of working individuals perceived their job as very or extremely stressful. Working days lost attributed to stress has not significantly changed over recent years (HSE 2012). As with other subjective health complaints, the actual incidence and prevalence cannot be objectively determined since there is no adequate case definition for 'stress' and it is not included in standard diagnostic taxonomies (DSM-IVR, ICD-10). Nevertheless, the term is widely used and is the subject of published guidance in many countries, including the UK. This situation invites wide variation in interpretation about the nature of stress, who experiences it, its severity, its possible causes, how to identify it, and how to manage it.

The experience of stress can be work-relevant irrespective of its source. It shares the same two main components with the other CHPs: the potential for workplace stressors to contribute to the health status of workers; and, interference in the ability to work or be productive as a result of the impact of experiencing stress. The first is related to the concept of 'comfortable jobs', and the second to the notion of an 'accommodating workplace'.

The premise that exposure to adverse psychosocial work conditions can be a hazard for the health of workers has largely been based on Karasek's demand/control model in which task-level work conditions characterised by low control and high demand are considered to be predictive of outcomes such as cardiovascular disease and sickness absence. One of the key criticisms of this model is its reliance on supposedly objective measures of the work environment only. However, in real life workers respond differently to the same constellation of control and demand conditions leading to varied biological outcomes. This means that a measure of individual worker differences, specifically in coping style, must be included in any job strain model (Ostry et al. 2003).

To try to overcome this potential weakness Siegrist (1996) developed the effort-reward imbalance (ERI) model in the early 1990's. This postulates that jobs characterised by a perceived imbalance between high effort and low rewards are stressful and will lead to negative health outcomes, particularly in persons with limited coping abilities. That is, the sustained stress responses and ill health are elicited by the high ratio of occupational effort spent relative to rewards received in terms of money, esteem, job security and career opportunities. It may explain the finding that worker health status may be lower where people have no alternative choice in the labour market or where they are exposed to heavy competition. The ERI model

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<sup>8</sup> An example of this ambiguity in a single sentence is the statement "stress [i.e. the consequence] is not a disease but prolonged exposure to it [i.e. the cause] may reduce effectiveness at work and may cause ill health". See p.4 of the Framework Agreement on Work-related Stress published in 2004 by the European Trade Union Confederation (ETUC): [www.etuc.org/IMG/pdf\\_Framework\\_agreement\\_on\\_work-related\\_stress\\_EN.pdf](http://www.etuc.org/IMG/pdf_Framework_agreement_on_work-related_stress_EN.pdf)

uses the attribute of an individual's "need for control", a personality characteristic related to flexibility in coping. It is proposed that a person with high need for control will respond in an inflexible way to work situations of high effort and low reward, and will therefore be more stressed and disease prone than a person in the same situation who has less need for control (Hagger & Orbell 2003; van Vegchel et al. 2005).

According to the ERI model, adverse health effects can also be triggered by an individual's exhaustive coping style, known as 'over commitment'. This refers to a set of attitudes, behaviours, and emotions reflecting excessive striving in combination with a strong desire to be approved of and esteemed. However, the evidence of adverse health effects is stronger for high efforts and low rewards (i.e., high ERI) than for over commitment. In addition to work-related morbidity, the model assumes that high ERI promotes lifestyle risk factors, such as smoking, high alcohol consumption, unhealthy dietary habits, and sedentary behaviour. However, empirical research to support this hypothesis is scarce (Kouvonen et al. 2006).

The main conclusions are:

- 1) Considerable care is needed to avoid ambiguity and tautology when discussing 'stress' since the term is in regular use with at least two separate meanings: it is used to describe both the external and internal stimuli that may contribute to feelings of being ill at ease; and, it is used to describe the subjective state that an individual experiences. In this report we use the term 'stressor' to refer to the former, and 'stress' is reserved for the latter (see Definitions and Glossary section)
- 2) Stress complaints are subjective in nature. There is no agreement on what defines a stress 'case', and diagnostic classification is not available. This makes accurate determination of incidence and prevalence impossible. For this reason estimates are necessarily based on self-report surveys, along with the biases inherent to that method.
- 3) Available evidence indicates that experience of stressors, especially when prolonged, can lead to subjective states of feeling stress with physiological, behavioural, cognitive, and affective responses. It is assumed that persistently 'feeling stressed' might contribute to the development of psychological disorders such as anxiety and depression and physiological disorders, although such links are hard to verify empirically. The role of sympathetic nervous system arousal and endocrine system involvement seems important.
- 4) Subjective stress complaints have become a common health problem. This means, in effect, that 'stress' is often described as if it were a health condition, despite lack of diagnostic criteria.
- 5) The experience of stress is very commonly attributed to work in surveys (e.g. Labour Force). However, it can be argued that this measures what people believe is affecting them, and does not itself represent evidence of cause and effect.
- 6) The symptoms of stress can range across the cognitive, emotional, behavioural and physiological realms. The impact on the individual can involve interference in any major area of functioning, including work. Hence, stress can be work-relevant.

- 7) There is no direct evidence that stress complaints can be totally prevented. However, well-being can be facilitated through workplace health promotion and the provision of comfortable jobs.
- 8) Attempts to facilitate well-being at work, and thereby reduce the probability of experiencing subjective stress, entail making jobs comfortable. There are multiple approaches that appear applicable to work-relevant stress problems
- 9) Both individual-level and organisation-level interventions can contribute to ameliorating stress symptoms, although a combination of the two is probably more effective. Accommodating people with stress problems at work will entail actions by the individual worker, their line manager and the organisation.
- 10) Incorporating psychosocial aspects of work into risk assessments remains potentially viable but is perhaps an incomplete approach to targeting interventions. This is because underlying mechanisms are not well understood and there is a lack of unequivocal evidence demonstrating beneficial effects from stress-reduction interventions on symptoms or incidence.
- 11) Other interventions such as line manager training, and high performance work systems, might be considered as useful.
- 12) The effectiveness of the Management Standards has not been fully evaluated, partly due to the complexity of the task<sup>9</sup>. Other evidence suggests that the approach can be demanding. Organisational capability is insufficient for its implementation in some organisations. The Management Standards may need to be expanded beyond the current job characteristics and assumptions concerning job design it currently embodies in order to improve their relevance to CHPs other than symptoms of stress.

## EVIDENCE STATEMENTS

The extracted data from references supporting the evidence statements in this section are in Tables 3 and 4.

### Nature of complaints

ST-1            \*\*\*        There has been substantial growth in ‘stress cases’ with little medical basis to explain the trend. The term ‘stress’ is ambiguous since it is used both to describe causes and consequences.

Table 3: (Henderson et al. 2003; Waddell et al. 2008)

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<sup>9</sup> Two issues are worth noting:

- The Management Standards focus on six major psychological risk factors, e.g. job demands, low job control, low support from co-workers and lack of role clarity. However, it is quite clear from other evidence that the range of psychosocial working conditions that may affect stress-related psychological and psychosomatic complaints is much wider (e.g., Warr 2007).
- The Management Standards follows a logical problem-solving sequence that includes elements of worker involvement through for example the recommendation to involve workers in solution definition through focus groups. This gives the potential for the Standards to have some sensitivity to local contexts.

ST-2 \* There is no scientific agreement on the conceptual basis of ‘stress’, its definition, assessment, or its causal relationship with work. ‘Stress’ is not included as a separate category in standard diagnostic classifications of mental illness, and is not accepted as a prescribed disease.

Table 3: (Cooper et al. 2001; Daniels 2011; Waddell et al. 2008)

ST-3 \* Traditional job characteristics models may not be the best explanation of how well-being and stress-related symptoms develop.

Table 3: (Daniels 2011)

Notes:

- Features of comfortable jobs that appear applicable to work-relevant stress include: job control; skill development and use; reasonable level of demands; variety in tasks; adequate breaks; allowing workers to regulate their own problems, distressing experiences, and responses to them; clarity concerning the future, role, and performance; good social contact; fair pay; physical security and safety; significance to self and society; good leadership/supervision; job security and career prospects; fairness in how workers are treated; allowing workers to pursue their own goals.

Table 3: (Cass et al. 2002; Daniels 2011; de Lange et al. 2003; Hornung et al. 2008; Hornung et al. 2009; Hornung et al. 2010; Leana et al. 2009; Rousseau et al. 2006; Warr 2007)

- When employees feel their employer has made promises concerning various benefits (including skills development, interesting work, careers, remuneration, job security), and these promises are perceived to have been broken, then workers experience poorer psychological well-being.

Table 3: (Bal & Van Der Velde 2008; Topa Cantisano et al. 2008; Zhao et al. 2007)

- Other management aspects that may be potentially important include considerate, empowering, supportive and transformational leadership. Ideally, when (line) managers conduct assessments of adverse work events (e.g., dealing with difficult internal customers), they need to be aware that work events impact on workers’ personal goals, expectations, emotions and specific forms of coping (e.g. problem-solving, recovery activities). Line managers also need to consider whether workers shaping their own work may be a more proximal and better predictor of work related well-being and emotions than top-down management-led changes in job design.

Table 3: (Daniels 2011; Kuoppala et al. 2008; Skakon et al. 2010; Warr 2007)

## Interventions

Attempts to facilitate well-being in the workplace need to be differentiated from approaches aiming to prevent stress.

ST-4           \*\*       Key concepts differentiating non-standard well-being approaches from stress-based approaches appear to concern how intrinsically rewarding a job is, or the extent to which the job aligns with the individual's value system.

Table 3: (Guest & Conway 2002; Nelson & Simmons 2002)

### *Facilitating well-being*

ST-5           \*\*       Behavioural variables that moderate the impact of environmental influences upon well-being include coping style and physical exercise. Workplace health promotion may be effective at improving psychological well-being. A higher job status provides improved health status and life expectancy. Absence of harmful health behaviours such as smoking, poor diet and high level of job control can explain at least part of this relationship.

Table 3: (Ferrie 2004; Marmot 2005)

ST-6           \*\*\*      Organisational change (regardless of direction), perceived organisational justice, job status, and job insecurity may be predictive of well-being-related outcomes.

Table 4: (Deely 2006; Ferrie 2004; Marmot 2005)

### *Prevention of stress*

ST-7           <sup>0</sup>       The complete or large scale prevention of stress and its consequences, using current approaches, appears problematic (as for the other CHPs). Such an approach rests on a sequence of assumptions: that hazards are known and significant; that they can be accurately identified in practice; that they can be eliminated, or reduced, and that this will yield a subsequent reduction in cases. Direct evidence that stress complaints can be prevented is lacking to date.

Table 3: (Biron et al. 2006; Corbiere et al. 2009; HSE 2009a)

ST-8           \*       Risk taking behaviour, coping behaviours and health behaviours such as smoking, dietary insufficiency, low exercise levels, excessive alcohol and/or drugs, and participation in workplace screening can modify vulnerability to stress-related health problems.

Table 3: (Conner-Smith & Compas, 2004)

### *Individual-level intervention*

ST-9           \*\*       There is moderate evidence that stress management interventions improve subjective outcomes, such as mental well-being, complaints and perceived quality of



work (though these are usually measured at workforce level, and not specifically in workers with mental health problems).

Table 3: (Corbiere et al. 2009; Corbiere & Shen 2006; Martin et al. 2009; Richardson & Rothstein 2008; Ruotsalainen et al. 2008; Sin & Lyubomirsky 2009; van Wyk & Pillay-Van Wyk 2010)

ST-10 \* There is only limited evidence to support the view that stress management interventions improve sickness absence rates or return to work, for workers who have already developed mental health problems.

Table 3: (Blank et al. 2008; Corbiere & Shen 2006)

#### *Organisation – level intervention*

ST – 11 \*\*\* Organisation and job level interventions can sometimes be effective in improving psychological well-being, but they are not uniformly effective and do not have universally beneficial effects.

Table 3: (Awa et al. 2010; Bambra et al. 2007; Bambra et al. 2008a; Bambra et al. 2008b; Corbiere et al. 2009; Gilbody et al. 2006; Joyce et al. 2010; Ruotsalainen et al. 2008)

ST – 12 \*\*\* Organisational level interventions need to be combined with individual interventions to yield optimal impact on stress-related health outcomes and increase the likelihood of indirect as well as direct benefits. Multi-level interventions appear to have the best effect on individual well-being outcomes over and above that achieved by either in isolation.

Table 3: (Awa et al. 2010; Corbiere et al. 2009; Gilbody et al. 2006; Jordan et al. 2003; Richardson & Rothstein 2008; Semmer 2008)

#### **Implementation**

ST – 13 \* The severity of consequences of psychosocial hazards and individual coping/resilience to psychosocial hazards may need to be included in risk assessments to get a fuller picture of what needs to be prioritised for interventions.

Table 3: (Biron et al. 2006; Daniels 2011)

ST – 14 \*\*\* Delivery of combined organisational and individual level interventions needs to be considered. However, interventions provided to individuals often require multiple sessions over a period of time including follow-up, and top-up sessions to prevent relapse.

Table 3: (Awa et al. 2010; van Wyk & Pillay-Van Wyk 2010)

ST - 15 <sup>o</sup> Other forms of HR interventions need to be considered, including line manager training. For example, care can be taken by managers to provide employees with realistic expectations from their work but also to understand employees' needs and goals and to make sincere efforts, within reason, to meet these needs and goals. High performance work systems

(HPWSs) as integrated human resource management interventions, in conjunction with high levels of perceived support/justice, may benefit well-being.

Table 3: (Becker & Huselid 2006; Butts et al. 2009; Combs et al. 2006; Delaney & Huselid 1996; Guthrie 2001; Huselid 1995; Kroon et al. 2009; Macky & Boxall 2008; Takeuchi et al. 2009; Wu & Chaturvedi 2009)

## **INTERPRETATION**

In the literature, the term 'stress' tends to be used interchangeably to refer both to antecedents and consequences. However, the main focus of this project is on stress as a complaint, i.e. when individuals experience symptoms. By their very nature stress complaints are subjective. This is because there is little agreement on what defines a case of stress, and there are no diagnostic criteria available. Furthermore, the symptoms ascribed to the experience of stress are difficult to link objectively to external events or actions. This situation presents a major challenge to investigating stress, and is analogous to other subjective symptoms such as pain or fatigue. It means that all aspects of the stress field are necessarily based on estimates and associations, and are therefore open to wide interpretation.

The relationship between stress and health is complex, and cannot be stated with certainty. The effects of prolonged stress are of interest when considering the relationship with health. The epidemiology of stress is poorly understood. Incidence and prevalence are difficult to determine accurately without an agreed case definition. This means that conclusions concerning causation and identification of potential contributing or risk factors are prone to significant error: as a result, the relationship between stress and work is somewhat ambiguous.

Despite this we are faced with an important finding. Namely, a large number of individuals report that they experience stress as a problem, and their healthcare providers (such as GP's) frequently interpret this as a health problem. An equally important finding is that many individuals, and their healthcare providers, attribute the onset and/or exacerbation of stress symptoms to their work. This has been objectively observable as increasing rates of sickness absence and reduced productivity due to stress. In this manner stress has become a significant work-relevant common health problem. However, the perception that stress is due to work is a belief, and not necessarily evidence of direct cause and effect.

Given all of these challenges it is unsurprising that understanding the causes and contributing factors to stress remains complicated and lacking certainty, and obtaining direct evidence of how to prevent stress remains a challenge.

When an individual complains of stress they report experiencing a mixture of symptoms that are typically cognitive, emotional, behavioural and physiological in nature. Many of these symptoms overlap with those clinically ascribed to anxiety states and the anxiety disorders. However, their essentially subjective nature makes them difficult to quantify reliably and this in turn makes studying them a challenge. There is also a significant problem in determining the extent to which perception of subjective symptoms is modulated by other psychological events. For example, the onset of worry (cognitive) may be initiated by fear (emotion), resulting in sympathetic nervous system arousal (physiological) and changes in behaviour; but, the physiological changes experienced (e.g. increased heart rate) may be appraised as reason for increased worry, thereby exacerbating the subjective experience of stress. Researchers face similar problems with investigating other important subjective symptoms such as pain and fatigue.

The consequence of experiencing stress can yield markedly different impacts between different individuals, and within the same individual at different points in time. In order to explain the inter- and intra-individual differences psychological theorists have invoked a variety of models with various features. The most enduring has been the Holmes & Rahe (1967) diathesis-stress model that explains behaviour both as a result of biological and genetic factors, and life experiences, thereby transcending the classic 'nature-nurture debate'. The term diathesis refers to a biological/genetic predisposition toward a disease or abnormal condition. When this predisposition is combined with certain kinds of environmental stress, the abnormal behaviour or disease is manifested. The greater the underlying vulnerability, the less stress is needed to trigger the behaviour or disorder. Conversely, where there is a smaller genetic contribution, greater life stress is required to produce the particular result. Even so, someone with a diathesis towards a disorder does not necessarily mean they will ever develop the disorder. Both the diathesis and the stress are required for this to happen. Newer formulations of the diathesis-stress model include the 'stress-vulnerability-protective factors' model attributed to Robert Liberman (Liberman, 1994).

This approach has led to interest in trying to identify potentially protective factors, both within the individual and from external sources, which might prevent the combination of stress and predisposition/vulnerability resulting in an abnormal state. Examples include resilience and coping. The approach has also led to the development of methods to ameliorate the subjective experience of stress, either before it develops or once it had developed. The field of 'stress inoculation training', pioneered by Donald Meichenbaum (Meichenbaum 1985), emerged out of an attempt to integrate the research on the role of cognitive and affective factors in coping processes with the emerging technology of cognitive-behaviour modification. Stress inoculation training has been used on a treatment basis to help individuals cope with the aftermath of exposure to stressful events, and on a preventative basis to "inoculate" individuals to future and ongoing stressors. It subsequently became the foundation for cognitive-behavioural models for managing chronic pain and chronic fatigue syndromes. Stress management was developed as an intervention for stress once it has begun, especially if it is persistent or chronic. Clinical stress management is the amelioration of stress for the purpose of improving everyday functioning. Techniques vary according to the theoretical paradigm adopted. Common examples include autogenic (relaxation) training, progressive relaxation, cognitive-behaviour therapy and meditation.

Approaches to stress that separate individuals from their environments have been criticised for failing to recognise the important role individual interpretation and agency play in how psychosocial environments influence emotional well-being and stress-related symptoms, and how individuals themselves shape their psychosocial environments. Such ideas are central to the heavily influential 'transactional' approach to stress and emotions (see e.g., Lazarus, 1999). In transactional approaches, individuals are seen as active sense makers in which an individual's appraisal of events shape initial emotional reactions and coping responses, which in turn can shape subsequent changes in the psychosocial environment (Lazarus 1999). Whilst appraisals were originally conceived in many models to refer to appraisals of how events impact on personal goals, a more recent cognitive model of appraisals subsumes both appraisals of events' impact on goals and inferences concerning events' likely impact on emotions (Power & Dalgleish 2008). This model has been developed and applied successfully in predicting work-related well-being (Daniels, 2011). The notion of coping is important in transactional models, and is also relevant to the interface between the psychosocial work environment and the individual. For example, an intervention that enhanced job control had stronger effects on mental health and reduced absence for people with predispositions to cope better with work-related stressors (Bond et al. 2008). In summary, transactional models emphasise the importance of both: a) considering individuals' interpretations of the work environment, especially in relation to impact on goals and well-being, as important determinants of the stressfulness of work characteristics; and b) individual coping responses to self-regulate well-being and aspects of the work environment in facilitating that coping.

The workplace and the process of undertaking work are potential sources of stressors for every worker. This proposition is supported by a large amount of correlational research, but much less longitudinal research. As noted above, there is widespread belief, yet to be supported by definitive evidence, that work and the workplace can create adverse health effects expressed as stress symptoms. The consequence has been a search for risk factors<sup>10</sup>, in the hope that through avoidance or control of those factors, stress may be prevented. A related interventionist approach is to facilitate well-being in order to buffer stressors and reduce stressors' impact.

Direct evidence that the subjective experience of stress, or the report of stress complaints, can be totally prevented in the workforce is lacking to date. There is some evidence that a sense of well-being can be facilitated through workplace health promotion and the provision of comfortable jobs. However, it is not known whether this has a beneficial effect on stress.

Interventions intending to facilitate well-being at work, and thereby reduce the probability of experiencing subjective stress, might reasonably involve making jobs comfortable. There are multiple features that appear applicable to work-relevant stress problems. In addition there are actions that can be taken by the individual worker, their line manager and the organisation.

Features of comfortable jobs that appear applicable to work-relevant stress include: job control; skill development and use; reasonable level of demands; variety in tasks; adequate breaks; allowing workers to regulate their own problems, distressing experiences, and responses to them; clarity concerning the future, role and performance; good social contact; fair pay; physical security and safety; significance to self and society; good leadership/supervision; job security and career prospects; fairness in how workers are treated; allowing workers to pursue their own goals. Many of the features of comfortable jobs (e.g., variety, control, clarity) can be related to job resources that can be defined as characteristics of jobs that stimulate personal growth, development and attainment of personal goals (Demerouti et al. 2001).

Other management aspects that may be potentially important include considerate, empowering, supportive and transformational leadership. Ideally, when (line) managers conduct assessments of adverse work events (e.g., dealing with difficult internal customers), they need to be aware that work events impact on workers' personal goals, expectations, emotions and specific forms of coping (e.g. problem-solving, recovery activities). Line managers also need to consider whether workers shaping their own work may be a better predictor of well-being at work and emotions than top-down management-led changes in job design. Once stress symptoms have developed and become work-relevant (not all stress symptoms will be work-relevant), there are two main workplace units of intervention: the individual and the organisation.

Both individual-level and organisation-level interventions can contribute to ameliorating work-relevant stress symptoms, although a combination of the two is probably more effective (e.g. (Awa et al. 2010; Jordan et al. 2003; Semmer 2008).

Incorporating psychosocial aspects into risk assessments may assist in targeting interventions, so it seems feasible that an approach such as that outlined by the Psychosocial Flags Framework

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<sup>10</sup> The literature contains a number of overlapping and similar terms that are often used interchangeably. These include: risk factors, predictive factors, prognostic factors, etc. This can be confusing. For the purposes of this project terms are used in the following way (Main et al. 2008):

- 'Risk factors' refer to features associated with the future development or occurrence of an event such as a disease of some sort. They may or may not be implicated causally in the development of the disease, but the disease is not present at the time of risk estimation. Further investigations may be able to demonstrate a direct causal relationship, but the relationship may be indirect (possibly mediated by other factors) or, in so far as can be investigated, may turn out to be a chance association.
- 'Predictive factors' refer to those that are associated statistically with some sort of outcome in the future. Whether or not they are predictive therefore is a matter of statistical association, using whatever criteria are appropriate. They make no assumptions about the relationship, or lack of, between the two sets of events. In practice, they can be divided into risk factors and prognostic factors.
- 'Prognostic factors' refer to factors predictive of outcome of a current disease or condition.

for musculoskeletal problems could provide additional insights into the management of work-related stress.

Other interventions such as line manager training (Skakon et al. 2010; Yarker et al. 2008) and high performance work systems, might be considered as useful (Becker & Huselid 2006; Butts et al. 2009; Combs et al. 2006; Delaney & Huselid 1996; Guthrie 2001; Huselid 1995; Kroon et al. 2009; Macky & Boxall 2008; Takeuchi et al. 2009; Wu & Chaturvedi 2009).

There is also potential for individuals to develop their own interventions to ensure comfortable or accommodating workplaces – either through negotiation with managers or through individuals or groups of workers shaping the content of their own work (Daniels 2011; Hornung et al. 2010; Leana et al. 2009).

The Management Standards approach is demanding (Broughton et al. 2009; Tyers et al. 2009) and does not appear to have been effective to date, perhaps due to problems with implementation and the weak evidence and theoretical base supporting the underpinning model (Daniels 2011). Various aspects of the approach suggest that it is not directly applicable to other CHPs (see section ‘Relationship with Management Standards’).

A review of components necessary for an occupational health climate tool revealed those management and work practices that potentially affect occupational health climate as encompassing: organisational responsiveness to occupational health issues; line management responsiveness to occupational health issues; organisational values regarding people; quality and quantity of support; supervisor support; procedural justice; role ambiguity, role overload; recognition of goal attainment; feedback practices; performance management; recognition of goal attainment; values fit; job demands; job resources; autonomy; worker involvement; skills utilisation; communication practices; leadership styles; reporting; co-worker influence; and group norms (Lunt & Fox 2010).

As with other CHPs, the symptoms of stress can become work-relevant irrespective of their source. Stress shares the same two main components with the other common health problems: the potential for workplace stressors to contribute to the health status of workers; and, interference in the ability to work or be productive as a result of the impact of experiencing stress. The first is related to the concept of ‘comfortable jobs’, and the second to the notion of an ‘accommodating workplace’.

## **GENERIC ISSUES**

The term ‘common health problems’ covers a wide range of conditions and complaints, for which there is a variety of causative agents and exposures: some purported, some known. Where work-relevance is concerned, there seems to be some commonality: many of the work factors that influence the expression of musculoskeletal complaints at work are not dissimilar to those that influence the expression of mental health complaints and stress. Furthermore, mixtures of musculoskeletal, mental health, and stress complaints are frequently reported in combination. It would follow, then, that there are generic issues to be explored before a comprehensive intervention toolbox can be conceived and put together. This will involve an awareness of competing underlying conceptual models, the factors related to concurrence of complaints, the ways in which influencing factors can be identified and assessed, and elaboration of the concepts of comfortable and accommodating workplaces.

Main conclusions are:

- Interventions that might be directed to work-relevant common health problems will variously aim to minimise the occurrence of ill-health and contribute to maintaining work participation. Broadly, the interventions will be at the organisational and individual levels respectively. It will be necessary to find the optimal balance between the two to maximise control of both the occurrence of work-relevant common health problems and their consequences.
- The conventional health and safety (injury; stress/strain; risk-management) model appears insufficient for tackling common health problems and their work-relevant consequences. This approach may be necessary for workplace safety but it is certainly not sufficient to tackle common health problems at work. The biopsychosocial model, importantly, widens the range of intervention and permits effective individual level interventions that focus on maintaining work participation.
- Organisational level interventions (even those based on biopsychosocial principles) may achieve comfortable workplaces and satisfying jobs, which can impact on the health outcomes for groups of people, but they do not deal with the individual in need of accommodation. An additional layer is needed to tackle work-relevant common health problems, for which the biopsychosocial approach is ideally suited: Accommodating people who are ill or injured either to remain in work or return early whilst they recover.
- Greater integration between occupational health management, health promotion, human resource management and operations management seems to provide an important backdrop for creating a healthy work environment. This is implied by increased recognition within the evidence base that organisational and individual level interventions should be combined. Inter-disciplinary working is a prerequisite for greater integration and optimal impact.
- The Management Standards provided too narrow a basis for capturing all relevant factors implicated in CHP development and progression. This, together with incomplete evaluation, could partly account for the debate over the level of impact the Management Standards have achieved to date.
- Positive affect (feelings that reflect a level of pleasurable engagement with the environment, such as happiness, joy, excitement, enthusiasm, and contentment) can facilitate better health outcomes, so it is presumed that creating a work and organisational environment fostering well-being and promoting job satisfaction may reduce the likelihood of development or progression of common health problems and their consequences. However, this has yet to be demonstrated.
- There are various obstacles to overcome in implementing initiatives to minimise and manage common health problems, and these include inadequate knowledge and skills, resistance/lack of commitment from employees, line managers, senior managers and organisation inertia. Various facilitators can overcome these obstacles, and these include senior management involvement, which includes, but is not limited to, visible senior management, consultation, persistence and integration with business strategy to ensure CHP relevant initiatives contribute to long-term business success. A planned and consultative process involving developing a clear, written strategy, implementation plans and

monitoring/evaluation is desirable. A key necessity for any intervention is to get all the players onside and acting collaboratively.

## EVIDENCE STATEMENTS

The extracted data from references supporting the evidence statements in this section are in Tables 1, 2, 3, and 4.

### Conceptual models

To satisfactorily underpin a comprehensive intervention toolbox for management of common health problems at work requires a basic model of work and health that takes account of the variable nature of common health problems and their inconsistent relationship with work.

G-1<sup>0</sup> The orthodox health and safety approach is largely rooted in an ‘injury’ (stressor-strain) model of the relationship between work and health. It is based around the idea that exposure to some level of workplace stressors (physical or mental) leads to disease or injury: removal of those stressors will be preventive. When there is a clear causal relationship between the exposure and the outcome, this paradigm can explain associations and point to solutions. However, it does not account for causal complexities and the observed individual variation in response, and does not readily embrace the beneficial aspects of work. Thus it fails to explain the phenomenon of work-relevant CHPs.

Table 4: (Cole et al. 2005; Cox et al. 2009; EASHAW 2005; EASHAW 2007a; EASHAW 2007b; EASHAW 2009; Hassan et al. 2009; Howell et al. 2007; IOSH 2009; Waddell & Aylward 2010; Waddell & Burton 2006)

G-2<sup>\*</sup> The biopsychosocial model, when applied to the relationship between health and work, builds on the strengths of less comprehensive models (including the injury model, and the diathesis-stress model) by incorporating them but also takes account of the complex interactions between the individual, their health condition and their social environment: it helps to explain the limited potential for primary prevention of common health complaints (by recognising that influences on important behaviours such as not going to work are influenced by multiple factors, not simply the presence or absence of symptoms, and that CHP symptoms themselves are subjective and easily influenced by a variety of factors). It allows for the beneficial effects from work and enables explanation of the variation in individual response to occupational stressors. The psychobiological interface is enigmatic and difficult to study, but the biopsychosocial model provides a pragmatic evidence-informed framework for developing comprehensive assessment and intervention protocols.

Table 4 (Adler 2009; Hill et al. 2007; Novack et al. 2007; Seymour & Grove 2005; Waddell & Aylward 2010)

G-3<sup>\*</sup> The psychosocial flags framework is a practical extension of the biopsychosocial model aimed at tackling work-relevant musculoskeletal problems, with potential application to any common health problem. The basic tenet is that some people struggle to maintain workability and activity during spells of trouble, not because they have a more serious illness or injury, but because they face biopsychosocial obstacles to normal recovery and work participation. The framework guides identification of obstacles, development of an individual plan, and implementation using a stepped care approach.

Table 4 (Burton et al. 2008; Kendall et al. 2009; Shaw et al. 2009; Waddell & Burton 2004)

G-4 \* The Management Standards (for work-related stress) is a framework based around the conventional health and safety model. Whilst some account is taken of psychosocial factors, the focus is firmly based on risk identification and control to achieve prevention. Use of the Management Standards approach alone appears an incomplete means for tackling work-related stress, can be insensitive to local conditions, and so will probably fall short in tackling other common health problems. The Management Standards probably provide too narrow a basis for capturing all relevant factors implicated in the development and progression of common health problems.

Table 3 (Biron et al. 2006; Daniels 2011; Tabanelli et al. 2008)

### **Concurrent complaints**

A significant proportion of people experiencing a common health problem also report complaints associated with other common health problems. The existence of concurrent complaints raises a number of questions: e.g. do different common health problems have shared causative factors; can one common health problem cause or exacerbate another; can interventions operate on more than one common health problem at once?

G-6 \*\*\* The background epidemiology of common health problems makes extensive reporting of coexisting complaints inevitable in the population: At any given point in time it is likely that a relatively high proportion of people will be experiencing more than one common health complaint.

Table 1: (Miranda et al. 2010)

Table 2: (Michie & Williams 2003)

(Burton et al. 2008; Ursin 1997; Waddell et al. 2008; Waddell & Burton 2006)

G-7 \*\* Stressors (physical and mental) may contribute to common health problems through adoption of harmful health behaviours or non-uptake of beneficial health behaviours.

Table 4: (Nieuwenhaijsen et al. 2005; Steptoe, 2005)

G-9 \*\*\* Subjective well-being has a beneficial effect on health status in the general population. It is believed that well-being may buffer the impact of stress. Furthermore, positive affect (e.g., happiness, enthusiasm) is associated with cognitive, behavioural and physiological processes that promote health and functioning.

Table 4: (Howell et al. 2007; Lyubomirsky et al. 2005; Sin & Lyubomirsky 2009)

G-10 \*\*\* Effective interventions applicable to all CHPs involve early intervention based on biopsychosocial principles with all players onside and acting, directed at the individual and focused on work participation.



(Waddell et al. 2008; Waddell & Burton 2004)

G-11           \*\*       The associations between organisational factors and psychological ill health and sickness absence are similar enough across sectors to justify a generic approach. Designing, developing and evaluating interventions needs to encompass all the bases of behaviour change as well as specify contextual characteristics consistently and in full.

Table 4: (Michie & Williams 2003)

#### **Assessment (person, workplace, context)**

G-12           \*\*       Psychosocial obstacles and enablers to work participation can be identified (assessed) by simple non-specialist techniques such as guided observation and questioning. Focusing on salient psychosocial features allows selection of cases for interventions targeting specific issues.

Table 1: (Burton et al. 2008; Pincus et al. 2006; Schultz et al. 2007; Shaw et al. 2009; Waddell et al. 2003; Waddell & Burton 2000; Waddell & Burton 2004)

Table 2: (Couser 2008; Graveling et al. 2008; Harvey et al. 2006; Krupa 2007; Michie & Williams 2003; Olsson et al. 2009; Varekamp et al. 2006)

Table 4: (Kendall et al. 2009)

#### **Comfortable jobs and accommodating workplaces**

Although work is generally good for our health and well-being (Coats & Lehti 2008; Waddell & Burton 2006), there is an important caveat – the benefits are most applicable to ‘good work’. A detailed review of the literature on what good work comprises is beyond the scope of this review, and would duplicate previous work (e.g. by Coats & Lehti 2008). The general tenets are around security, fairness, satisfaction, capability matching, social capital and safety. It is clearly linked to the idea that work should be both comfortable and accommodating (Hadler 1997), but the notion of comfortable and accommodating is about the job more than the work – the needs of the individual rather than the group is the focus.

The ability to provide and have ‘good work’ stems mostly from actions at the level of our society; such as enabling legislation and suitable policy frameworks and guidance for implementation. It is then up to organisations and individuals to make it happen. Whilst the principal level of intervention to generate ‘good work’ is at the socio-political level, the provision and experience of a comfortable job derives in the main from the systems and processes that exist in the workplace, including work organisation. All the features required for ‘good work’ may be in place, yet the workplace may not be a comfortable one. The level of intervention to ensure a workplace is comfortable is usually at the group or organisational level, but also involves the individual. Accommodation takes place at the individual level, perhaps under facilitative workplace policies. The requirement for, and type of, workplace accommodation is necessarily tailored to the needs of the individual, possibly driven by workplace policy. The worker-line manager relationship is the key to making it happen effectively. This means the level of intervention is predominantly at the individual level (See Appendix 1 - Figure 4).

G-13           \*\*       Good work is associated with job control; skill use; reasonable level of demands; task variety; clarity concerning the future, role, and performance; good social support; fairness in pay and distribution of rewards/benefits; safety; significance to self and society;

leadership/supervision; job security and career prospects; fairness in how workers are treated. Good work is associated with higher levels of safety and lower chance of developing health problems.

Table 3 (Cass et al. 2002; de Lange et al. 2003; Warr 2007)

Table 4: (Bambra et al. 2009; Boorman 2009)

G-14 \* Good Jobs allow workers to pursue their own goals, regulate their own problems, affective experiences, breaks and symptoms. Job control and social support might be particularly useful in allowing this – especially if supplemented with relevant training. Jobs that are organised for psychological well-being can also help those with ill-health control the disease and its symptoms.

Table 3: (Daniels 2011)

Table 4: (Bevan et al. 2007; Bilsker et al. 2005)

G-15 \*\*\* Low job satisfaction is moderately correlated with presence of self-reported mental/psychological problems (burnout, self-esteem, depression, and anxiety). The correlation with self-reported physical complaints is smaller. While there are theoretical reasons for proposing that organisations might take steps to foster job satisfaction because job disaffection may lead to poorer employee health, such mediation of interventions needs to be demonstrated and such an intervention properly tested.

Table 4: (Bartley et al. 2005; Faragher et al. 2005)

G-16 \*\*\* Flexible work conditions that increase worker control and choice (e.g. self-scheduling or gradual/partial retirement) can have a positive impact on health outcomes (including systolic blood pressure and heart rate; tiredness, mental health, sleep patterns, and self rated health status) providing they are not imposed on the worker.

Table 4 (Joyce et al. 2010)

G-17 \*\* It is expected that ‘good work’ has the best chance of facilitating well-being, and this may best be achieved through minimising workplace stress by suitable human resource and person management techniques such as managing job expectations to optimise the fit between personal goals, ability and job requirements/role.

Table 4: (Bilsker et al. 2005; Layard 2006)

G-18 \*\*\* The workplace can have a role in reducing the detrimental effects of health inequalities on health outcomes. Health inequalities result from social inequalities. Action from health inequalities therefore requires action on all the social determinants of health, including any arising in the workplace.

Table 4: (Bambra et al. 2009; Marmot 2010)

## **Interventions – principles and practicalities**

G-19 \*\*\* Individual differences in beliefs about the cause, consequences and control over health problems can explain variations in disability outcomes where the underlying pathology is constant. This effect is mediated by coping behaviours. Interventions on ill health complaints should assess and modify where necessary illness perceptions in order to enable faster return to work. Belief in ability to control symptoms can, in general, be an important component of an adaptive response to common health problems.

Table 4: (Creed & Barsky 2004; de Gucht & Maes 2006; Esler & Bock 2004; Hagger & Orbell 2003)

G-20 \* Remaining off-sick due to fears that return to work may worsen a condition can be self-reinforcing: an individual's choice not to return to work means that the underlying assumption is not then tested.

Table 3: (Franche et al. 2005)

Table 4: (Dunstan & Covic 2006)

## **Job satisfaction**

The concept of job or work satisfaction is intrinsically subjective: two individuals may experience an identical job very differently, one may be satisfied and the other dissatisfied. Furthermore, satisfaction with one's job is unlikely to be a constant, but may vary across time. Job satisfaction appears related to job performance (Judge et al. 2001), although the nature and magnitude is debated (Saari & Judge 2004). Results from a recent meta-analysis indicate much of the co-variation between job performance and job satisfaction can be accounted for by individual differences such as aspects of personality (Bowling 2007). On the other hand, a meta-analysis of studies examining links between average levels of job satisfaction within an organisational unit and unit performance indicates a reliable association (Whitman et al. 2010). It is less likely this association is due to 'aggregate' personality but it is not impossible. However, because of a dominance of cross-sectional studies concentrating on aggregate job satisfaction and unit-level performance, the direction of causation is unclear.

For the purposes of this project, job satisfaction is an attitudinal variable that refers to a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences (Locke 1976; Thoresen et al. 2003). More simply, it is how people feel about their jobs and different aspects of their jobs. It is the extent to which people like (satisfaction) or dislike (dissatisfaction) their jobs. The measurement of job satisfaction is itself a large field. Measures can be 'faceted', whereby they measure various dimensions of the job, while others are 'global'. These measure a single, overall feeling toward the job. An example of a global measure is 'How satisfied are you with your job?' If a measure is facet-based, overall job satisfaction is typically defined as a sum of the facets (Saari & Judge 2004). There are a large variety of faceted measures (Adler 2009; Rafferty & Griffin 2009; van Saane et al. 2003). Estimates of job satisfaction in various populations potentially allow comparisons. However, there are many confounders and cohort effects that make interpretation difficult.

Reviewing the entire field of job satisfaction is beyond the scope of this project. The main focus here is on addressing three key questions: what contributes to job satisfaction; what are the health effects, if any; and how might job satisfaction be enhanced?

### *Contributions to job satisfaction*

The best examples of recent systematic reviews have focused on healthcare workers (including nurses and GPs). Leadership style has a role of in promoting job satisfaction among nurses (Cummings et al. 2010; Kuoppala et al. 2008; Utriainen & Kyngas 2009), as well as span of control and workload (Lee & Cummings 2008). Among GP's, factors increasing job satisfaction appear to be diversity of work, relations and contact with colleagues and being involved in teaching medical students. Factors decreasing job satisfaction are low income, too many working hours, administrative burdens, heavy workload, lack of time and lack of recognition (Van Ham et al. 2006).

### *Health Effects of Job Satisfaction*

There are a very large number of cross-sectional and observational studies (in excess of 480) indicating job satisfaction is correlated with mental/psychological problems (Faragher et al. 2005). The strongest relationships are found for burnout ( $r=0.48$ ), self-esteem ( $r=0.43$ ), depression ( $r = 0.42$ ) and anxiety ( $r = 0.42$ ). The correlation with subjective physical illness is more modest ( $r = 0.29$ ). However, correlation does not demonstrate causation. This means that the relationship between job satisfaction and mental health and stress remains uncertain. In the musculoskeletal area there is more prospective, longitudinal research available. There is good evidence that job satisfaction is related to future musculoskeletal problems such as back pain (Lakke et al. 2009; Linton & van Tulder 2001; Macfarlane et al. 2009) and moderate evidence it is related to neck pain (Côté et al. 2008).

### *Enhancing job satisfaction*

As an indicator of well-being and because of inverse relationships with indicators of stress such as depression and anxiety, many of the conclusions concerning interventions and causal factors for stress and mental health can be extended to job satisfaction, including issues concerning job characteristics, job crafting, high performance work practices, psychological contracts and goal pursuit. Indeed, many studies of these topics include job satisfaction as an indicator of well-being.

A recent Cochrane systematic review (van Wyk & Pillay-Van Wyk 2010) included ten studies (using a total of  $n=716$  subjects). None assessed the effects of support groups for health workers. Eight studies assessed the effects of training interventions in various stress management techniques on measures of stress and/or job satisfaction, and two studies assessed the effects of management interventions on stress, job satisfaction and absenteeism (one assessed an intervention involving process consultation for nurse managers to improve their problem solving ability in interdisciplinary staff teams, and the other assessed the effect of an intervention aimed at improving managers' ability to manage organisational change on job satisfaction). Of the two studies that assessed the effects of stress management training interventions on job satisfaction, neither - using low and moderate levels of intensity in training interventions, respectively - demonstrated a positive effect of the intervention on job satisfaction over the short (less than one month after the intervention) or medium term (between one and six months after the intervention). The results of one study showed no difference in job satisfaction among nurses and nurse aides who received four sessions of mindfulness training; and, the results of the second showed no difference in job satisfaction between health workers who received six sessions of stress management training post-intervention. The single study of a change management intervention demonstrated a small beneficial effect on job satisfaction among the intervention group on 30-week follow-up measure after the intervention, compared to the control group. The authors concluded there is insufficient evidence for the effectiveness of stress management training interventions to reduce job stress and prevent burnout among healthcare workers beyond the intervention period. Low quality evidence suggests that longer-term interventions with refresher or booster sessions may have more sustained positive effect, but this needs to be rigorously evaluated in further trials.

## **INTERPRETATION**

### *Conceptual models*

There are two predominant overarching models that seek to explain the relationship between work and health: the conventional health and safety (injury) approach, and the biopsychosocial approach. The former reflects the strong principles of the biomedical model and the diathesis-stress model. The latter builds upon this by incorporating all those aspects but extending the approach to include bidirectional interactions between all facets of the person.

In essence, the health and safety approach seeks to prevent harm by controlling workplace hazards: it is typically implemented as an intervention on the workforce not the individual, with the assumption that the effect of an intervention will be equivalent across that workforce. Historically, the approach has been effective in controlling disease and injury among workers when there is a clear direct causative relationship between the hazard and the harm (e.g. falls from heights or exposure to noxious substances). The paradigm has not worked as well when used to control common health problems and their consequences.

The biopsychosocial approach, on the other hand, recognises and accounts for the multiplicity of influences determining the manifestation of common health problems. Whilst there are aspects of the approach that can underpin interventions directed at the workforce level, its particular strength in respect of common health problems lies in the development of interventions at the individual level. The biopsychosocial approach does not focus exclusively on primary prevention; rather there is a recognition that complaints will occur irrespective of workplace influences and prevention strategies and campaigns. This puts an additional focus firmly on rapidly and effectively managing cases as and when they arise.

The health and safety and biopsychosocial approaches are complementary to each other and are not mutually exclusive. Neither is right or wrong, they are simply trying to explain the problems in different ways and provide solutions to tackle challenging problems. Interventions using the orthodox health and safety approach at the workforce level do not preclude biopsychosocial interventions at the individual level. The evidence, though, is strongly in favour of the biopsychosocial approach when it comes to tackling work-relevant common health problems. Although an explanatory 'one size fits all' biopsychosocial model does not and is not likely to exist, a detailed understanding of underlying mechanisms will not necessarily add value to developing the intervention toolkit. Taken overall, the biopsychosocial model is useful as a foundation for ensuring all important layers of influence are accounted for, encompassing the psychobiological and psychosocial interfaces as applied to prevention, staying at work or returning to work, including those influences arising at the organisational/societal layer.

In summary, the biopsychosocial model provides a conceptual framework for organising the attributes of a comfortable and accommodating work environment so that all the layers of influence on prevention and maintaining work participation are systematically considered, and will allow for an intervention toolbox with a multidisciplinary approach.

### *Concurrent complaints*

The basic epidemiology of common health problems shows that concurrent complaints are inevitable for most people on occasion, added to which healthcare providers may give the person multiple labels to explain concurrent symptoms. Usually, there is no obvious common aetiological factor linking the different complaints that are occurring at the same time in a given individual (e.g. musculoskeletal or mental health), and similarly there is often no apparent connection between different episodes of the same complaint (e.g. back pain) in the same individual. In effect the person has concurrent complaints (perhaps physical and mental). The term 'concurrent' is preferred over comorbidity since it simply describes co-occurrence and coexistence, and makes no assumptions about shared causation or pathology.

However, that does not mean there cannot be a common cause for the same complaint affecting numerous people at (about) the same time. For instance, a high proportion of a workforce exposed to a toxic substance may develop the same complaint. Nevertheless, any suggestion that clusters of common health complaints have a common aetiology must be made with substantial caution: Mostly an unequivocal occupational cause cannot be determined, so mutual causation is unlikely.

An interesting question is whether one common health problem can cause another. A classic example is stress causing cardiac complaints. Undoubtedly there is some supporting evidence (both epidemiological and physiological) for that particular relationship (Marmot et al. 1991). However, both complaints have high background prevalence so it is inevitable they will often arise together in the same individual; the idea of reciprocal causation (whether physical or psychological) between any of the common health problems should not be assumed without strong supporting evidence.

The evidence is mixed and incomplete, there are alternative views. Although complicated, pathways explaining concurrence have been proposed, and are considered to be either direct through physiological processes or indirect through coping behaviour. If the concurrence between CHPs can at least be partly explained by the health behaviours used to either cope with stressors or the experience of a common health problem, then the toolkit should encourage uptake of positive health behaviours and discourage harmful coping behaviour. An emerging physiological explanation for the link between stress-related health outcomes and common mental health problems concerns the inflammatory response: an upsurge in certain stress-induced biomarkers such as proinflammatory cytokines may actually cause depressive symptoms (Dantzer 2005; Von Korff 2005). A self-perpetuating cycle of depression, physiological response and more depression may then ensue (Von Korff 2005).

The issue of concurrence is also relevant to interventions. Putting aside primary causative mechanisms for common health problems, the similarities across their work-relevant consequences (e.g. illness behaviour, sickness absence, disability) suggests shared mechanisms for work-relevant consequences, which may be amenable to the same interventions. There is strong evidence that interventions based on biopsychosocial principles, applied early with all players onside and acting, can be effective in facilitating work participation across the CHPs (Waddell et al. 2008). Similarly, it seems likely that interventions aimed at improving well-being (i.e., interventions antecedent to complaints concerning CHPs, and initiated at the group level) have a generic effect that is not confined to particular CHPs. Overall, there is reason to think that both group level and individual level interventions, based on biopsychosocial principles, do not need to be condition-specific; beneficial effects can be expected whether or not there are concurrent complaints (though that is not to suggest that specifically targeted healthcare is not needed to deal with biological aspects of the conditions).

#### *Comfortable Jobs and Accommodating Workplaces*

The notion that work should be comfortable when we are well and accommodating when we are ill or injured hardly needs to be based on scientific evidence: it is simply what a worker should expect from a 21<sup>st</sup> century workplace. However, the characteristics of comfortable and accommodating, and how to create those states, is not entirely straightforward, and scientific evidence is appropriate for selecting or designing interventions aimed at achieving those goals.

The characteristics of 'good work' mean that suitable policy and process at the societal and organisational levels are required to make work good, yet the attributes of comfort and accommodating may elude such interventions. A good 'job' is an altogether more subjective construct, which relies on job-specific characteristics and how they are perceived by individual workers. At this level, due to local circumstances, 'good work' may be far from comfortable or accommodating, and there is no implication in the concept of comfortable work or good work that all individuals find the same characteristics of work either comfortable or good. So far as management of common health problems is concerned, it is the goodness of the job that is

important, and it is this individual level that will need to be built into an intervention toolbox. A comfortable job will be determined by organisation-wide or group-level intervention, and will impact on all workers in the workplace and most would be expected to perceive benefit. However, some jobs within the same workplace inevitably may be more comfortable than others, or at least perceived to be so. Ensuring a job is as comfortable as possible may rely on individual intervention, with possible input from the worker(s). An accommodating job will be determined by individual-level interventions: person-specific helpful responses to reports of work-relevant health problems with the aim of maintaining work participation. Potential resentment in peers created by perceptions that accommodations are unfair could occur if accommodations are made without addressing the wider social context.

*A comfortable job:*

- Reduces the likelihood of complaints (about symptoms, the job, and the organisation), and may (in principle) reduce the incidence of episodes of complaints (both physical and mental).
- Fosters job satisfaction and well-being: it increases the probability for workers to progress towards personal goals and values that will give them satisfaction or to engage in activities they find intrinsically enjoyable.
- Goes beyond safety, and the need to prevent harms.
- Minimises discomfort (both perceived and actual) and takes account of physical and psychosocial comfort/needs.
- Usually involves delivery of strategies aimed at the whole group of workers, but may involve consideration of aspects of the job at the individual level.

*An accommodating workplace:*

- Is flexible enough to allow and offer temporary helpful individual-level changes when a worker is experiencing common health problems and is having short-term difficulty with coping.
- Can offer changes in a variety of domains tailored for the individual worker: work organisation, job tasks, job demands, etc. Allows the worker to achieve an acceptable work-life balance.
- Facilitates individuals perceiving themselves as in control of their work conditions.
- Has some measure of flexibility to accommodate the impact on work from life events outside of work.
- Is perceived as fair practice by colleagues.

There is likely to be a strong correlation between higher levels of job satisfaction and the perception that the work is comfortable. Disaffection with work (low job satisfaction) is associated with poorer health outcomes, yet positive affect (e.g., happiness, enthusiasm) can lead to better health outcomes. It might logically follow that work which is organised to provide a reasonable level of comfort (physical and psychological) will contribute to job satisfaction and well-being, and thus reduce the likelihood of development of work-relevant common health problems and their consequences. This link, whilst attractive, has yet to be fully tested.

A range of features of 'good work' have been associated with psychological and psychosomatic well-being. In addition to those included in the Management Standards, the literature also indicates fairness of procedures at work, good treatment from others, and for rewards (broadly conceived to include pay, careers, skill development, job security, other intangibles) to be allocated fairly and proportionately to effort (also broadly conceived to include effort to develop

skills). Such an approach lends itself to a recommendation that changes to job design and organisational policies and procedures will contribute to the prevention of common health problems. However, there are important caveats here. First, simple stressor-strain/psychosocial risk management models are an oversimplification. Second, we know individual differences are more influential on some CHPs and many individuals self-regulate their own work and well-being effectively. Third, most of the research in this area is based on self-reports of job characteristics – lending itself to the criticism that good work is in the eye of the beholder. All of these three caveats indicate that individual differences and individual self-regulation need to be considered and integrated into job/organisational level changes.

#### *Job satisfaction*

Job satisfaction is an attitudinal variable that refers to how people feel about their jobs and different aspects of their jobs. It can be assessed using a variety of measures ranging from simple to complex, although interpretation is made difficult by the intrinsic subjectivity of what is being measured. Job satisfaction can potentially be influenced by multiple factors involving the individual worker, the workplace, and the context.

There is a moderate correlation between job satisfaction measures and mental health problems including burnout, depression, anxiety, and self-esteem. However, causation has not been demonstrated in longitudinal studies to date. In contrast, there is good evidence that job satisfaction is related to future musculoskeletal problems such as back pain (Lakke et al. 2009; Linton & van Tulder 2001; Macfarlane et al. 2009), and moderate evidence it is related to neck pain (Côté et al. 2008). As a result, it is recommended that seven workplace variables are included in early screening by clinicians including job satisfaction (Shaw et al. 2009). The others are physical job demands, ability to modify work, job stress, workplace social support, expectation for resuming work and fear of re-injury.

#### **SUMMARY**

The evidence indicates that the conventional risk-management approach may be necessary but it is certainly not sufficient for tackling work-relevant common health problems. Nor is it sufficient for creating comfortable jobs and accommodating workplaces. Organisational interventions based on biopsychosocial principles will contribute to comfortable jobs, and will impact on health outcomes for groups of people. However, those interventions do not deal with the individual needing accommodation to cope with a health problem at work. That is an additional layer, for which the biopsychosocial approach is ideally suited: it provides a framework for action - accommodating people who are ill or injured either to remain in work whilst they recover, or to return in a timely fashion even if not fully recovered.



## EVIDENCE SYNTHESIS

### COMMON HEALTH PROBLEMS

#### NATURE OF CHPs

CHPs exact a substantial toll in the workplace with societal, commercial, and personal costs. This makes them a natural target for workplace prevention and management. First, though, it is necessary to understand the nature of CHPs and their consequences in order to determine just what reasonably can be achieved by any intervention. The defining feature is that they are characterised largely by complaint: it is symptoms rather than disease or damage that brings them to the fore. Those symptoms are subjective in nature, tend to recur with varying severity and periodicity, and they also tend to coexist. For example, musculoskeletal symptoms can coexist at numerous anatomical sites, or mental health symptoms can coexist with musculoskeletal symptoms, but that does not mean they necessarily share a common genesis. Nevertheless, CHPs do have many shared characteristics and these are best understood from a biopsychosocial perspective. Key among these are beliefs and the behavioural consequences stemming from them. Myths, such as considering a symptom to indicate a serious problem when none exists, are common; e.g. fear of movement leading to fear-avoidance cycles. Deleterious consequences include withdrawal from usual activities (such as domestic, social and recreational) and reduced participation in productive activity and work. Whilst the complaints are ubiquitous and capable of leading to disabling consequences, with the right support, opportunities and encouragement, people with CHPs usually maintain (or return to) their usual level of participation in activity and work.

In fact, for most symptoms and CHP episodes, people do not seek healthcare and do remain at work. That is, they self-manage the problem effectively. This means it is often exceedingly difficult or impossible to differentiate on objective or clinical grounds between those who complain and seek help and those with the same problems who do not. Therefore a 'case' should not be determined simply in terms of the presence of symptoms, but rather where the symptoms are sufficiently bothersome to trigger one or more of the following: a complaint (reporting); care-seeking; a struggle to be active; a struggle to attend work: i.e. at the point where the person is struggling with a work-relevant complaint. CHPs can readily be work-relevant: that is, the symptoms may be felt predominantly at work and may (temporarily) reduce the person's ability to do their usual job. This encourages the (often) false belief that work is mainly or wholly responsible. In most cases there is limited objective evidence of injury or disease cogently related to the work exposures. In occupational terms it is, again, the consequences of CHPs that are more important than any (assumed) pathology. When a person becomes a case, it is not because they have a more severe injury, disease or set of symptoms. This is an important distinction. The focus shifts from the disorder to the consequences and responses: It is not so much a matter of what has happened to the person; rather it is about why they are not able to cope on their own with a particular episode. Invariably they face a range of psychosocial obstacles to participation – and these are the factors that account for the variability in reporting, attribution of cause and symptoms, care seeking, sickness absence, and the level of disability.

#### PREVENTION OF CHPs

The concept of 'risk' is clearly relevant to how CHPs can be most effectively managed at work, but perhaps not in the way it has been usually expressed. Many factors, both physical and psychological, have been proposed as 'risk factors' for CHPs. But, the question is risk factors for what? For example, it is difficult to see how psychological factors may directly generate musculoskeletal pain or cause tissue damage (although they may contribute behaviourally to accidents), yet they can be related to other outcomes such as reporting patterns, bothersomeness, or level of disability. Unfortunately, the scientific literature does not always make a distinction between the various outcomes of interest. Throughout much of the existing literature linking

work to health outcomes, the term 'risk' is used in a statistical sense that reflects a correlation or non-causal association between work variables and the outcome.

Numerous occupational health problems are unlikely to occur without some intervening action or exposure to a known and demonstrated hazard (e.g. injury due to falls from heights; disease due to exposure to asbestos), so in those situations the exposure can be considered a hazard that presents some level of risk for the occurrence of the outcome. However, CHPs are extremely common irrespective of work exposure, and do not always occur despite persistent exposure to putative hazards. This, combined with the fact that numerous theoretical occupational hazards have turned out to be doubtful causal factors, renders direct occupational causation for most episodes of CHPs difficult to establish. Furthermore, reported effect sizes tend to be small, meaning that even for those with direct causal properties, any intervention aimed solely at preventing the occurrence of the complaint will have limited overall impact. This situation holds true for both physical and psychosocial factors. For this reason, many traditional risk factors reported in the literature might be better termed 'risk indicators' – features noted to be correlated with one or more health outcomes, but without a demonstrable (or theoretical) causal link.

According to recent studies, interventions based on the conventional occupational health and safety model (hazard → worker → harm) has limited preventive effect for CHPs. Perhaps this is because that approach has already achieved its optimal effect through regulation and control, and there is no marginal benefit to be obtained. What is left is the situation where people with CHPs become cases, not because their work has necessarily damaged them but because (part of) their work is not sufficiently comfortable or accommodating to enable them to continue without help. It is this aspect of 'risk' that can be more effectively controlled.

### **MANAGEMENT OF CHPs**

The biopsychosocial model provides an alternative perspective to the conventional health and safety model, but it is one that has received little attention in the prevention area to date. Under this model, biological considerations are not ignored, but psychosocial factors often emerge as the important determinants of occupational outcomes. The evidence indicates that most CHPs can, and should, be managed at work ideally before they escalate to problems requiring time off work. This means employers, workers and the health and safety community all have crucial roles to play in ensuring that: (i) workers have jobs that are sufficiently comfortable to minimise the occurrence and severity of symptoms; and (ii) workplaces are temporarily accommodating if they develop a health problem and are unable to cope.

Important initiatives have been established to provide approaches that might be used to improve the identification and management of CHPs at an early stage in order to prevent detrimental consequences. Two recent examples in the UK are HSE's Management Standards (aimed at stress problems: [www.hse.gov.uk/stress/standards](http://www.hse.gov.uk/stress/standards)) and the Psychosocial Flags Framework (aimed at musculoskeletal problems: [www.tsosshop.co.uk/flags](http://www.tsosshop.co.uk/flags)). Both call for a collaborative approach between the health and safety system and the workplace. In essence these approaches use an identify/plan/action process, albeit that the underlying rationale and methods are rather different: the Management Standards focus more on typical risk-control whilst the Psychosocial Flags Framework focuses more on minimising work-relevance of symptoms and facilitating their accommodation at the workplace. Arguably, there is good evidence about what to do to manage or control CHPs, but this is not often delivered in practice. Instead, much effort has gone into efficiently delivering less effective interventions and providers have tended to be inefficient at delivering the more effective ones.

Implementation of interventions addressing the full range of psychosocial issues inevitably requires a cultural shift, mostly in the way the relationship between CHPs and work is regarded and then tackled. To achieve this, all key parties need to both understand the limitations of the conventional health and safety paradigm, and how to ensure that rapid, targeted, and effective

strategies are adopted and delivered. This necessarily involves provision of information and something of an educational approach.

A new framework for tackling work-relevant CHPs entails some challenge to existing concepts and expansion of new ones, but should be evolutionary in practice by building on existing strategies and tactics. The novel comprehensive model offered here contains the conventional approach in its entirety, losing nothing but gaining much. A parsimonious set of key considerations embedded in the various perspectives on work-relevant CHPs is laid out below.

#### **LIMITATIONS OF THE CURRENT CONCEPTUAL FRAMEWORK**

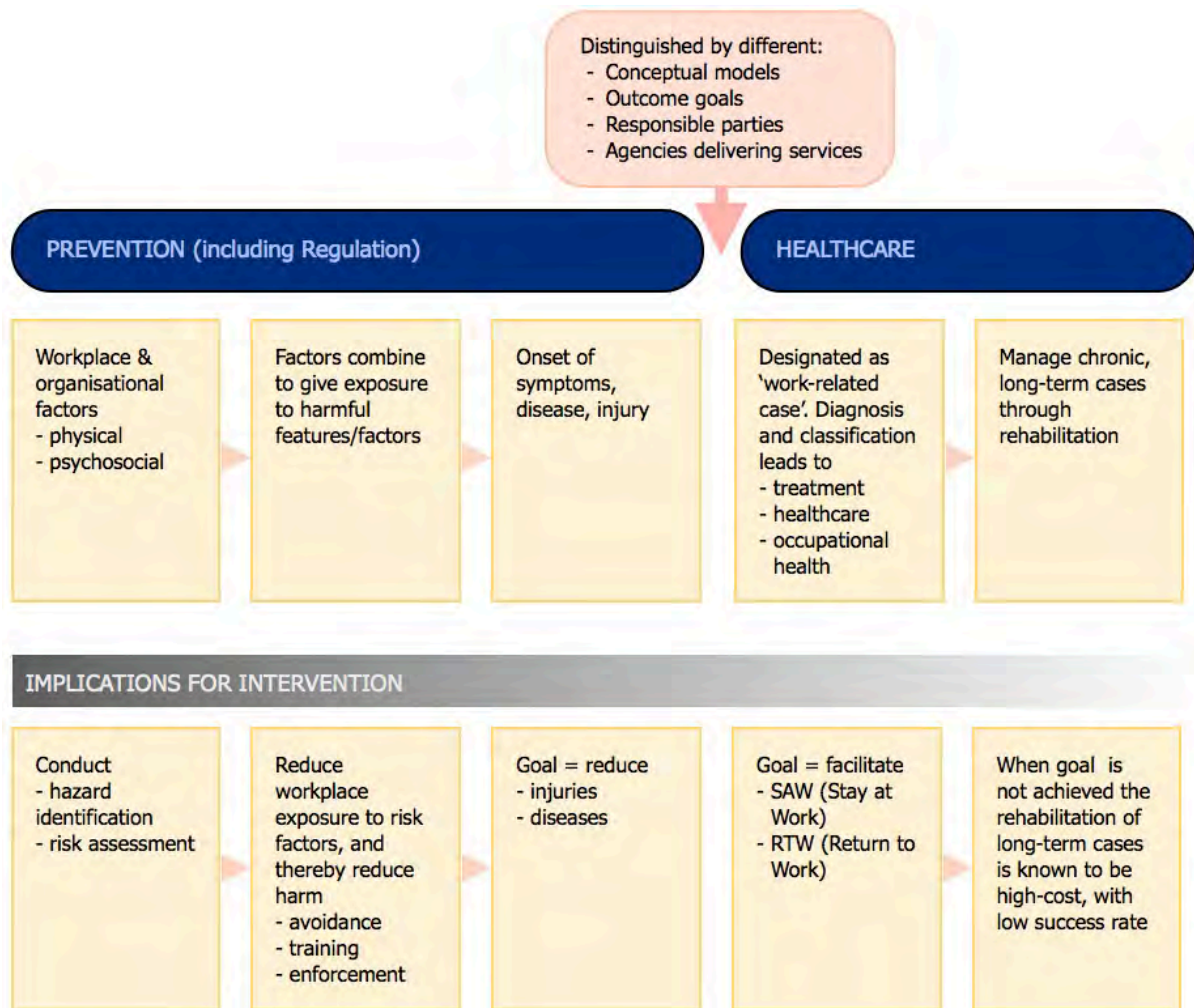
The available evidence indicates that current approaches to preventing and controlling CHPs in the workplace are suboptimal and potentially disadvantageous. At least part of the reason for this is ongoing adherence to an orthodox prevention model that has functioned well for more serious occupational injuries and diseases, but that has failed to deliver anticipated results when deployed in the CHP area. This situation is highly analogous to that which has occurred in the healthcare arena, based on the simple biomedical model that (falsely) predicts treatment → cure → return to activity and work. Uncritical adherence to this model has resulted in massive increases in the number and costs of investigations and treatments delivered to people with CHPs, but with unintended consequences of dramatic increases in disability and long-term work loss, mostly through iatrogenic processes.

The success of the conventional prevention model for controlling serious occupational injury and disease appears to have led to its adoption for controlling symptoms. The concepts are compelling because they are simple and familiar, although this can easily lead to simply following traditional approaches while lacking critical appraisal. That is to say, there is an inherent danger from simply repeating the same approach to any problem, especially in the face of evidence that it is not having the desired effect.

A fresh approach appears to be required, one that takes full account of the nature of CHPs and their relationship with work. However, any new conceptual framework should be built on an appreciation of the limitations and strengths of existing approaches, allowing development to be evolutionary. For this reason, it is worth briefly considering what we have learned so far about work-relevant CHPs from the two major areas of interest:

#### **WHAT WE HAVE LEARNED ABOUT CHPs FROM OCCUPATIONAL HEALTH AND SAFETY**

The 'typical' approach to occupational health and safety (OHS) is shared across the developed world (see Appendix 1 - Figure 2). It is based on a model in which harm (expressed as injury or disease) is seen to result from exposure to a (workplace) hazard, and that higher exposures will increase the likelihood of harm and increase the severity of injury/disease [hazard → worker → harm].



**Appendix 1 - Figure 2.** Conventional occupational health & safety approach

It follows that removing (or reducing) the exposure should result in prevention (or minimisation of harm). The underlying logic necessitates a number of assumptions, which variously may or may not apply in practice.

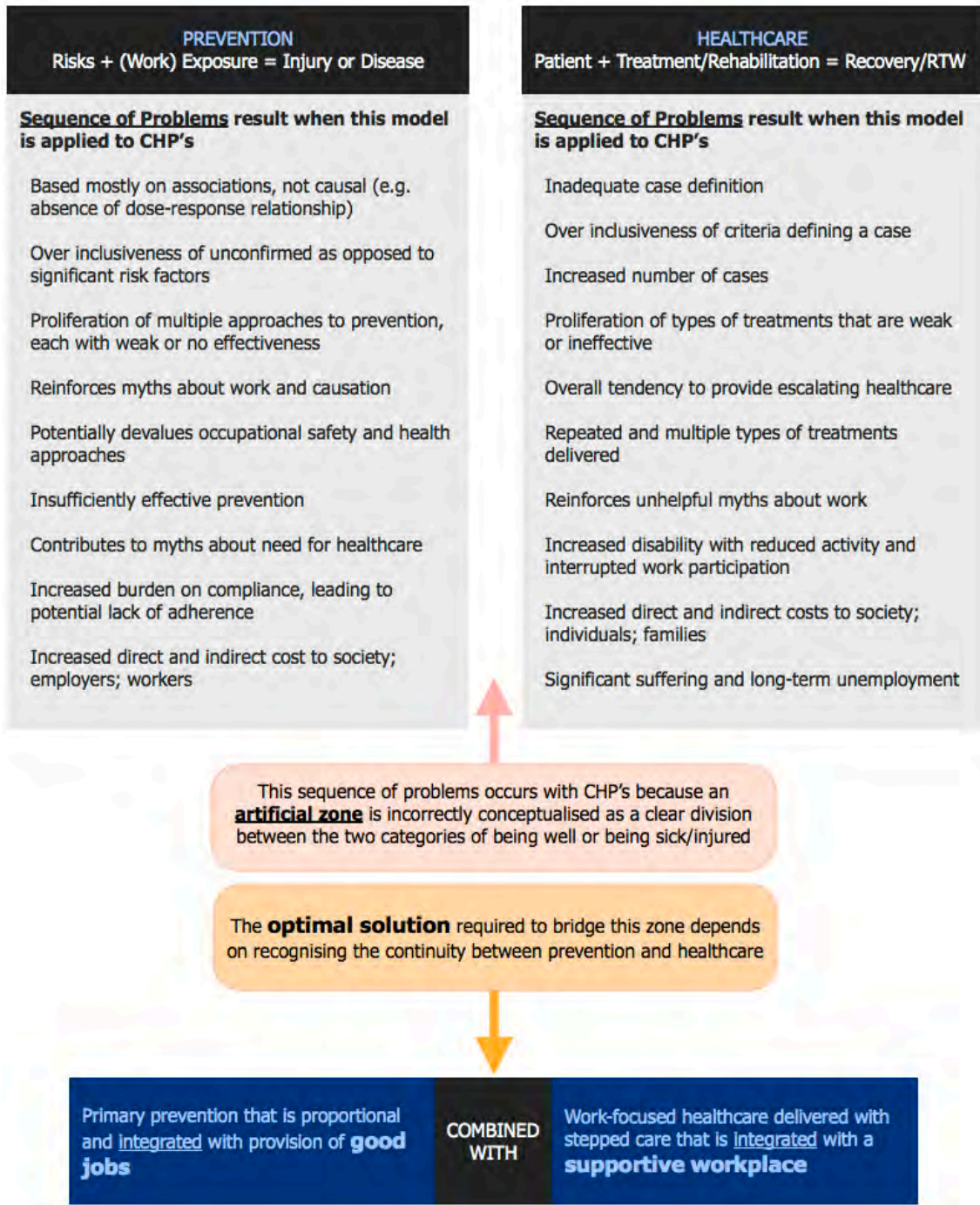
Strategies for primary prevention at the workplace are based on the logic that: (1) injury/disease are produced by exposure to workplace hazards (possibly combined with aspects of the person, their workplace, and their circumstances); (2) there is a cogent physiological link between hazard and injury/disease; (3) there is a meaningful dose-response relationship between hazard and injury/disease; (4) identifying potential workplace hazards and reducing exposure to them can successfully interrupt the causal sequence; (5) there is a distinct demarcation between the harmed and unharmed state (cases distinct from non-cases).

The evidence indicates that the conventional approach to OHS, articulated by enabling legislation and by current regulation and guidance, can be highly effective for the primary prevention of workplace fatalities and more serious disease or injury (where there are direct causal links). This usually relies on a mixture of workplace engineering and adequate training and awareness programmes. Examples include falls from heights, machine guarding, and latex allergies.

Primary prevention strategies seemingly are not particularly effective for CHPs (or perhaps it is that their optimal potential may already have been realised). It seems the 'typical' OHS model does not adequately reflect the nature of CHPs. By way of example: (1) the symptoms have high prevalence rates, irrespective of work status; (2) there is often gradual onset of symptoms, with variable patterns of frequency and severity; (3) reliably defining a 'case' is problematic; (4) causation is known to be complex, often with multiple interacting factors, and may be bi-directional; (5) attributions of cause to work are commonly made, but often mistaken; (6) dose-response relationships are usually absent and presumed risk factors have small effect sizes – even if some measure of prevention seems possible, the effect of reducing the exposure may have a small/undetectable effect.

Because there are a large number of potentially salient factors and each uniquely explains a small amount of variance, it is difficult to quantify the exposure that comprises a significant hazard, even on a population basis. Symptoms experienced with CHPs are common across the population and have equivalent severity and frequency irrespective of whether the person becomes a 'case' (work-relevant symptoms or care seeking). Although it is possible on a population basis to identify some factors that may contribute to the development of CHPs, this is much more difficult to achieve for an individual.

Application of a simple OHS model based on the assumption that the presence of 'risks' combined with exposure to them in the workplace will inexorably result in development of harm in the form of a CHP (whether it is called an injury, sickness, or a disease), contributes to a sequence of unwanted consequences. These are outlined in Appendix 1 - Figure 3.



**Appendix 1 - Figure 3.** The major problems with using a simple model for occupational health and safety and the delivery of healthcare interventions and rehabilitation for CHPs, together with optimal solutions

This is not to say the conventional OHS model is wrong, rather it is limited by being incomplete. It functions best when cases are well defined, harms can be objectively observed, and exposure to meaningful hazards can be identified, allowing practical interruption of the 'chain of causation'. It is less appropriate when the (presumed) harm is reflected largely as subjective symptoms and exposure is restricted to simple correlations with multiple factors. CHPs clearly fall into this latter category.

This is not a reason to cease existing prevention efforts. Quite the contrary, proportionate adherence to the conventional OHS principles is an important prerequisite for providing comfortable jobs. Furthermore, it is important to recognise that work-relevant CHPs will inevitably arise, and complaints about them will occur. The health and safety imperative then is to ensure these do not escalate into problems that are perceived as too big to cope with, and which result in all of the unfortunate consequences that invariably follow once a CHP is escalated into sickness absence and seeking healthcare.

#### **WHAT WE HAVE LEARNED ABOUT CHPs FROM TREATMENT AND REHABILITATION**

When outright prevention fails and symptoms develop, healthcare and vocational rehabilitation is the traditional fall-back position. This involves a number of assumptions: (1) 'work-related' disorders are well delineated; (2) CHPs can be reliably diagnosed and effectively treated; (3) that return to productive activity automatically follows. Unfortunately, these have not been borne out in practice. The relationship between work and health is known to be complex, and the relationship between work and numerous aspects of CHPs is tenuous. Diagnoses for CHPs are unreliable, applied with wide variation that sometimes follows 'fads' and trends, and provide little insight into either the underlying causes or potential remedies. Resumption of participation in activity and work demonstrably does not occur automatically, and it is known that increasing time away from work results in escalating costs and the chance of successful rehabilitation reduces.

It is clear that CHPs vary widely in the way they present to healthcare services and clinicians, who then respond in multiple and often inconsistent ways. The array of signs and symptoms and are met with a wide variety of responses, along with high probability that some type of intervention will be provided. This is invariably based on a set of clinical formulations that seek to explain the presence of symptoms, the reporting of symptoms, the attribution of them to work and other activity, and the presumed underlying pathology, without recognising these may have different determinants. When sickness absence is recommended for CHPs, there may be little or no thought given to trying a 'stay at work' approach using temporary modifications or devising a strategy for eventual return to work and other activities. The result may be long-term incapacity. The advent of the 'fit note' seeks to overcome at least some of the clinically related obstacles by asking clinicians to focus on what the person can still do in addition to acknowledging what they cannot do.

For people with most health conditions, including work-relevant CHPs, early return to work or staying at work is generally beneficial: facilitating early RTW requires workplace accommodation – logically, a comfortable workplace should facilitate staying at work and result in a reduction in cases (incidence, prevalence and impact of work-relevant episodes).

It is important to acknowledge the sound epidemiological studies showing that the majority of individuals do experience symptoms of CHPs, both at work and elsewhere, and the majority of them continue to participate in activity and work without report or complaint, and appear to come to no harm. There are clearly people who are capable of coping by themselves, using effective self-management strategies (perhaps aided by an inherently comfortable job and accommodating workplace). These individuals are probably better endowed with resilience, and can be described as 'active copers'. However, there are also those who avoid activity and work when they experience symptoms. It is clear that an individual's beliefs can be significant obstacles to work participation - among other things, beliefs about what has gone wrong, about what to do, and about what will happen. Unhelpful myths about work and health are abundant, and must be tackled (Burton et al. 2006).

The current state of the art in managing CHPs from a treatment and rehabilitation perspective has been well described elsewhere (Waddell et al. 2008). It is best delivered as a process of stepped care. There is good reason to believe that the application of these same principles very

early can be beneficial in the attempt at stopping the symptoms of CHPs developing into long-term cases.

## **A FRAMEWORK OPTIMISED FOR PREVENTION AND CONTROL OF CHPS**

In devising this framework the most important issue is to retain sight of the key prevention goals: (1) to reduce the occurrence of new cases (defined by the person having a work-relevant problem) and the potential for them to become persistent and long-term; (2) to reduce the number of people struggling to cope at work; (3) to interrupt the escalation process that leads individuals with CHPs to receive unnecessary healthcare or sickness absence.

This is best achieved through the provision of comfortable jobs and accommodating workplaces. Current provision, though, is through ‘silos’ of prevention and healthcare, whereby there is a sharp demarcation: if prevention fails then treatment and rehabilitation are needed. This has resulted in a lost opportunity with an artificial gap between two key areas. What is required is recognition of the continuity and overlap, and to ensure seamless integration.

At the *treatment* end, interventions are provided to individuals who meet, or are close to meeting, diagnostic criteria. There are two components to treatment: case identification through assessment and diagnosis, and standard treatment for the known disorder, which includes interventions to reduce the likelihood of future co-occurring disorders. The optimal treatment protocol aims to reduce the length of time the disorder exists, halt a progression of severity, and halt the recurrence of the original disorder, or if not possible, to increase the length of time between episodes. Clinicians also try to halt or manage the occurrence of other disorders (i.e. co-morbidity), and provide rehabilitation to increase participation thus decreasing the disability associated with the disorder. This does not typically include work as a health outcome, although there is reason to believe this will improve with current Government initiatives.

At the *prevention* end of the continuum, ‘universal preventive interventions’ for CHPs are targeted to the general public or a population group displaying a high prevalence of the relevant problem. The intervention is considered desirable for everyone in that group. Universal interventions have advantages when their cost per individual is low, the intervention is effective and acceptable to the population, and there is a low risk of side effects from the intervention. ‘Targeted preventive interventions’ for CHPs are targeted to individuals or a subgroup of the population whose chance of developing problems is deemed significantly higher than average. The probability may be imminent or it may be present throughout the lifetime. Relevant groups may be identified on the basis of biological, psychological or social risk indicators that are believed to be associated with the onset of symptoms. Targeted interventions are most appropriate if the interventions do not exceed a moderate level of cost and if negative effects are minimal or non-existent. ‘Individualised preventive interventions’ are directed to individuals who are identified (by others or by themselves) as having bothersome or work-relevant symptoms with which they are struggling at work. Many are unlikely to meet diagnostic criteria, but there is a subgroup that are given diagnoses and are struggling yet still at work.

The overall aim of these three types of preventive intervention for CHPs is the reduction of the occurrence of new cases and the potential for them to become persistent and long-term. In this context, cases are defined by people complaining of bothersome or work-relevant symptoms. The key marker for this is the individual struggling to cope. A critical component of *universal* and *targeted* preventive interventions is that although some members of the group may have symptoms of CHPs when the intervention begins, this is not the reason why that group is selected for delivery of the intervention. In contrast, when individuals are chosen for a preventive intervention because of the early presence of symptoms, then by definition the intervention is an *individualised* one (not universal, or targeted). This means that in broad terms, groups and individuals can be targeted (through provision of *comfortable jobs*), and individuals who are struggling can be identified (and managed effectively through provision of *accommodating workplaces*).

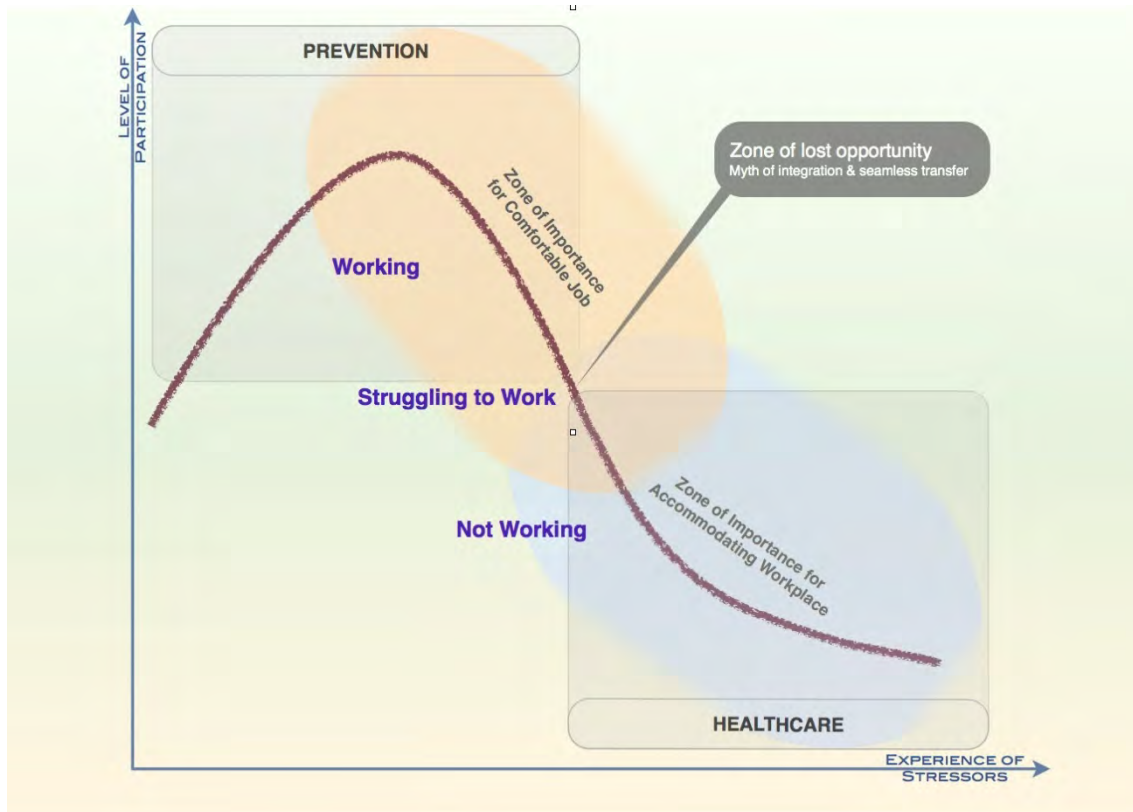


## ZONES OF IMPORTANCE FOR CHPs

The ‘inverted-U’ relationship between variables such as level of participation and the experience of stressors has long been recognised (Yerkes & Dodson, 1908), and it provides a useful *heuristic* for CHPs (see Appendix 1 - Figure 4). The lowest part of the start of the curve represents a ‘zone of inactivity’. The upward slope of the curve represents the trend toward increased participation in productive activity and work as motivation increases. The top of the curve represents ‘peak’ or optimal performance. This zone is often described as having an appropriate ‘work-life balance’. Ideally it is the zone where everyone should function, at his or her peak but without distress. However, there are a substantial proportion of people who begin to slide down the curve beyond their peak.

The portion of the curve beyond the peak represents a zone of potential distress (e.g. exposure to a known hazard and/or experiencing symptoms of a CHP). Under ideal circumstances all individuals are likely to be capable of functioning in this zone for periods of time by using appropriate self-management skills, and this will be easier if the exposure is intermittent. However, coping and resilience will be taxed when it is sustained, leading to a situation that is ‘out of balance’. For most people, correction of this imbalance can be achieved with appropriate responses and coping techniques. Indeed, this appears to be the method that allows most people with CHPs to continue activity and work, and maintain their quality of life, albeit with temporary changes to what and how they do things. For people who are working, it is at this stage that the quality of their job becomes salient. *Comfortable jobs* provide the best opportunity to facilitate a positive and proactive coping response, thus curbing (and perhaps preventing) the slide to becoming a *struggling* individual. The level of intervention is mainly at the group level but need not preclude some individualised intervention (c.f. targeted preventive interventions). When a person begins to struggle to cope with work-relevant symptoms there is increasing probability that sickness absence will ensue, perhaps starting as reduced productivity. This phase involves the transition from ability to disability. With CHPs this is not a definitive line, it is a journey that involves an escalation process. Complaints of symptoms lead to seeking help, and the risk that the problem will be medicalised increases rapidly. This is the important zone of the *accommodating workplace*. Provision of temporary arrangements makes it possible for the person either to stay at work successfully, or achieve early return to work. The level of intervention is at the individual level (c.f. individualised preventive interventions).

There is an important possibility to bridge the ‘chasm’ or ‘zone of lost opportunity’ between prevention and healthcare for CHPs. This necessitates challenging the myth that the prevention and healthcare arenas butt tightly up against each other, and that there is seamless integration between them.



**Appendix 1 - Figure 4.** The 'zone of lost opportunity' to prevent the adverse consequences of work-relevant CHPs

## RELATIONSHIP WITH THE MANAGEMENT STANDARDS

The Management Standards approach covers six areas of work design which, if not properly managed, are believed to be associated with poor health and well-being, lower productivity and increased sickness absence. The approach helps managers to improve the way they manage pressures in the workplace, and so reduce the levels of work-related stress, sickness absence and poor performance.

A study commissioned by HSE, published in 2009, sought to determine whether the Management Standards approach to preventing work-related stress could be transferred to control of other CHPs such as musculoskeletal and mental health complaints (Cox et al. 2009). The main research objective for the study was "...to provide evidence, arguments and recommendations in relation to the development of a more unified framework for the Health & Safety Executive's programme on Health, Work and Well-being. Essentially it is to answer the key question 'Can the Management Standards approach be used more widely to address the most common health problems at work?'" This was supplemented by a brief narrative literature review to answer three questions: "(i) what is known of the Management Standards approach and its current strengths and weaknesses, (ii) what is known of the most common health problems at work, and, finally, (iii) could an argument be made, on the basis of what is known, that the most common health problems at work might be managed through a single (unified) approach as attempted with the Management Standards for work-related stress?" (p. 1).

On the basis of this non-systematic review, the authors concluded "There is sufficient evidence on relationships among exposure to psychosocial hazards, the experience of work-related stress, and effects on employee health, to justify the development and application of a risk management approach to work-related health based in joint problem solving" (p. 1). This conclusion was formed principally on arguments about occupational mental health and musculoskeletal disorders that can be questioned. For example, Cox et al (2009) display significant conceptual confusion between the terms 'stress', 'anxiety', and 'depression'. The latter two have a substantial presence in all major clinical taxonomies in the world, whereas the former does not. They cite two reviews (Hill et al. 2007; Seymour & Grove 2005) as evidence of the high prevalence of mild to moderate common mental health problems such as depression and anxiety in both the general as well as the working population. Both of these reviews use the terms 'anxiety' and 'depression' to refer to diagnosable conditions. Seymour & Grove state explicitly that "for the purposes of this review we have... treated the term common mental health problems as synonymous with mild to moderate mental illness when referring to any form of mental distress or disorder which has acquired clinical caseness, excluding those which meet the criteria for severe mental illness as defined in the National Service Framework for Mental Health". They also explicitly delineated 'stress' from mental health problems: "for the purposes of this review we have made a distinction between stress and common mental health problems and we have not used job stress or job burnout as synonyms for common mental health problems". That is, they did not consider stress to be a diagnosable condition. In contrast, Cox et al (2009) state that "work-related stress is the most common mental health problem associated with working people" (p. 2), substantiating it by making reference to an online summary of a seminar (Cox & Jackson 2007). On page 8 of this seminar summary it is stated, "critically, prolonged occupational stress can lead to the development of anxiety and depression in many workers": no supportive citations are given. Despite this, Cox et al (2009) conclude there is "some validity in grouping the three states together" (p. 17) in reference to stress, anxiety and depression. No evidence is provided to substantiate this claim, nor is any argument advanced that defines all three as "states". In fact the only argument made to support the idea of grouping them is that they all occur commonly.

The Cox et al (2009) review also stated "existing epidemiological evidence suggests there are shared risk factors between the most common health problems" (p. 17). This view is supported by seven citations. However, close inspection of these citations indicates that none addressed the issue of shared risk factors. All seven articles focused on musculoskeletal problems, but are not representative of the overall musculoskeletal pain research arena. It seems that the level of analysis used to reach the conclusion only extended to recognition that psychosocial factors may play some, unspecified, role in various common health problems. No evidence is provided to demonstrate that work plays a causal role in the development of anxiety or mood disorders, whatever the severity. A further argument was advanced that "comorbidity is well documented" (p. 18), however the citations used to support this were cross-sectional surveys that relied on self-report only, and two used only subjects with chronic musculoskeletal pain. Surprisingly, this was taken to provide evidence of "a shared causation" (p. 19) by Cox et al (2009), and thus to support "the possibility of a single (unified) approach to the management of the two main common health problems at work" (p. 19). Note, that in this statement stress, anxiety and depression have been subsumed into a single category.

The literature review conducted for the present project was based on a systematic search of the literature and assessed a much wider and more recent evidence-base. It came to an alternative

conclusion. Namely, there is a lack of robust evidence showing that the same causal factors operate across the spectrum of CHPs. This means that simply extending the Management Standards approach to all CHPs would not be supported by current evidence, and an alternative approach to underpin an intervention toolbox is needed.

The principles for an intervention toolbox that have emerged from this evidence synthesis have aspects that are similar to the Management Standards and some that are different and additional.

#### *Similarities to the Management Standards*

- Incorporates the goals of facilitating ‘good work’;
- Acknowledges the overlap between job characteristics as captured by the Management Standards and the attributes of a comfortable job;
- Involves workers and line managers in a problem-solving approach.

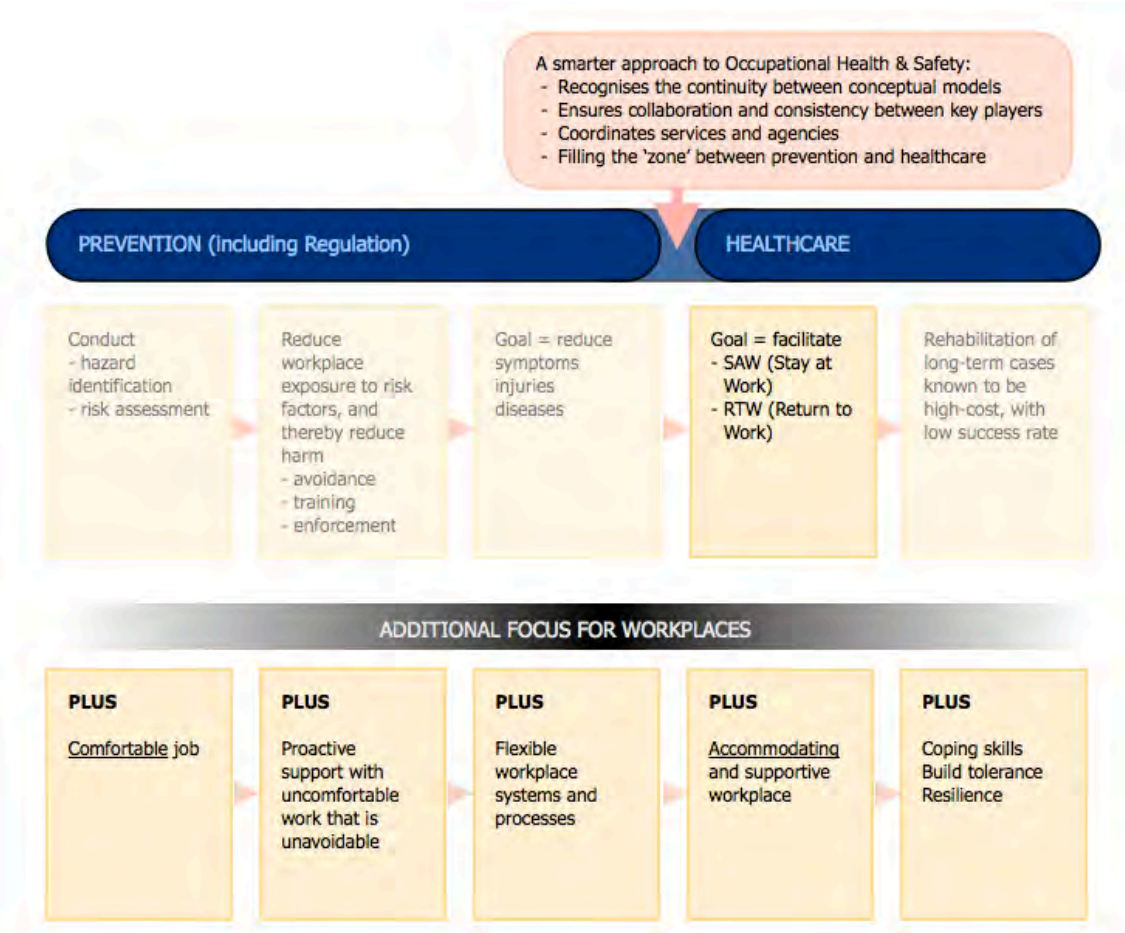
#### *Differences from the Management Standards*

- Bridges the ‘zone of lost opportunity’ to ensure continuity between prevention and healthcare;
- Allows for interventions that are optimised to the characteristics of CHPs;
- Enables use of targeted and individualised approaches, in addition to the universal one offered by the Management Standards;
- Identifies obstacles and enablers to staying at work or returning to work, instead of sole focus on risks;
- Encompasses co-existing CHP symptoms and emphasises control of the detrimental work-relevant consequences;
- Avoids inadvertently conveying the message that work causes CHPs;
- Focus is on the provision of comfortable jobs to counter excessive job-demands, and provision of accommodating workplaces for people starting to struggling to stay at (or return to) work because of their symptoms;
- The concept of ‘comfortable jobs’ includes building resilience to cope with the unavoidable aspects of work that may be perceived as unpleasant or uncomfortable.

## **LOGIC UNDERPINNING THE CHP-OPTIMISED FRAMEWORK**

### **TOWARDS A NEW CONCEPTUAL FRAMEWORK**

The conceptual model of comfortable jobs and accommodating workplaces needs to be incorporated into existing occupational safety and health (OHS) provision. Specifically, it needs to be seen as a *supplementary* provision, one that recognises the nature of CHPs and how they differ to other problems, their work-relevance, and how they can be effectively managed in the workplace. This requires a more comprehensive model based on a biopsychosocial approach (Appendix 1 - Figure 5). It recognises that there is no sharp artificial division between the concepts of being healthy/uninjured, versus being sick/injured; and, that this is especially true for symptoms of CHPs. The model allows for workplace approaches that are optimised for the needs of controlling CHPs, and are aimed at delivering proportional and effective interventions.



**Appendix 1 - Figure 5.** Comprehensive OH&S Model recognises additional focuses for workplaces

This model recognises that for CHPs:

- Symptom development is usually multifactorial, based on a mixture of physical and psychosocial issues *and* these are exceedingly difficult to reliably measure and identify, which makes attempts to prevent the onset of symptoms impracticable.
- Complaining about symptoms, reporting them to others, and asking for help or seeking care is also multifactorial, usually based on a different mix of physical and psychosocial issues from those relevant to symptom onset *and* these can often be identified, which allows rapid response strategies to prevent escalation of the problem.
- Long-term sickness absence (work disability) and withdrawal from activity (i.e. inactivity) occurs because of changes in the level of participation the individual engages in, and this is principally due to psychosocial issues *and* these can be identified by any key player, and effectively addressed.

A biopsychosocial OHS model acknowledges the limitations in the existing health and safety and biomedical approaches. But, it draws an extra breadth of knowledge from the analysis of why these approaches are necessary, but not sufficient when it comes to managing CHPs. This is briefly summarised in Appendix 1 - Figure 6.

Focus	General population People of working age	Onset of symptoms • New/recurrent • Multiple/coexisting • Variable severity	Report/complaint of symptoms Seeks help for common health problem	Diagnosed with a clinical common health problem	Rehabilitation Return to work (vocational rehabilitation)
Major activity	Injury and primary prevention	Common health problems	Case implies need for help from workplace, or healthcare, or both	Treatment	Healthcare delivery
Important questions	What causes CHPs? What are the risk factors? Can CHPs be prevented?	What is a CHP? Is it work-relevant? Can it be managed at work?	What is a case? Accept all cases, or only selected cases? Work or not - stay active or not?	What is diagnosis? What is appropriate treatment? Is treatment effective? Work or not - stay active or not?	What is appropriate rehabilitation? Is rehabilitation effective? Work or not - stay active or not?
Data sources	Epidemiology Surveillance Surveys	Epidemiology Surveillance systems Surveys	Clinical Sickness absence Incident logs	Clinical Sickness absence	Clinical Sickness absence
Important players	Government Quangos Insurers Industry, organisations Line managers Workers	Industry, organisations Line managers Workers	Industry, organisations Line managers Workers (Healthcare)	Industry, organisations Line managers Workers Healthcare Benefit system Insurers Solicitors	Industry, organisations Line managers Workers Healthcare Case management NHS services Benefit system Insurers Solicitors
Strengths	Promise of prevention Aimed at both organisation and individual levels	Early report allows early intervention and rapid resolution	Potential for problem to be managed in workplace, without escalation to healthcare Allows selection of cases for specific workplace interventions, at either individual or group level	Diagnosis should lead to treatment Allows selection of cases for specific workplace interventions, usually at individual level	Potential to integrate clinical care with workplace intervention (e.g. graded RTW) Use of stepped care approach to make efficient use of resources
Weakness	Complexity Lack of evidence	Unclear relevance Lack of knowledge about what to do	Requires skills and Intervention Toolbox	Lack of reliable and valid diagnoses Lack of effective treatment	Tendency for work as an important health outcome to be overlooked by clinicians

**Appendix 1 - Figure 6.** Indications for an Intervention Toolbox from applying the biopsychosocial model to occupational health and safety, and the delivery of healthcare interventions and rehabilitation for CHPs

For CHPs, there is a critically important area (zone) between that traditionally addressed by primary prevention initiatives and that which is usually considered the responsibility of healthcare and rehabilitation providers. In reality, there is no simple binary distinction between presence/absence of CHPs and their subjective symptoms. This means that a more comprehensive model, based on a biopsychosocial approach, allows detailed scrutiny of this area and provides a wealth of potential applications for an Intervention Toolbox.

Although work is good for our health and well-being, there is the caveat that this applies to 'Good Jobs'. Whilst the characteristics of Good Jobs owe much to job security, fair pay, and personal fulfilment as well as safety, it seems likely that provision of comfortable jobs and accommodating workplaces could contribute to other important elements such as social support, good communication, and job satisfaction.

The evidence indicates that an effective intervention toolbox for tackling work-relevant CHPs will be focused as much on identifying and overcoming obstacles to stay at work (SAW) and return to work (RTW), as on provision of primary prevention initiatives. Of critical importance, these need 'joining-up' so that they are consistent and seamless instead of potentially being contradictory and counter-productive to each other.

### PRINCIPLES OF AN INTERVENTION TOOLBOX

The evidence reviewed here indicates that the simple expedient of extending the HSE Management Standards approach to cover CHPs in general would be a suboptimal solution. This is because the two fundamental aspects deployed regularly on a day-to-day basis, namely a risk management methodology and an assessment model aimed solely at primary prevention, do not adequately address the essential characteristics of work-relevant CHPs. There are clearly

useful concepts within the Management Standards, but in order to tackle the adverse consequences of CHPs, there is a need to develop additional approaches that are more comprehensive and more 'user-friendly'. The intervention toolbox under development aims to reduce the toll of work-relevant CHPs by being practical and effective yet avoiding over-simplification.

A new framework for tackling work-relevant CHPs is needed from both societal and occupational perspectives. The key finding from the evidence review is that prevention approaches based on the conventional hazard-risk-control model have not empirically yielded the hoped-for outcomes with CHPs. This explains the lack of evidence supporting current approaches to tackling CHPs, and why they have not succeeded in reducing the substantial workplace impact. It is evident from the epidemiology that people will hurt and feel ill irrespective of occupational exposures, so current approaches to primary prevention of CHPs do contain an inherent limitation. Whilst many episodes of CHPs are not caused by work some doubtless are, though there is considerable uncertainty over the levels of exposure that might be implicated, both qualitatively and quantitatively. However, even for those that may result from some aspect of the work, there is uncertainty over the extent to which outright prevention is practicable because of the uncertainty over just what hazards need to be controlled.

The comprehensive model adopted here contains the established approach in its entirety, losing nothing but gaining much. The dimmed boxes in the top part of Appendix 1 - Figure 5 represent existing provision for prevention and healthcare. Those provisions remain in place – whilst they may contribute to further preventing CHP symptoms among workers, they do contribute to good work and comfortable jobs, and act as a valuable foundation for and additional focus for workplaces (i.e. the 'PLUS' parts of the new framework) for tackling work-relevant CHPs. A great deal of conceptual understanding and practical knowledge has been gained to date through study and practice of 'prevention' and 'healthcare and rehabilitation' - the core of this project, the Additional Focus for Workplaces, builds on these endeavours. It does not seek to replace them. What has clearly emerged is an appreciation that there is a 'zone of lost opportunity' between the established approaches of prevention and healthcare – it is in this region that the workplace can provide a smarter, additional form of intervention that has the potential to control and prevent the detrimental consequences of work-relevant CHPs. This novel approach to workplace intervention will naturally require appropriate tools, advice and guidance, both to ensure careful integration with the new framework and to avoid 'iatrogenic' obstacles.

In summary, effective management of work-relevant CHPs requires all players to be onside and to act consistently and collaboratively. These are key features of the toolbox under development. It is designed to provide the tools needed to create a positive work-health culture, and to construct a comfortable and accommodating work environment, one that enables workers to cope with reasonable job demands both when they are well and when they are not. The aspiration is reduction of work-relevant CHPs, leading to fewer cases requiring prolonged sickness absence, and a minimal number progressing to long-term disability.

## **SAFETY, WORK AND JOBS**

A more comprehensive biopsychosocial model for OHS is required for a greater understanding of the relationships between all the key areas.

*Occupational Safety:* Is an overarching concern given that the workplace can be a contributor to injuries and fatalities. There are both moral and practical dimensions to occupational safety and health systems, resulting in the appropriate conclusion that employees should not risk injury or damage to their health when working, nor should others be adversely affected by their working. The regulation and control of hazardous work activities and dangerous workplaces is an essential overarching principle of modern work. However, work is clearly an essential component of a healthy life and it should not be viewed primarily as a dangerous, injurious or

toxic activity. For example, ‘good work’ has several additional aspects that seem to lie mostly in social realms such as security, fairness, capability matching, and social capital.

*Good Work:* Work that is both ‘good’ and safe has become an expected minimum standard in industrialised societies, but it is not sufficient to fully support the health and well-being of workers. Provision of good work does not necessarily produce a ‘good job’. That additionally requires jobs to be ‘comfortable’, and for workplaces to be ‘accommodating’. This means the relationship between employment and health is considered to be close, enduring and multidimensional. Being without work is rarely good for one’s health, but while ‘good work’ is linked to positive health outcomes, jobs that are ‘not good work’ (e.g. insecure, low-paid and lack of protection from stressors and danger) may make people ill. The ability to provide and have ‘good work’ stems mostly from actions at the level of our society: enabling legislation, and suitable policy frameworks with implementation. It is then up to organisations and individuals to make it happen, but the principal level of intervention to generate ‘good work’ is at the socio-political level.

*Comfortable Jobs:* The provision and experience of a comfortable job derives in the main from the systems and processes that exist in the workplace, including work organisation and the quality of management. All the features required for ‘good work’ may be in place, yet the job may still not be a comfortable one. Clearly, many jobs retain some aspects that may be considered unpleasant or uncomfortable, and this cannot practicably be avoided. The comfortableness of a job is likely to influence a person’s sense of job satisfaction, either for better or worse. Job satisfaction can also reciprocally influence the perception of whether a job is comfortable or not. Highly satisfied workers may exhibit higher resilience in coping with less comfortable aspects. The unit of intervention to ensure a job is comfortable is usually at the group or organisational level, but must also involve consideration of the individual. The perception of what is ‘comfortable’ is subjective and varies between individuals.

*Accommodating Workplaces:* Accommodation takes place principally at the individual level. The requirement for, and type of, workplace accommodation is necessarily tailored to the needs of the individual, although its availability invariably depends on workplace policy. The worker-line manager relationship appears key to making it happen effectively.



## 9.2. EVIDENCE TABLES

- **Key**  
[.....] Indicates location of omitted references where text is quoted verbatim from author's other work

**Table 1<sup>11</sup>: Work-relevant musculoskeletal complaints**

<b>Table 1: Work-relevant musculoskeletal complaints</b>	
<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
(Bakker et al. 2009)  Systematic review	<b>Spinal mechanical load as a risk factor for low back pain: a systematic review of prospective cohort studies</b> There was strong evidence that leisure time sport or exercises, sitting, and prolonged standing/walking are not associated with low back pain (LBP). Evidence for associations in leisure time activities (e.g., do-it-yourself home repair, gardening), whole-body vibration, nursing tasks, heavy physical work, and working with ones trunk in a bent and/or twisted position and LBP was conflicting. We found no studies, thus no evidence, for an association between sleeping or sporting on a professional level and LBP.
(Bell & Burnett 2009)  Systematic review	<b>Exercise for the primary, secondary and tertiary prevention of low back pain in the workplace: a systematic review</b> A comprehensive literature search of controlled trials published between 1978 and 2007 was conducted and a total of 15 studies were subsequently reviewed and analysed. There was strong evidence that exercise was effective in reducing the severity and activity interference from LBP. However, due to the poor methodological quality of studies and conflicting results, there was only limited evidence supporting the use of exercise to prevent LBP episodes in the workplace. Other methodological limitations such as differing combinations of exercise, study populations, participant presentation, workloads and outcome measures; levels of exercise adherence and a lack of reporting on effect sizes, adverse effects, and types of sub-groups, make it difficult to draw definitive conclusions on the efficacy of workplace exercise in preventing LBP.
(Bigos et al. 2009)  Systematic review	<b>High-quality controlled trials on preventing episodes of back problems: systematic literature review in working-age adults</b> For inclusion, articles had to describe prospective controlled trials of interventions to prevent BPs in working-age adults, with intervention assignment either to individual participants or pre-existing groups. Of 185 articles identified as potentially relevant, 20 trials met inclusion criteria. Only exercise was found effective for preventing self-reported BPs in seven of eight trials (effect size 0.39 to >0.69). Other interventions were not found to reduce either incidence or severity of BP episodes compared with controls. Null trials included five trials of education, four of lumbar supports, two of shoe inserts, and four of reduced lifting programs. Twenty high-quality controlled trials found strong, consistent evidence to guide prevention of BP episodes in working-age adults. Trials found exercise interventions effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. The varied successful exercise approaches suggest possible benefits beyond their intended physiologic goals.
(Briand et al.	<b>How well do return-to-work interventions for musculoskeletal conditions address the multicausality of work disability?</b>

<sup>11</sup> These evidence tables have been prepared by Kim Burton and Nicholas Kendall. Content has been collated from open source literature, but the number and diversity of sources has meant it has not been practicable to seek permission for reproduction from each individual original author / publisher. In collating this content, the authors that have prepared this table make no claim to any third party copyright and acknowledge the rights in the respective text entries as belonging to the original authors / source publications. References to the original source literature are provided. Any use of content from the literature was intended as "fair dealing" for the purposes of research under the UK Copyright, Designs and Patents Act 1988.

**Table 1: Work-relevant musculoskeletal complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
2008) Descriptive content analysis	The best-documented return-to-work rehabilitation programs concern workers with musculoskeletal disorders. For this clientele, a global perspective has been adopted which explains the multicausality of work disability. This perspective of work disability proposes that return-to-work interventions should address three central elements: individual psychological factors, work environmental factors and factors related to the involvement of the various stakeholders. Long-term work disability is no longer seen simply as the consequence of impairment, but rather as the result of interactions between the worker and main systems: the health care, work environment and financial compensation systems. This paper presents a descriptive content analysis of return-to-work interventions delivered to workers with MSKD which consider this global perspective and which are found to be effective in systematic reviews of the literature. The review of programs designed for workers with musculoskeletal disorders showed that eleven programs address the individual clinical and psychological factors, work environmental factors and factors related to the involvement of the various stakeholders, but in different ways. Only two programs met the essential components identified by the literature. These essential components are: centralized coordination of the worker's return to work, formal individual psychological and occupational interventions, workplace-based interventions, work accommodations, contact between the various stakeholders and interventions to foster concerted action. Interventions which involve the work environment and concerted action by the various partners seem to require the most investment in terms of energy. The establishment of common principles and shared values regarding work rehabilitation as well as less divided mechanisms for action among the various partners should be considered.
(Burton 1997) Narrative review	<b>Back injury and workloss – biomechanical and psychosocial issues</b> The exponential increase in occupational low back pain disability is a problem that is not being addressed adequately in clinical practice. The notion of achieving primary control through ergonomic intervention, based on biomechanics principles, has so far been unhelpful. The traditional secondary prevention strategies of rest and return to restricted work duties are seemingly suboptimal. Biomechanics/ergonomic considerations may be related to the first onset of low back pain, but there is little evidence that secondary control based solely on these principles will influence the risk of recurrence or progression to chronic disability. More promising in this respect are programs that take account of the psychosocial influences surrounding disability. Work organizational issues are clearly important, but so also is the behaviour of clinicians. The balance of the available evidence suggests that clinicians generally should adopt a proactive approach to rehabilitation by recommending, whenever possible, early return to normal rather than restricted duties as well as complementary psychosocial advice if the issue of chronic disability is to be successfully tackled.
(Burton et al. 2004) Evidence- based guideline	<b>European guidelines for prevention in low back pain</b> The general nature and course of commonly experienced LBP means that there is limited scope for preventing its incidence (first-time onset). Prevention, in the context of this guideline, is focused primarily on reduction of the impact and consequences of LBP. Primary causative mechanisms remain largely undetermined: risk factor modification will not necessarily achieve prevention. There is considerable scope, in principle, for prevention of the consequences of LBP – e.g. episodes (recurrence), care seeking, disability, and workloss. Overall, there is limited robust evidence for numerous aspects of prevention in LBP. Nevertheless, there is evidence suggesting that prevention of various consequences of LBP is feasible. However, for those interventions where there is acceptable evidence, the effect sizes are rather modest. The

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	<p>most promising approaches seem to involve physical activity/exercise and appropriate (biopsychosocial) education, at least for adults. But, no single intervention is likely to be effective to prevent the overall problem of LBP, owing to its multidimensional nature. Prevention in LBP is a societal as well as an individual concern. So, optimal progress on prevention in LBP will likely require a cultural shift in the way LBP is viewed, its relationship with activity and work, how it might best be tackled, and just what is reasonable to expect from preventive strategies; it is important to get all the players onside.</p> <p><u>Summary of recommendations for workers:</u></p> <ul style="list-style-type: none"> <li>• Physical exercise is recommended in the prevention of LBP (Level A), for prevention of recurrence of LBP (Level A) and for prevention of recurrence of sick leave due to LBP (Level C). There is insufficient evidence to recommend for or against any specific type or intensity of exercise (Level C).</li> <li>• Back schools based on traditional biomedical/biomechanical information, advice and instruction are not recommended for prevention in LBP (Level A). There is insufficient evidence to recommend for or against psychosocial information delivered at the worksite (Level C), but information oriented toward promoting activity and improving coping may promote a positive shift in beliefs (Level C).</li> <li>• Lumbar supports or back belts are not recommended (Level A).</li> <li>• Shoe inserts/orthoses are not recommended (Level A). There is insufficient evidence to recommend for or against in-soles, soft shoes, soft flooring or anti-fatigue mats (Level D).</li> <li>• Temporary modified work and ergonomic workplace adaptations can be recommended to facilitate earlier return to work for workers sick listed due to LBP (Level B).</li> <li>• There is insufficient consistent evidence to recommended physical ergonomics interventions alone for prevention in LBP (Level C). There is some evidence that, to be successful, a physical ergonomics programme would need an organisational dimension and involvement of the workers (Level B); there is insufficient evidence to specify precisely the useful content of such interventions (Level C).</li> <li>• There is insufficient consistent evidence to recommend stand-alone work organisational interventions (Level C), yet such interventions could, in principle, enhance the effectiveness of physical ergonomics programmes.</li> <li>• Whilst multidimensional interventions at the workplace can be recommended (Level A), it is not possible to recommend which dimensions and in what balance.</li> </ul> <p><i>(Levels refer to evidence grading, A being highest: see original article for details).</i></p>
<p>(Burton et al. 2008)</p> <p>Best evidence synthesis</p>	<p><b>Management of upper limb disorders and the biopsychosocial model</b>  <i>(This review was undertaken for HSE and presented as a research Report)</i> The review used a best evidence synthesis to examine the evidence on management strategies for work-relevant upper limb disorders and established the extent to which the biopsychosocial model can be applied. The main results are presented in thematic sections covering classification/diagnosis, epidemiology, associations/risks, and management/treatment, focusing on return to work and taking account of distinctions between non-specific complaints and specific diagnoses. There is considerable uncertainty over classification and diagnosis for upper limb disorders; the inconsistent terminology impacts</p>

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	<p>on studies of their epidemiology, treatment, and management. Upper limb disorders (ULD) are commonly experienced irrespective of work and can lead to difficulty undertaking everyday tasks; this applies to specific diagnoses as well as non-specific complaints. Work has a limited overall role in the primary causation of ULDs, yet the symptoms are frequently work-relevant (some work tasks will be difficult for people experiencing upper limb symptoms, and may sometimes provoke symptoms that may otherwise not materialise). Management of cases shows more promise than attempts at primary prevention. The biopsychosocial model is certainly appropriate to understand the phenomenon of work-relevant upper limb disorders, and has important implications for their management. Biological considerations should not be ignored, particularly for initial treatment of cases with specific diagnoses, but it is psychosocial factors that are important when developing and implementing work retention and return to work interventions. Implementation of interventions that address the full range of psychosocial issues will require a cultural shift in the way the relationship between upper limb complaints and work is conceived and handled. Neither medical treatment nor ergonomic workplace interventions alone offer an optimal solution; rather, multimodal interventions show considerable promise, particularly for vocational outcomes. Some specific diagnoses may require specific biomedical treatments, but the components of supplementary interventions directed at securing sustained return to work seem to be shared with regional pain disorders. Early return to work, or work retention, is an important goal for most cases and may be facilitated, where necessary, by transitional work arrangements. The emergent evidence indicates that successful management strategies require all the players to be onside and acting in a coordinated fashion, in order to overcome obstacles to recovery and return to work.</p> <p>A number of evidence-based messages have been distilled, which should contribute to the needed cultural shift:</p> <p><u>Concept messages</u></p> <p>Upper limb symptoms are a normal experience - although often initiated by physical mechanism (minor injury), recovery and return to full activities can be expected: activity is usually helpful: prolonged rest is not</p> <p>Work is not the predominant cause - although some work will be difficult or impossible initially, that does not mean the work is unsafe: most people manage to stay at work, but absence is appropriate when job demands cannot be tolerated.</p> <p>Early return to work is important - it contributes to the recovery process and will usually do no harm.</p> <p>All players onside is fundamental - sharing goals, beliefs and a commitment to coordinated action.</p> <p><u>Process messages</u></p> <p>Evidence-based information and advice - adopt a can-do approach, focusing on recovery rather than what's happened.</p> <p>Intervention – stepped care approach: treatment only if required (beware detrimental labelling); encourage and support early activity; avoid prolonged rest; focus on participation, including work.</p> <p>Return to work - stay in touch with absent worker; use case management principles; focus on what worker can do rather than what they can't; provide transitional work arrangements (if required) - time limited.</p> <p>Work organisation - ensure physical demands are within normal capabilities; assess and control significant risks; don't rely on ergonomics alone.</p> <p>Rehabilitation - principles of rehabilitation should be applied early: focus on overcoming biopsychosocial obstacles to participation - all</p>

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	players communicating openly and acting together, avoiding blame and conflict. <i>(See also Table 4).</i>
(Clemes et al. 2010)  Systematic review	<b>What constitutes effective manual handling training? A systematic review</b> Manual handling training programmes have been designed to reduce the likelihood of injury among the workforce; however, concerns have been raised over the efficacy of current manual handling training methods. This systematic review concerned the effectiveness of different approaches to training in manual handling. The review identified little evidence supporting the effectiveness of both technique- and educational-based manual handling training. In addition, there was considerable evidence supporting the idea that the principles learnt during training are not applied in the working environment. Strength and flexibility training shows promise; however, further research is needed to ascertain whether such an intervention is sustainable over the long term. The evidence collected indicates that manual handling training is largely ineffective in reducing back pain and back injury. High priority should be given to developing and evaluating multidimensional interventions, incorporating exercise training to promote strength and flexibility, which are tailored to the industrial sector.
(Côté et al. 2008)  Systematic review and best evidence synthesis	<b>The burden and determinants of neck pain in the workers: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders</b> The objective was to describe the prevalence and incidence of neck pain and disability in workers and identify risk factors for neck pain in workers. Previous reviews of the aetiology of neck pain in workers relied on cross-sectional evidence. Recently published cohorts and randomized trials warrant a re-analysis of this body of research. One hundred and nine papers on the burden and determinants of neck pain in workers were scientifically admissible. The annual prevalence of neck pain varied from 27.1% in Norway to 47.8% in Québec. Each year, between 11% and 14.1% of workers were limited in their activities because of neck pain. Risk factors associated with neck pain in workers include age, previous musculoskeletal pain, high quantitative job demands, low social support at work, job insecurity, low physical capacity, poor computer workstation design and work posture, sedentary work position, repetitive work and precision work. We found preliminary evidence that gender, occupation, headaches, emotional problems, smoking, poor job satisfaction, awkward work postures, poor physical work environment, and workers' ethnicity may be associated with neck pain. There is evidence that interventions aimed at modifying workstations and worker posture are not effective in reducing the incidence of neck pain in workers. Neck disorders are a significant source of pain and activity limitations in workers. Most neck pain results from complex relationships between individual and workplace risk factors. No prevention strategies have been shown to reduce the incidence of neck pain in workers. <i>(Note, whilst this study reports on the determinants of neck pain, the reported associations with 'risk' factors reflect a relationship with reported symptoms – it is not possible to distinguish symptoms that are simply worse with work from those that may be caused by work).</i>
(da Costa & Vieira 2010)	<b>Risk factors for work-related musculoskeletal disorders: a systematic review of recent longitudinal studies</b> Risk factors with at least reasonable evidence of a causal relationship for the development of work-related musculoskeletal disorders include: heavy physical work, smoking, high body mass index, high psychosocial work demands, and the presence of co-morbidities. The most

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Systematic review	commonly reported biomechanical risk factors with at least reasonable evidence for causing WMSD include excessive repetition, awkward postures, and heavy lifting. <i>(The results of that review are somewhat at odds with other systematic reviews in that 'reasonable evidence' was found for a range of physical factors causing work-related musculoskeletal disorders. This may have arisen because, among other things, work-relevancy and work-causation of symptoms were not clearly distinguished, so it should not be assumed that this review overturns the more circumspect findings of other reviews.)</i>
(Denis et al. 2008)  Narrative review	<b>Intervention practices in musculoskeletal disorder prevention: a critical literature review</b> The steps (or phases) of the "classical" ergonomic intervention process are: (a) Preliminary analyses: first step that consisted of defining the scope of the problems in the work situation studied and eventually orienting the data collection in the diagnostic step. (b) The diagnostic step: central step in the process that found causes (or determinants) for the identified problems, causes to which the changes or work situations should be directly related. (c) The solution-development step: final step in which solutions to change the work situation were developed. The review found the intervention approaches used in musculoskeletal prevention are diverse, but have common characteristics that make their grouping possible. There are variants to the classical intervention model, which suggests that the prevention intervention is not a recipe and that it can be adapted: going further, as well as limiting the usually recommended process, can be justified. However, these adaptations may not always be appropriate, particularly when deciding to use a "fast track" method. Three classes of intervention were described: Complete: Based on the "classical" work analysis model in which risk factor identification is a central aspect. Shortened: Diagnosis based on determinant analysis. Extensive reference to standards. Turnkey: No diagnosis. Rapid route. Almost direct use of existing/pre-packaged solutions.
(Driessen et al. 2010)  Systematic review	<b>The effectiveness of physical and organisational ergonomic interventions on low back pain and neck pain: a systematic review</b> A systematic review of randomised controlled trials (RCTs) on the effectiveness of ergonomic interventions. 10 RCTs met the inclusion criteria. There was low to moderate quality evidence that physical and organisational ergonomic interventions were not more effective than no ergonomic intervention on short and long term LBP and neck pain incidence/prevalence, and short and long term LBP intensity. There was low quality evidence that a physical ergonomic intervention was significantly more effective for reducing neck pain intensity in the short term (ie, curved or flat seat pan chair) and the long term (ie, arm board) than no ergonomic intervention. The limited number of RCTs included means the results should be interpreted with care. <b>Key points:</b> < Ergonomic interventions are usually not effective for preventing or reducing low back pain and neck pain among non-sick listed workers. < Ergonomists should pay more attention to compliance and researchers should improve reporting on compliance. < The effectiveness of ergonomic intervention should be confirmed by future randomised controlled trials. <i>(The article was accompanied by a debate (unresolved) about the appropriateness of the RCT research design, along with compliance issues, for testing workplace interventions).</i>

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(Hadler 1997a)  Editorial	<b>Back pain in the workplace: what you lift or how you lift matters far less than whether you lift or when</b> According to Hadler: In spite of more than 50 years of concerted effort to diminish task demand, the incidence of compensable back injuries has not wavered. Before we persist for another 50 years in the quest for the "right way to lift," we should consider recent multivariate clinical investigations that suggest alternative approaches. Because task context is at least as important as task content in this regard, it follows that including regional backache under the rubric of "compensable injury" demands reconsideration. Likewise, rather than pursuing the "right way to lift," <u>the more reasonable and humane quest might be for workplaces that are comfortable when we are well and accommodating when we are ill.</u> (Although the focus is on back injuries, the same notion of comfortable and accommodating might reasonably be expected to apply to other work-relevant complaints). (See also Table 4).
(Hanson et al. 2006)  Narrative review + model development	<b>The costs and benefits of active case management and rehabilitation for musculoskeletal disorders (MSD)</b> 'Active case management' describes the goal-oriented approach to achieving specific work retention and return to work outcomes. It is a strategy for supporting individuals (with MSDs) stay in work or return to work. In practice, case managers integrate clinical and occupational management with the needs of the individual to facilitate early return to work (or work retention). There is good international scientific evidence that case management methods are cost-effective through reducing time off work and lost productivity, and reducing healthcare costs. There is even stronger evidence that best-practice rehabilitation approaches have the very important potential to significantly reduce the burden of long-term sickness absence due to musculoskeletal disorders. Many of the factors influencing the adoption of cost-effective case management and rehabilitation approaches rest with employers, and funders/commissioners of healthcare. It may be easier to integrate these practices into large and medium-sized workplaces, but there is no reason why the same principles cannot be applied to small businesses and the self-employed. It appears to be very timely for the distribution of information to employers and other key players about how effective case management and suitable rehabilitation approaches can be, and how applicable they are to UK settings. An evidence-based model for managing those with MSDs was developed that is widely applicable to all types of industry and business in the UK. It describes the principles to apply in order to integrate case management and rehabilitation with the workplace. There is a clear message in the model for all those involved on what they should do and why, using a staged approach: create the right culture; manage workers with musculoskeletal problems; manage the return to work process; monitor and review the programme effectiveness. The model may be used by all sizes of organisation, and should be suitable for all forms of musculoskeletal disorders. The role of the case manager may be taken by an occupational health professional or the employer (e.g. a line manager). The important points are to respond to the needs of individuals quickly, make appropriate arrangements for them (which may include treatment and workplace changes), and gain agreement from the individual, employer, healthcare provider and case manager as to the individual's planned return to work if absent. The review highlighted the importance of good communication and the need to ensure all the players are onside. (This review for HSE, presented as a Research Report, was supplemented with stakeholder focus groups to assess the model). (See also Table 4)
(Hogg-Johnson et al.	<b>The burden and determinants of neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders</b>



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2008) Best evidence synthesis	The Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders performed a systematic search and critical review of literature published between 1980 and 2006 to assemble the best evidence on neck pain, including its burden and determinants. 249 studies were scientifically admissible; 101 articles related to the burden and determinants of neck pain in the general population. Incidence ranged from 0.055 per 1000 person years (disc herniation with radiculopathy) to 213 per 1000 persons (self-reported neck pain). Incidence of neck injuries during competitive sports ranged from 0.02 to 21 per 1000 exposures. The 12-month prevalence of pain typically ranged between 30% and 50%; the 12-month prevalence of activity-limiting pain was 1.7% to 11.5%. Neck pain was more prevalent among women and prevalence peaked in middle age. Risk factors for neck pain included genetics, poor psychological health, and exposure to tobacco. Disc degeneration was not identified as a risk factor. The use of sporting gear (helmets, face shields) to prevent other types of injury was not associated with increased neck injuries in bicycling, hockey, or skiing. Neck pain is common. Nonmodifiable risk factors for neck pain included age, gender, and genetics. Modifiable factors included smoking, exposure to tobacco, and psychological health. Disc degeneration was not identified as a risk factor.
(Iles et al. 2008)	<b>Psychosocial predictors of failure to return to work in non-chronic non-specific low back pain: a systematic review</b> To identify psychosocial predictors of failure to return to work in non-chronic (lasting less than 3 months) non-specific low back pain (NSLBP). There is strong evidence that recovery expectation is predictive of work outcome and that depression, job satisfaction and stress/psychological strain are not predictive of work outcome. There is moderate evidence that fear avoidance beliefs are predictive of work outcome and that anxiety is not predictive of work outcome. There is insufficient evidence to determine whether compensation or locus of control are predictive of work outcome. To predict work outcome in non-chronic NSLBP, psychosocial assessment should focus on recovery expectation and fear avoidance.
(Iles et al. 2009)	<b>Systematic review of the ability of recovery expectations to predict outcomes in non-chronic non-specific low back pain</b> A systematic review of prognostic studies. Included studies took baseline measures in the non-chronic phase of NSLBP, included at least one baseline measure of recovery expectation, defined as a prediction or judgement made by the person with NSLBP regarding any aspect of prognosis, and studied a sample with at least 75% of participants with NSLBP. Recovery expectations measured using a time-based, specific single-item tool produced a strong prediction of work outcome. Recovery expectations measured within 3 weeks of NSLBP onset provide a strong prediction of outcome. It is not clear whether predictive strength of recovery expectations is affected by the length of time between the expectation measure and outcome measure. Recovery expectations when measured using a specific, time-based measure within the first 3 weeks of NSLBP can identify people at risk of poor outcome.
(Kendall et al. 2009) Evidence-informed	<b>Tackling musculoskeletal problems – a guide for clinic and workplace: identifying obstacles using the psychosocial flags framework</b> What is known as the Psychosocial Flags framework has been devised to help understand and identify psychosocial obstacles. People usually need help to overcome or navigate round obstacles. Flags point to the obstacles in need of action. All the players in and around the workplace, as well as health professionals, need to be looking for obstacles. <ul style="list-style-type: none"><li>• Yellow Flags are about the person – unhelpful thoughts, feelings and behaviours that impede normal recovery, e.g. distress, uncertainty,</li></ul>

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guidance	<p>dysfunctional beliefs and expectations</p> <ul style="list-style-type: none"><li>• Blue Flags are about the workplace – unhelpful interactions between the person and the workplace: e.g. low expectation of resuming work, low social support in workplace, lack of modified work</li><li>• Black Flags are about the context – unhelpful aspects of systems and policies: e.g. unhelpful procedures used by company; delays due to mistakes, waiting lists, or claims; misunderstandings and disagreements between key players (employee; employer; healthcare).</li></ul> <p>The essential steps to helping people back to work are: “Identify flags, develop a Plan, take Action”. Identifying the relevant Flags is about looking for unhelpful behaviours and circumstances. Anything about the person, the workplace or the context (including influential others) that stands in the way of early return to work. Developing a plan of action is about agreeing goals and sorting out who does what when. Taking action is all about overcoming obstacles at work: problem-solving approaches by the key players working together. It means providing timely and effective treatment and an accommodating workplace, with helpful policies and coordinated actions.</p> <p>The Action must address the identified Flags and obstacles, using both healthcare and workplace interventions. Psychosocial factors, such as beliefs, fears, and avoidance behaviours need to be tackled. Psychosocial interventions such as problem-solving training and suitable coping strategies can usefully supplement exercises and accurate information/advice, and contribute to increasing activity. An accommodating workplace can be the key to work retention and early return to work. Clinical intervention should take a stepped care approach – providing just what is needed when it is needed. Involve the workplace setting if possible, rather than the clinic alone. Ensure (through communication) that all players know what Actions are to be done, by whom, and when. Interventions to address psychosocial factors are more effective, and use fewer resources when they are delivered early. Psychologists are usually not needed – the principles can be adopted and used by all key players. Many urban myths are powerful obstacles: e.g. muscle and joint pain is caused by work; time off work is essential; cannot return to work until 100% pain free; contacting the absent worker is intrusive. They need to be dispelled.</p>
(Kennedy et al. 2010)  Systematic review	<p><b>Systematic review of the role of occupational health and safety interventions in the prevention of upper extremity musculoskeletal symptoms, signs, disorders, injuries, claims and lost time</b></p> <p>The review involved 36 studies of occupational health and safety interventions to reduce upper extremity musculoskeletal disorders and injuries, and concerned either primary or secondary prevention or both. Overall, a mixed level of evidence was found. Levels of evidence for interventions associated with positive effects were: moderate evidence for arm supports; and limited evidence for ergonomics training plus workstation adjustments, new chair and rest breaks. Levels of evidence for interventions associated with “no effect” were: strong evidence for workstation adjustment alone; moderate evidence for biofeedback training and job stress management training; and limited evidence for cognitive behavioural training. No interventions were associated with “negative effects”. It can be concluded that it is difficult to make strong evidenced-based recommendations about what practitioners should do to prevent or manage upper extremity musculoskeletal problems. It was recommended that worksites not engage in occupational health and safety activities that include only workstation adjustments. However, when combined with ergonomics training, there is limited evidence that workstation adjustments are beneficial.</p>
(Marras et al.	<p><b>National occupational research agenda (NORA) future directions in occupational musculoskeletal disorder health research</b></p>

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2009) Narrative review / position statement	The scientific literature has indicated that psychosocial factors, individual factors, workplace physical requirements, and workplace organizational factors have been associated with risk for musculoskeletal disorders. Since musculoskeletal risk is multi-dimensional, the magnitude of risk attributable to various factors can be of importance to scientists and policy makers in designing countermeasures to reduce injury incidence. Traditionally, the disciplines of biomechanics, physiology, and psychophysics have dominated the body of knowledge that has defined exposure limitations to work. However, recent research has explored the association of psychosocial and work organization factors with musculoskeletal problems. Advances have been made to better quantify the levels of occupational exposure by improved exposure metrics, quantification of three dimensional loads experienced by certain joints (e.g. the spine), identification of tissue tolerance limits and tissue response to mechanical stresses, and the impact of psychosocial stresses. However, efforts to quantitatively link epidemiological, biomechanical loading, soft tissue tolerance, and psychosocial studies should be pursued to establish a better understanding of the pathways of injury and resultant preventive strategies. Although we are beginning to understand how the major risk factors influence the load-tolerance relationship of human tissue, how these risk factors interact is virtually unexplored. Since the impact of the interactions may be far greater than that of any individual factor, the impact of the interactions between risk factors must be delineated so that work-related risk can be better quantified. Efforts to quantitatively link epidemiological, biomechanical loading, soft tissue tolerance, and psychosocial studies should be pursued to establish a better understanding of the pathways of injury and resultant preventive strategies. <i>(The authors conclude that our understanding of injury mechanisms is insufficient and propose that more effort should be placed on understanding interactions between different types of risk factor: however, the focus seems to be largely on a work-related injury model, which does not fit readily with much of the epidemiological data and does not take account of consequences of experiencing symptoms at work (which may or may not be due to tissue damage (injury))).</i>
(Martimo et al. 2008) Systematic review	<b>Effect of training and lifting equipment for preventing back pain in lifting and handling: systematic review</b> A Cochrane review to determine whether advice and training on working techniques and lifting equipment prevent back pain in jobs that involve heavy lifting. Six randomised trials and five cohort studies met the inclusion criteria. Two randomised trials and all cohort studies were labelled as high quality. Eight studies looked at lifting and moving patients, and three studies were conducted among baggage handlers or postal workers. Those in control groups received no intervention or minimal training, physical exercise, or use of back belts. There is no evidence to support use of advice or training in working techniques with or without lifting equipment for preventing back pain or consequent disability. The findings challenge current widespread practice of advising workers on correct lifting technique.
(Miranda et al. 2010) Original study	<b>Musculoskeletal pain at multiple sites and its effects on work ability in a general working population</b> Based on a representative sample of Finnish adults in the 30-64 year-old group, this study explored musculoskeletal pain during the preceding month in the lower back, neck or shoulders, upper extremities, hips and lower extremities, and work ability and intentions to retire early. Single-site pain was reported by 33% of subjects, 20%, 9% and 4% reported pain in two, three and four sites, respectively. Poor work ability with respect to physical work demands was reported by 16%, and with respect to the mental demands of work by 14%. Some 13% estimated that their work ability will deteriorate during the next 2 years, and 8%) estimated that they will not be able to continue working due to health

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	issues in the same job for the next 2 years. Every fifth person had thought about retiring early. Age- and gender-adjusted risks of poor physical work ability and own prognosis of poor future work ability increased from 2 for single-site pain to 8 for pain at four sites. Risks remained considerably elevated after adjustment for various covariates, including clinical musculoskeletal disorders and functional capacity. Poor current work ability was most affected by multi-site pain at older age (50-64 years) and intentions to retire early at age 40-49 years. Co-occurring pain is a considerable threat to work ability. Workers with multi-site pain may benefit from targeted preventive measures to sustain their work ability. <i>(This original study is included because no reviews were found on the important topic of concurrent symptoms and workability).</i>
(Nelson & Hughes 2009)  Systematic review	<b>Quantifying relationships between selected work-related risk factors and back pain: a systematic review of objective biomechanical measures and cost-related health outcomes</b> The objective of this investigation was to use published literature to demonstrate that specific changes in workplace biomechanical exposure levels can predict reductions in back injuries. A systematic literature review was conducted to identify epidemiologic studies which could be used to quantify relationships between several well-recognized biomechanical measures of back stress and economically relevant outcome measures. Eighteen publications, describing 15 research studies, which fulfilled search criteria were found. Quantitative associations were observed between back injuries and measures of spinal compression, lifting, lifting ratios, postures, and combinations thereof. Results were intended to provide safety practitioners with information that could be applied to their own work situations to estimate costs and benefits of ergonomic intervention strategies before they are implemented. <i>(This review takes epidemiological data concerning workplace exposure associated with low back pain, and suggests health and safety practitioners may be able to make a cost-benefit case for ergonomic intervention. However, no intervention studies were reviewed. The epidemiological studies were apparently reviewed more for their exposure assessment methods than for their ability to show causative links – they showed associations rather than establishing causation. The outcome in many reviewed studies was purported ‘injury’ without objective confirmation. This study actually confirms nothing about causation, prevention or cost-benefits regarding ergonomics and low back pain).</i>
(Okunribido 2009)	<b>Lower limb MSD: scoping work to help inform advice and research planning (HSE RR706)</b> This work was commissioned to examine more closely the nature and extent of workplace lower limb musculoskeletal disorders and injuries (LLD) and the causal agents with the aim of informing evidence based guidance and advice for workers and employers. LLDs, particularly knee conditions, are a problem in many workplaces and they tend to be associated with conditions <i>(actually reports of symptoms)</i> in other areas of the body. Both acute and <i>(so-called)</i> overuse injuries may be suffered by workers, although overuse injuries tend to be more common. There are consequences of occupationally caused LLD for society, the economy and industry in terms of lost working time, medical treatment and hospitalisation, decreased ability to carry out the work, and effects on quality of life. The particular impact depends on the condition and the number of joints affected. The risk factors for LLD are not specific to any of the sites of the lower extremities and they are also associated with disorders in other regions of the body such as the upper limb and torso. There is appreciable evidence of a causal association for kneeling/squatting, climbing

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	stairs or ladders, heavy lifting, walking/standing, and slips and trips hazards as risk factors for LLD. The evidence of a causal association is plausible but less clear for jumps from height (e.g., from a vehicle's bed or cabin to the ground), driving and sitting. There is appreciable evidence for implementation of workplace redesign/modification initiatives, implementation of protection equipment and participatory programmes as interventions for control and prevention of LLD risks, and it was possible to identify useful strategies that may be applied. Further work is recommended to clarify the inter-relationships between injury/pain at different regions of the body; to provide more detailed measures of workplace ergonomics risk exposures; to determine the suitability of existing control strategies and prevention interventions that have been proposed against conditions in other regions of the body (back and upper limbs); to explore the benefits of exercise regimes and coping programmes for those with a condition; and to identify strategies other than regulation that would aid increased awareness of the problems in workplaces and encourage commitment of employers. <i>(The review looks at a wide range of risk factors (physical, personal and occupational) but the majority of the studies reviewed were not prospective, thus limiting conclusions about cause-effect: the odds ratios tended to be modest. LLDs clearly can be work-relevant, and the review found some evidence that modified work could be effective for reducing lower limb symptoms – overall the findings suggest that comfortable and accommodating work should be beneficial in respect of lower limb complaints).</i> (See also Table 4).
(Pincus et al. 2006)  Systematic review	<b>Fear avoidance and prognosis in back pain: a systematic review and synthesis of current evidence</b> Fear of pain, which is hypothesized to result in avoidance behaviour, has been described as an obstacle to recovery in populations of patients with low back pain. This review aimed to explore current evidence and to propose further development of theoretical models. Nine prospective studies were reviewed. Several of these had acceptable/good methodology. Three studies, of which at least 1 had excellent methodology, showed no link between measures of fear at baseline and poor prognosis in the short term (3 months) or the long term (12 months). Three studies with acceptable methodology showed weak evidence for such a link, but the effect sizes were small. The only study with acceptable methodology to find a clear link suggested that fear of movement was linked to long-term pain. In summary, despite the prevalent focus on fear of pain at early stages of back pain, there is little evidence to link such fear states with poor prognosis. There is some evidence to suggest that fear may play a role when pain has become persistent. There is a growing consensus that distress/depression plays an important role at early stages, and clinicians should focus on these factors. <i>(This review had a strong clinical focus).</i>
(Rivilis et al. 2008)  Systematic review	<b>Effectiveness of participatory ergonomic interventions on health outcomes: a systematic review</b> The objective of this study was to conduct a systematic review of the literature on the effectiveness of participatory ergonomic (PE) interventions for improving workers' health. The search strategy targeted six electronic databases and identified 442 potential articles. Each article was examined by pairs of reviewers for relevance (assessed a participative ergonomic workplace intervention, with at least one health outcome, published in English in peer reviewed literature). Twenty-three articles met relevance criteria and were then appraised for methodological strength. Using a best evidence synthesis approach, 12 studies that were rated as 'medium' or higher provided partial to moderate evidence that PE interventions have a positive impact on: musculoskeletal symptoms, reducing injuries and workers' compensation claims, and a reduction in lost days from work or sickness absence. However, the magnitude of the effect requires more precise definition.

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	The authors noted the main reason for not finding full support for PE is the low number of methodologically sound studies currently available in the literature. (See also Table 1: van Eerd et al 2008; St-Vincent et al 2006).
(Schultz et al. 2007)  Narrative review	<b>Models of return to work for musculoskeletal disorders</b> The emerging conceptual models of return to work (RTW) represent more comprehensive approaches than what has been proposed in the past. The new models are transdisciplinary, integrative, interactive, and multidimensional. They focus on the interaction between the individual and the multiple systems within which an individual functions and the interactions among these systems. All of these models propose dynamic interactions and some incorporate a temporal dimension. Both clinical and occupational perspectives on disability are typically incorporated. Furthermore, both physical and psychological capacity dimensions of occupational disability are considered important in RTW. The empirical validation of these models is an emerging trend and future research will serve to refine them. It is important to note that, at present, there is no single unifying biopsychosocial model that is used in research or clinical application. The inherent problem with biopsychosocial theory is its generic nature and lack of specificity. In fact, this lack of specificity and the fact that the model is largely based upon many of the strongest features of other prior models, such as the psychosocial and ecological/case management models, makes it at times difficult to distinguish as a standalone, distinct model. Further, this issue is apparent in the current multiplicity of conceptual and empirical biopsychosocial models of RTW. We have known that RTW definitions based on a single RTW episode need to be replaced by the identification of patterns of RTW, and supplemented by other sources of data including duration of disability and cost; yet, this continues to be a future goal of research and is rarely an aspect of a model of occupational disability and RTW. Despite the absence of an agreed upon RTW taxonomy, researchers across several disciplines related to RTW recognized the importance of both safe and sustained return to work. Several models of RTW have emerged over the past two decades. These have evolved from conceptual understandings of pain, physical functioning, biopsychosocial research, and their impact on function. Newer models have been more expansive in their focus on potential factors that can impact occupational disability and RTW. While there is a role for many of these models, at this point in time there is a need for a parsimonious multi-variable model with major explanatory qualities for enhancing our understanding of occupational disability and, consequently, improving prevention and management.
(Shaw et al. 2009)  Narrative review by Working group	<b>Early patient screening and intervention to address individual-level occupational factors (“blue flags”) in back disability</b> This review aimed to develop a consensus plan for research and practice to encourage routine clinician screening of occupational factors associated with long-term back disability. The Working Group identified seven workplace variables (blue flags) to include in early screening by clinicians: <ul style="list-style-type: none"><li>• physical job demands</li><li>• ability to modify work</li><li>• job stress</li><li>• workplace social support or dysfunction</li></ul>

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	<ul style="list-style-type: none"> <li>• job satisfaction</li> <li>• expectation for resuming work</li> <li>• fear of re-injury</li> </ul> <p>Five evaluation criteria for screening methods were established: reliability, predictive performance, feasibility, acceptability, and congruence with plausible interventions. An optimal screening method might include a stepped combination of questionnaire, interview, and worksite visit. There is a clear indication that occupational factors influence back disability, but to expand clinician practices in this area will require that patient screening methods show greater conceptual clarity, feasibility, and linkages to viable options for intervention. <i>(Although the focus was on screening by clinicians, the seven workplace variables/flags there is no fundamental reason why they cannot be identified at the workplace).</i></p>
<p>(St-Vincent et al. 2006)</p> <p>Summary of implementation</p>	<p><b>Participatory ergonomics to reduce musculoskeletal disorders: summary of a Quebec experience</b></p> <p>Review of 11 participatory ergonomic interventions carried out in Quebec by the Occupational Health and Safety Research Institute. The intervention approach aims to provide company personnel with the skills to analyze and correct hazardous workstations in relation to musculoskeletal disorders, using a formulaic analysis process that the researchers developed. The participatory process is based on mobilization of the company's players; its implementation therefore requires the establishment of working groups with clear mandates. In the 11 interventions, 40 work situations were analyzed, and in 31 cases, changes were implemented to reduce MSD risks. The most common changes dealt with the tools/equipment (77.4%) and physical layouts (84%); changes involving work methods (29%) and work organization (12.9%) were less common. The authors concluded that the participatory process was successful in implementing changes in companies and that other studies are necessary for a better understanding of the process and its impacts. <i>(This study is not strictly an evidence review, but a summary of implementation. It provides, as recognised by the authors, of evidence on the effectiveness of the participatory ergonomics programme on health).</i></p>
<p>(Tullar et al. 2010)</p> <p>Systematic review</p>	<p><b>Occupational safety and health interventions to reduce musculoskeletal symptoms in the health care sector</b></p> <p>A systematic review of the literature used a best evidence synthesis approach to address the general question "Do occupational safety and health interventions in health care settings have an effect on musculoskeletal health status?" This was followed by an evaluation of the effectiveness of specific interventions. A moderate level of evidence was observed for the general question. Moderate evidence was observed for: (1) exercise interventions and (2) multi-component patient handling interventions. A moderate level of evidence indicates: (1) patient handling training alone and (2) cognitive behaviour training alone have no effect on musculoskeletal health. Few high quality studies were found that examined the effects of interventions in health care settings on musculoskeletal health. The findings here echo previous systematic reviews supporting exercise as providing positive health benefits and training alone as not being effective. Given the moderate level of evidence, exercise interventions and multi-component patient handling interventions (MCPHI) were recommended as practices to consider. A multi-component intervention includes a policy that defines an organizational commitment to reducing injuries associated with patient</p>

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	handling, purchase of appropriate lift or transfer equipment to reduce biomechanical hazards and a broad-based ergonomics training program that includes safe patient handling and/or equipment usage. <i>(The recommendation concerning MCPHI seems plausible, but is not based on solid evidence and such intervention could well be difficult to implement and sustain).</i>
(van den Berg et al. 2009)  Systematic review	<b>The effects of work-related and individual factors on the Work Ability Index: a systematic review</b> This paper systematically reviews the scientific literature on the effects of individual and work-related factors on the Work Ability Index (WAI). Studies were included if the WAI was used as measure of work ability and if quantitative information was presented on determinants of work ability. In total, 20 studies were included with 14 cross-sectional studies and six longitudinal studies. Factors associated with poor work ability were lack of leisure-time vigorous physical activity, poor musculoskeletal capacity, older age, obesity, high mental work demands, lack of autonomy, poor physical work environment, and high physical work load. The WAI is associated with individual characteristics, lifestyle, demands at work, and physical condition. This multifactorial nature of work ability should be taken into account in health promotion programmes aimed at maintaining and promoting the participation of the labour force and improvement of the performance at work. <i>(Whilst the conclusion seems reasonable, the specific factors identified must be viewed with some caution in respect of possible preventive interventions because the majority of studies reviewed were cross-sectional).</i>
(van Duijn et al. 2010)  Literature review and data analysis	<b>The effects of timing on the cost-effectiveness of interventions for workers on sick leave due to low back pain</b> The cost-benefits of a RTW intervention among workers on sick leave due to low back pain were determined by the estimated effectiveness of the intervention, the costs of the intervention, the natural course of RTW in the target population, the timing of the enrolment of subjects into the intervention, and the duration of the intervention. It was concluded that with a good RTW in the first weeks, the only early interventions likely to be cost-beneficial are inexpensive work-focused enhancements to early routine care, such as accommodating workplaces. Structured interventions are unlikely to have an additional impact on the already good prognosis when offered before the optimal time window at approximately 8 to 12 weeks. The generalisability of the effectiveness of a RTW intervention depends on the comparability of baseline characteristics and RTW curves in target and source populations.
(Van Eerd et al. 2008)	<b>Report on process and implementation of participatory ergonomic interventions: a systematic review</b> This is a review of processes and implementation not effectiveness. Participatory ergonomic (PE) programs or interventions are considered helpful in reducing work-related musculoskeletal problems. A participatory ergonomic program involves key players from the workplace in problem solving, planning and controlling a significant amount of their work activities. With most PE programs, some type of team or committee forms. They usually receive training in ergonomic principles and use this knowledge to make improvements. To increase the chances of a successful program, it is important to be aware of potential facilitators and barriers in initiating and putting the PE program into practice. The facilitators and barriers that should be considered: <ul style="list-style-type: none"><li>• management support of the PE intervention</li><li>• ergonomic training (which is a separate recommendation)</li></ul>



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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<ul style="list-style-type: none"><li>• resources such as staff time, funds or materials</li><li>• creating an appropriate team (also a separate recommendation)</li><li>• communication levels</li><li>• organizational training/knowledge in general areas such as team-building skills</li></ul> To increase the likelihood of a successful participatory ergonomic (PE) program: <ul style="list-style-type: none"><li>• Create PE teams with appropriate members, including workers, supervisors and advisors</li><li>• Address key facilitators/barriers, such as management support and resources for the program</li><li>• Involve the right people from the workplace in the overall PE process</li><li>• Provide ergonomic training</li><li>• Involve a PE champion to guide and monitor the process</li><li>• Define participants' responsibilities, which usually include problem-solving, developing solutions and implementing change</li><li>• Make decisions using group consultation.</li></ul> <i>(See also Table 1: Rivilis et al 2008; St-Vincent et al 2006)</i>
(van Oostrom et al. 2009)  Cochrane review	<b>Workplace interventions for preventing work disability</b> Cochrane review of 6 RCTs of workplace interventions for the prevention of workplace disability stemming from musculoskeletal disorders, common mental health problems such as depression and adjustment disorders. In this review, interventions allude to changes in the workplace or equipment, work design/organisation, working conditions or work environment. The primary outcome indicator was sickness absence period. Authors conclude that workplace interventions are effective to reduce sickness absence, but not effective at improving health outcomes for workers with musculoskeletal disorders. As only one of the 6 selected studies looked at mental health issues, the authors considered that conclusions about workplace interventions cannot be drawn for this health condition from this review. A secondary conclusion drawn by the authors is that stakeholders in the return to work process should focus on return to work as a primary goal ( <i>see also Table 2</i> ).
(van Rijn et al. 2009b)	<b>Associations between work-related factors and the carpal tunnel syndrome--a systematic review</b> Jobs with the highest risk of carpal tunnel syndrome (CTS) included work in the meat- and fish-processing industry, forestry work with chain saws, and electronic assembly work (OR 76.5, 21.3, and 11.4, respectively). The occurrence of CTS was associated with high levels of hand-arm vibration, prolonged work with a flexed or extended wrist, high requirements for hand force, high repetitiveness, and their combination. No association was found between any psychosocial risk factor and CTS. Contradictory findings were reported for associations between computer work and CTS.
(van Rijn et al. 2009a)	<b>Associations between work-related factors and specific disorders at the elbow: a systematic literature review</b> Handling tools >1 kg (ORs of 2.1-3.0), handling loads >20 kg at least 10 times/day (OR 2.6) and repetitive movements >2 h/day (ORs of 2.8-4.7) were associated with lateral epicondylitis. Psychosocial factors associated with lateral epicondylitis were low job control (OR 2.2) and

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(van Rijn et al. 2010)	<p>low social support (OR 1.8). Handling loads &gt;5 kg (2 times/min at minimum of 2 h/day), handling loads &gt;20 kg at least 10 times/day, high hand grip forces for &gt;1 h/day, repetitive movements for &gt;2 h/day (ORs of 2.2-3.6) and working with vibrating tools &gt;2 h/day (OR 2.2) were associated with medial epicondylitis. The occurrence of cubital tunnel syndrome was associated with the factor 'holding a tool in position' (OR 3.53). Handling loads &gt;1 kg (OR 9.0; 95% CI 1.4, 56.9), static work of the hand during the majority of the cycle time (OR 5.9) and full extension (0-45 degrees) of the elbow (OR 4.9) were associated with radial tunnel syndrome.</p> <p><b>Associations between work-related factors and specific disorders of the shoulder--a systematic review of the literature</b></p> <p>The occurrence of SIS was associated with force requirements &gt;10% maximal voluntary contraction (MVC), lifting &gt;20 kg &gt;10 times/day, and high-level of hand force &gt;1 hour/day (OR 2.8-4.2). Repetitive movements of the shoulder, repetitive motion of the hand/wrist &gt;2 hours/day, hand-arm vibration, and working with hand above shoulder level showed an association with SIS (OR 1.04-4.7) as did upper-arm flexion &gt; or =45 degrees &gt; or =15% of time (OR 2.43) and duty cycle of forceful exertions &gt; or =9% time or duty cycle of forceful pinch &gt;0% of time (OR 2.66). High psychosocial job demand was also associated with SIS (OR 1.5-3.19). Jobs in the fish processing industry had the highest risk for both tendinitis of the biceps tendon as well as SIS (OR 2.28 and 3.38, respectively). Work in a slaughterhouse and as a betel pepper leaf culler were associated with the occurrence of SIS only (OR 5.27 and 4.68, respectively). None of the included articles described the association between job title/risk factors and the occurrence of rotator cuff tears or suprascapular nerve compression. <i>(These studies do not confirm causal relationships, so (despite some high ORs) removal of the associated workplace exposures should not be assumed to contribute to primary prevention).</i></p>
(Waersted et al. 2010)  Systematic review	<p><b>Computer work and musculoskeletal disorders of the neck and upper extremity: a systematic review</b></p> <p>This review examines the evidence for an association between computer work and neck and upper extremity disorders (except carpal tunnel syndrome). Included studies concerned computer work and musculoskeletal disorders verified by a physical examination. Results show limited evidence for a causal relationship between computer work per se, computer mouse and keyboard time related to a diagnosis of wrist tendonitis, and for an association between computer mouse time and forearm disorders. Limited evidence was also found for a causal relationship between computer work per se and computer mouse time related to tension neck syndrome, but the evidence for keyboard time was insufficient. Insufficient evidence was found for an association between other musculoskeletal diagnoses of the neck and upper extremities, including shoulder tendonitis and epicondylitis, and any aspect of computer work. Overall, there is limited epidemiological evidence for an association between aspects of computer work and some of the clinical diagnoses studied. None of the evidence was considered as moderate or strong. <i>(The review does not confirm causal relationships - much of the data were cross-sectional and the 'diagnoses' were often mixed. Removal of the associated workplace exposures should not be assumed to contribute to primary prevention, but may contribute to accommodation of people with symptoms).</i></p>
(Waddell & Burton 2000)	<p><b>Occupational health guidelines for the management of low back pain at work: evidence review</b></p> <p><i>(This review underpinned the Faculty of Occupational Medicine's Occupational Health Guidelines for the Management of Low Back Pain at Work)</i></p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
Best evidence synthesis  (Carter & Birrell 2000)	<p><b>Background:</b> Non-specific low back pain (LBP) can be occupational in the sense that it is common in adults of working age, frequently affects capacity for work, and often presents for occupational health care. It is commonly assumed this means that LBP is caused by work but the relationship between the physical demands of work and LBP is complex and inconsistent. A clear distinction should be made between the presence of symptoms, the reporting of LBP, attributing symptoms to work, reporting 'injury', seeking health care, loss of time from work and long term damage. LBP in the occupational setting must be seen against the high background prevalence and recurrence rates of low back symptoms, and to a lesser extent disability, among the adult population. Workers in heavy manual jobs do report rather more low back symptoms, but most people in lighter jobs or even those who are not working have similar symptoms. Jobs with greater physical demands commonly have a higher rate of reported low back injuries, but most of these 'injuries' are related to normal everyday activities such as bending and lifting, there is usually little if any objective evidence of tissue damage (though clinical examination and current in vivo investigations may be insensitive tools to detect this), and the relationship between job demands and symptoms or injury rates is inconsistent. Physical stressors may overload certain structures in individual cases but, in general, there is little evidence that physical loading in modern work causes permanent damage. Whether low back symptoms are attributed to work, are reported as 'injuries', lead to health care seeking and/or result in time off work depends on complex individual psychosocial and work organisational factors. The development of chronic pain and disability depends more on individual and work-related psychosocial issues than on physical or clinical features. People with physically or psychologically demanding jobs may have more difficulty working when they have LBP, and so lose more time from work, but that can be the effect rather than the cause of their LBP. In summary, physical demands of work can precipitate individual attacks of LBP, certain individuals may be more susceptible and certain jobs may be higher risk but, viewed overall, physical demands of work only account for a modest proportion of the total impact of LBP occurring in workers.</p> <p><b>Pre-placement assessment:</b> Individual health, fitness and strength can affect the ability to perform tasks. Pre-placement assessment aims to identify those who may be at higher risk for LBP in a given occupational setting. The main factors that have been investigated include clinical and historical features, physical strength parameters and psychosocial factors. The recurrent nature of LBP means that previous history is the best predictor of future LBP, and all other pre-placement measures have no predictive value at all, or only a weak and unreliable predictive value.</p> <p><b>High risk:</b> There is a pragmatic argument that individuals at highest risk of LBP should not be placed in jobs that impose the greatest physical demands. The basic concern is that workers with physically (or psychologically) demanding work report rather more low back symptoms, have more work-related back 'injuries' and lose more time off work with LBP. Even if physical demands of work may be a relatively modest factor in the primary causation of LBP, people who have LBP (for whatever cause) do have more difficulty managing physically demanding work. It may be argued, therefore, that avoiding putting people at highest risk of recurrent LBP and sickness absence into more physically demanding work would be in the interests of the individual worker, the employer and the total societal burden of LBP. The problem is, a previous history of LBP simply identifies people who are more likely to have recurrent problems, but that has little to do with the job: they are probably likely to have such problems irrespective of which job they are recruited for – and even if they are not recruited. Indeed, those who remain unemployed may be at highest risk of all for chronic LBP and disability. Because a previous history of LBP is so common, it</p>

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	<p>could exclude many people who are medically fit for most work. At the same time, all pre-placement assessment methods miss many people who may later develop LBP. There is no clear evidence for a threshold of what constitutes a strong history of LBP or excessive job demands. Most of the evidence is from a population-based perspective whilst pre-placement assessment must try to predict future risks for the individual, which is a different matter. It may be concluded that the present evidence base is insufficient for reliable selection of individuals for particular types of work. Attempts to match individual susceptibility for LBP against a risk assessment of the job (and reduction of the risk of injury to the lowest level 'reasonably practicable') are therefore very much a question of judgement, and there is limited empirical evidence on their effectiveness.</p> <p><u>Management</u>: Clinical aspects of management should follow the Royal College of General Practitioners clinical guidelines. Occupational health management should focus on supporting the worker with LBP and facilitating remaining at work or returning to work as rapidly as possible, and should deal with any occupational issues that may form obstacles to achieving these goals. Occupational health practitioners should liaise closely with primary care. All stakeholders (i.e. the worker with LBP, supervisor(s) and management, union and health &amp; safety representatives, the occupational health team and other health professionals undertaking clinical management) need to work closely together with a common, consistent approach to agreed goals.</p> <p><u>Return to work with LBP</u>: Concern about return to work with residual symptoms is often expressed by workers themselves, their representatives, primary care health professionals, and occupational health professionals as well as supervisors and management, particularly if the LBP is attributed to work and if there is thought to be a risk of 're-injury'. This concern is natural but illogical. A recent study has highlighted the variability in physician advice on return to work and that recommendations often reflect personal attitudes of the physicians and their perception of the severity of symptoms. Studies of the natural history show that LBP is commonly a persistent or recurrent problem, and most workers do continue working or return to work while symptoms are still present: if nobody returned to work till they were 100% symptom free only a minority would ever return to work. Epidemiological and clinical follow-up studies show that early return to work (or continuing to work) with some persisting symptoms does not increase the risk of 're-injury' but actually reduces recurrences and sickness absence over the following year. Conversely, the longer someone is off work the lower the chance of recovery. Undue caution will form an obstacle to return to work and lead to protracted sickness absence, which then aggravates and perpetuates chronic pain and disability, and actually increases the risk of a poor long term outcome: this clearly is not in the interest of either the worker or the employer. Concerns are also sometimes expressed about legal liability for 're-injury' if the worker returns to work before they are completely 'cured' which is also illogical. Again, the natural history shows that LBP is commonly a persistent or recurrent problem, so expectations of 'cure' are unrealistic and recurrences are likely irrespective of work status. Refusing to allow a worker to return to work because they still have some LBP increases the likelihood of a break-down in worker-employer relationships and of the worker making a claim; and the longer the sickness absence the higher the cost of any claim. Helping and supporting the worker to remain at work, or in early return to work, is in principle the most promising means of reducing future symptoms, sickness absence and claims. Reducing any legal liability is best achieved not by forcing the worker into protracted sickness absence and possibly an adversarial situation, but by addressing the issues of job reassessment ('newly assessed duties'), the provision of modified work with adequate support, and good worker-employer relationships. All of these goals may best</p>

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	be achieved by the proposed active rehabilitation programme and organisational interventions. That is also more in keeping with the spirit and the requirements of the Disability Discrimination Act.
(Waddell et al. 2003)  Narrative review	<b>Screening to identify people at risk of long-term incapacity for work: a conceptual and scientific review</b> This review identified a wide range of individual predictors for long-term incapacity, but few have demonstrated consistent strength of prediction across different studies, there is little agreement on which are critical, and their performance usually does not match that expected for conventional diagnostic tests. Despite a great deal of research, no simple, robust, and generalisable screening tool has yet emerged. Even if they provide comparable accuracy of prediction, socio-demographic and clinical/psychosocial screening have different characteristics, limitations, and applications. Clinical predictors focus more on disease rather than illness, psychosocial predictors focus on mechanisms of developing chronicity and obstacles to recovery, socio-demographic predictors focus more on social factors rather than illness. The review demonstrated throughout that the timing of screening and intervention is critical. The context, requirements, and purpose(s) of screening therefore change with increasing duration of incapacity and increasing probability of long-term incapacity. There may therefore be an optimal 'window' (between a few weeks and a few months) for screening to identify those at risk of long-term incapacity. Whilst that time constraint applies to the first purpose of screening (to identify those at risk), and can help to focus early interventions on obstacles to recovery, it is not absolute.
(Waddell & Burton 2004)  Conceptual review	<b>Concepts of rehabilitation for the management of common health problems</b> <i>(This review, undertaken for the Department for Work and Pensions, explored concepts of rehabilitation for common health problems: musculoskeletal, mental health and cardio-respiratory).</i> "The stereotype of disability is a severe medical condition with objective evidence of disease and permanent physical or mental impairment (e.g. blindness, severe or progressive neurological disease, or amputation). In fact, most sickness absence, long-term incapacity for work and premature retirement on medical grounds are now caused by less severe mental health, musculoskeletal and cardio-respiratory conditions. These 'common health problems' often consist primarily of symptoms with limited evidence of objective disease or impairment. Importantly, many of them are potentially remediable and long-term incapacity is not inevitable. Rehabilitation has traditionally been a separate, second-stage process, carried out after medical treatment has no more to offer yet recovery remains incomplete: the goal was then to overcome, adapt or compensate for irremediable, permanent impairment. That approach is inappropriate for common health problems, where the obstacles to recovery are often predominantly psychosocial in nature rather than the severity of pathology or impairment. In this situation, rehabilitation must focus instead on identifying and overcoming the health, personal/psychological, and social/occupational obstacles to recovery and (return to) work. This implies that rehabilitation can no longer be a separate, second stage intervention after 'treatment' is complete. The evidence shows that the best time for effective rehabilitation is between about 1 and 6+ months off work (the exact limits are unclear). Earlier, most people recover and return to work uneventfully: they do not need any specific rehabilitation intervention and the priority is not to obstruct natural recovery. Later, the obstacles to return to work become more complex and harder to overcome: rehabilitation is more difficult and costly, and

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	<p>has a lower success rate. To take maximum advantage of this window of opportunity and minimize the number going on to long-term incapacity, rehabilitation principles should be an integral part of good clinical and occupational management:</p> <p>....</p> <p>Common health problems are not only matters for health care, but much broader public health issues of 'health at work'. Sickness absence and return to work are social processes that depend on work-related factors and employer attitudes, process and practice. This requires employers, unions and insurers to re-think occupational management for common health problems: addressing all of the health, personal and occupational dimensions of incapacity, identifying obstacles to return to work, and providing support to overcome them. The same principles are equally applicable to job retention, early return to sustained work and reintegration.</p> <p>This should not obscure the importance of the individual's own role in the management of common health problems. Rehabilitation is an active process that depends on the participation, motivation and effort of the individual, supported by health care and employers.</p> <p>....</p> <p>Action depends on accepting ownership of the problem. Everyone – workers; employers, unions and insurers; health professionals; government and the taxpayer – has an interest in better outcomes for common health problems. Effective management depends on getting 'all players onside' and working together to that common goal. This is partly a matter of perceptions (by all the players). It requires a fundamental shift in the culture of how we perceive and manage common health problems, in health care, in the workplace, and in society.</p> <p>Better management and rehabilitation of common health problems is possible, can be effective, and is likely to be cost-effective." (pp 3-4). (See also Tables 2, 3 and 4).</p>
<p>(Waddell &amp; Burton 2006)</p> <p>Best evidence synthesis</p>	<p><b>Is work good for your health and well-being?</b></p> <p><i>(This review for the Department for Work and Pensions covered common health problems in general, not just musculoskeletal problems).</i></p> <p>"The review focused on adults of working age and the common health problems that account for two-thirds of sickness absence and long-term incapacity (i.e. mild/moderate mental health, musculoskeletal and cardio-respiratory conditions)." (p. vi). <i>For convenience, the section relating to musculoskeletal problems is reproduced here verbatim and references to source material omitted as indicated by [.....]:</i></p> <p>* There is a high background prevalence of musculoskeletal conditions, yet most people with musculoskeletal conditions (including many with objective disease) can and do work, even when symptomatic. [.....]</p> <p>* Certain physical aspects of work are risk factors for the development of musculoskeletal symptoms and specific diseases. However, the effects sizes for physical factors alone are only modest, and tend to be confined to intense exposures. [.....]</p> <p>* Psychosocial factors (personal and occupational) exert a powerful effect on musculoskeletal symptoms and their consequences. They can act as obstacles to work retention and return to work; control of such obstacles can have a beneficial influence on outcomes such as pain, disability and sick leave. [.....]</p>

**Table 1: Work-relevant musculoskeletal complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>* Activity-based rehabilitation and early return to work (or remaining at work) are therapeutic and beneficial for health and well-being for most workers with musculoskeletal conditions. [There is an underlying assumption that significant physical hazards should be controlled]. [.....]</p> <p>* Control (reduction) of the physical demands of work can facilitate work retention for people with musculoskeletal conditions, especially those with specific diseases. [.....]</p> <p>* Organisational interventions, such as transitional work arrangements (temporary modified work) and improving communication between health care and the workplace, can facilitate early and sustained return to work. [.....]</p> <p>....</p> <p>The high background prevalence of musculoskeletal symptoms means that a substantial proportion of musculoskeletal conditions are not caused by work. Most people with musculoskeletal conditions continue to work; many patients with severe musculoskeletal diseases such as rheumatoid arthritis remain at work and experience health benefits [.....] Thus, musculoskeletal conditions do not <i>automatically</i> preclude physical work. Musculoskeletal symptoms (whatever their cause) may certainly make it harder to cope with physical demands at work, but that does not <i>necessarily</i> imply a causal relationship or indicate that work is causing (further) harm.</p> <p>Biomechanical studies and epidemiological evidence show that high/intense exposures to physical demands at work can be risk factors for musculoskeletal symptoms, 'injury' and certain musculoskeletal conditions. However, causation is usually multifactorial and the scientific evidence is somewhat ambivalent: much depends on the outcome of interest. Physical demands at work can certainly precipitate or aggravate musculoskeletal symptoms and cause 'injuries' but, viewed overall, physical demands of work only account for a modest proportion of the impact of musculoskeletal symptoms in workers. The physical demands of modern work (assuming adequate risk control and except in very specific circumstances) play a modest role in the development of actual musculoskeletal pathology. In contrast, there is strong epidemiological and clinical evidence that (long-term) sickness absence and disability depend more on individual and work-related psychosocial factors than on biomedical factors or the physical demands of work [.....]</p> <p>More fundamentally, it is wrong to view physical demands from a purely negative perspective as 'hazards' with potential only to cause 'harm'. Different physical activities may either load or unload musculoskeletal structures. Physical activity is fundamental to physiological health and fitness and an essential part of rehabilitation from injury or illness. Work can be therapeutic. Thus, modern clinical management for most musculoskeletal conditions emphasises advice and support to remain in work or to return as soon as possible. People with musculoskeletal conditions who are helped to return to work can enjoy better health (level of pain, function, quality of life) than those who remain off work [.....] Importantly, physical activity and early return to work interventions do not seem to be associated with any increased risk of recurrences or further sickness absence [.....]</p> <p>The return to work process may need organisational interventions: risk reassessment and control, and modified work if required. The duration of modified work depends on the condition: for common musculoskeletal conditions such as back, neck or arm pain it should be temporary</p>

**Table 1: Work-relevant musculoskeletal complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	and transitional, although for chronic musculoskeletal disease such as rheumatoid arthritis it may be permanent. This approach is about accommodating the musculoskeletal condition (whatever its cause) rather than implying that work is causal or harmful.”(pp 25-27) ( <i>Findings in respect of mental health are in Table 2, stress in Table 3, and generic issues in Table 4</i> ).
(Waddell et al. 2008)  Best evidence synthesis	<p><b>Vocational rehabilitation: what works, for whom, and when?</b></p> <p>“This review has demonstrated that there is a strong scientific evidence base for many aspects of vocational rehabilitation. There is a good business case for vocational rehabilitation, and more evidence on cost-benefits than for many health and social policy areas.</p> <p>Common health problems should get high priority, because they account for about two-thirds of long-term sickness absence and incapacity benefits, and much of this should be preventable. Vocational rehabilitation principles and interventions are fundamentally the same for work related and other comparable health conditions, irrespective of whether they are classified as injury or disease. ....</p> <p>Healthcare has a key role, but vocational rehabilitation is not a matter of healthcare alone – the evidence shows that treatment by itself has little impact on work outcomes. Employers also have a key role - there is strong evidence that proactive company approaches to sickness, together with the temporary provision of modified work and accommodations, are effective and cost-effective. (Though there is less evidence on vocational rehabilitation interventions in small and medium enterprises). Overall, the evidence in this review shows that effective vocational rehabilitation depends on work-focused healthcare <i>and</i> accommodating workplaces. <i>Both</i> are necessary: they are inter-dependent and must be coordinated.</p> <p>The concept of early intervention is central to vocational rehabilitation, because the longer anyone is off work, the greater the obstacles to return to work and the more difficult vocational rehabilitation becomes. It is simpler, more effective and cost-effective to prevent people with common health problems going on to long-term sickness absence. A ‘stepped-care approach’ starts with simple, low-intensity, low-cost interventions which will be adequate for most sick or injured workers, and provides progressively more intensive and structured interventions for those who need additional help to return to work. This approach allocates finite resources most appropriately and efficiently to meet individual needs.</p> <p>Effective vocational rehabilitation depends on communication and coordination between the key players – particularly the individual, healthcare, and the workplace.</p> <p>....</p> <p>There is strong evidence on effective vocational rehabilitation interventions for musculoskeletal conditions. For many years the strongest evidence was on low back pain, but more recent evidence shows that the same principles apply to most people with mostcommon musculoskeletal disorders. Various medical and psychological treatments for anxiety and depression can improve symptoms and quality of life, but there is limited evidence that they improve work outcomes. There is a lack of scientific clarity about ‘stress’, and little or no evidence on effective interventions for work outcomes. There is an urgent need to improve vocational rehabilitation interventions for mental health</p>



**Table 1: Work-relevant musculoskeletal complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>problems. 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 and so prevent long-term sickness. Current cardiac rehabilitation programmes focus almost exclusively on clinical and disease outcomes, with little evidence on what helps work outcomes: a change of focus is required. Workers with occupational asthma who are unable to return to their previous jobs need better support and if necessary retraining.” (pp 5-6)</p> <p>“1. Vocational rehabilitation is <i>whatever helps someone with a health problem to stay at, return to and remain in work</i>. It is an idea and an approach as much as an intervention or a service.</p> <p>2. This review has demonstrated that there is now a strong scientific evidence base for many aspects of vocational rehabilitation.</p> <p>3. There is a good business case for vocational rehabilitation, and more evidence on cost-benefits than for many health and social policy areas.</p> <p>4. Common health problems should get high priority, because they account for about two-thirds of long-term sickness absence and incapacity benefits and much of this should be preventable. Return-to-work should be one of the key outcome measures.</p> <p>5. Vocational rehabilitation depends on work-focused healthcare <i>and</i> accommodating workplaces. To make a real and lasting difference, both need to be addressed and coordinated.</p> <p>6. Most people with common health problems can be helped to return to work by following a few basic principles of healthcare and workplace management. This can be done with existing or minimal additional resources, and is low cost or cost-neutral. Policy should be directed to persuading and supporting health professionals and employers to implement these principles.” (p. 8)</p> <p><i>(This review was a policy document for the UK cross-sector Vocational Rehabilitation Task Group. It covered common health problems in general, not just musculoskeletal problems). (See also Tables 2, 3, and 4).</i></p>
(Waersted et al. 2010)	<p><b>Computer work and musculoskeletal disorders of the neck and upper extremity: a systematic review</b></p> <p>Examined the evidence for an association between computer work and neck and upper extremity disorders (except carpal tunnel syndrome). There was limited evidence for a causal relationship between computer work per se, computer mouse and keyboard time related to a diagnosis of wrist tendonitis, and for an association between computer mouse time and forearm disorders. Limited evidence was also found for a causal relationship between computer work per se and computer mouse time related to tension neck syndrome, but the evidence for keyboard time was insufficient. Insufficient evidence was found for an association between other musculoskeletal diagnoses of the neck and upper extremities, including shoulder tendonitis and epicondylitis, and any aspect of computer work. Viewed overall, there is limited epidemiological evidence for an association between aspects of computer work and some of the clinical diagnoses studied. None of the evidence was considered as moderate or strong.</p>
(Wai et al.	<p><b>Causal assessment of occupational bending or twisting and low back pain: results of a systematic review</b></p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
2010a) (Wai et al.	The evidence suggests that occupational bending or twisting in general is unlikely to be independently causative of low back pain. <b>Causal assessment of occupational lifting and low back pain: results of a systematic review</b>
2010c) (Roffey et al.	It is unlikely that occupational lifting is independently causative of low back pain (but simple association for types of lifting and lifting 25-35 kg apparent).
2010b) (Wai et al.	<b>Causal assessment of awkward occupational postures and low back pain: results of a systematic review</b> There is strong evidence of no association between awkward occupational postures and low back pain: there is no dose-response.
2010b) (Roffey et al.	<b>Causal assessment of occupational carrying and low back pain: results of a systematic review</b> The review found strong and consistent evidence against both an association and a temporal relationship between occupational carrying and low back pain.
2010e) (Roffey et al.	<b>Causal assessment of workplace manual handling or assisting patients and low back pain: results of a systematic review</b> It appears unlikely that workplace manual handling or assisting patients is independently causative of LBP (assisting ambulation may be an exception).
2010a) (Roffey et al.	<b>Causal assessment of occupational sitting and low back pain: results of a systematic review</b> Strong and consistent evidence did not support occupational sitting being independently causative of low back pain.
2010c) (Roffey et al.	<b>Causal assessment of occupational pushing or pulling and low back pain: results of a systematic review</b> It is unlikely that occupational pushing or pulling is independently causative of LBP in the populations of workers studied.
2010d) Systematic reviews	<b>Causal assessment of occupational standing or walking and low back pain: results of a systematic review</b> Based on the evidence reviewed, it is unlikely that occupational standing or walking is independently causative of low back pain. <i>(This series of reviews was characterised by a strict adherence to Bradford-Hill criteria for causality (statistical association; dose-response; temporality; biological plausibility; consistency; experiment; biological coherence; experimental evidence; analogy) are established as a framework for use in epidemiological research to minimize the possibility that important public health decisions are made on the basis of incomplete or flawed evidence. Applying these criteria to the available evidence revealed that whilst some criteria may be fulfilled for a given question, others were not, The reviewers' final conclusions were therefore duly cautious and mostly conclude that the physical stressors studied are not independently causative agents).</i>
(Williams et al. 2010) Systematic review + evidence synthesis	<b>The Hip and Knee Book: developing an active management booklet for hip and knee osteoarthritis</b> <i>(This review developed patient-centred messages to inform appropriate information and advice, and had a clinical focus. Nevertheless, the principles will apply to workers with hip or knee osteoarthritis).</i> In respect of the present review, potentially relevant messages are: “We don’t really know what causes the condition, and we don’t know how to prevent it. There is no single cause, but various things are thought to be involved: Genetic factors are important – it seems some people are just more prone than others. People who are very overweight are at greater risk. Various physical factors may play a part, but they do not have a consistent effect - previous damage to the joint surface, some physically intense occupations and sports, reduced muscle strength. Age is obviously the main factor, but that does not mean things inevitably

**Table 1: Work-relevant musculoskeletal complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	get worse. We now know that inactivity and excessive rest is bad for hip or knee joints with osteoarthritis. Of course, some things can make your pain worse, such as being overweight and letting your muscles get weak. Importantly though, there are also things that can help such as regular exercise, keeping the muscles around the joint strong, keeping a positive attitude, believing that you are in control and can help yourself, and getting support of friends and family”.

**Table 2<sup>12</sup>: Work-relevant mental health complaints**

<b>Table 2: Work-relevant mental health complaints</b>	
<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
(Bender & Kennedy 2004)  Narrative Review	<b>Mental health and mental illness in the workplace: diagnostic and treatment issues</b> <i>(Methodology details lacking)</i> The article reviews various screening instruments for stress related syndromes, burnout, depression, anxiety disorders and substance abuse. Screening for MSDs is also mentioned. The authors mention that the US Preventative Services Task Force found sufficient evidence for routine screening for depression. However, they comment that research into screening for anxiety disorder is less well advanced compared to depression.
(Couser 2008)  Narrative review	<b>Challenges and opportunities for preventing depression in the workplace: a review of the evidence supporting workplace factors and interventions.</b> Review of the field of preventing depression in the workplace. The commentary is extensive, focusing on topics such as precipitating and risk factors along with descriptions of supporting theoretical concepts e.g. from the stress literature. The author concluded that employees can take preventative steps to reduce the probability of the occurrence of depressive episodes by developing better coping skills. Evidence for the benefits of depression screening are also examined and discussed, as are the potential of organisational interventions such as promoting better work-life balance. Depression prevention measures can include: <ul style="list-style-type: none"> <li>• Promoting the development of employee resilience</li> <li>• Screening employees deemed to be at higher than average risk</li> <li>• Integrating work and health care such that employees can get easy access to effective interventions</li> </ul>
(Egan et al. 2007)  Systematic review	<b>The psychosocial and health effects of workplace reorganisation. a systematic review of organisational-level interventions that aim to increase employee control.</b> Systematic review focusing on site-specific organisational level interventions that aim to increase levels of employee control and capacity to influence decisions. A narrative synthesis rather than a meta-analysis was carried out due to issues with heterogeneity in study design, outcome measures, comparison groups etc. 18 studies were identified published between 1981 and 2000 that examined health and psychosocial impacts of interventions designed to increase levels of employee control, 12 of which had controlled designs. No randomised

<sup>12</sup> These evidence tables have been prepared by Nicholas Kendall, Jennifer Lunt and Kim Burton. Content has been collated from open source literature, but the number and diversity of sources has meant it has not been practicable to seek permission for reproduction from each individual original author / publisher. In collating this content, the authors that have prepared this table make no claim to any third party copyright and acknowledge the rights in the respective text entries as belonging to the original authors / source publications. References to the original source literature are provided. Any use of content from the literature was intended as "fair dealing" for the purposes of research under the UK Copyright, Designs and Patents Act 1988.

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>controlled studies were identified. The review identified evidence for some health benefits occurring after the introduction of measures designed to increase levels of employee control. Types of intervention included:</p> <ul style="list-style-type: none"><li>• Problem solving committees</li><li>• Workers steering committees</li><li>• Participatory intervention based on German Health Circles model</li><li>• Employee action teams</li><li>• Flexible working hours</li><li>• Control of production deferred to employee work groups</li><li>• Consultative committee</li><li>• Stress management training</li><li>• Participatory ergonomics team</li><li>• Conference on working conditions</li><li>• Management-employee design teams</li><li>• Empowerment initiative</li></ul> <p>8 of the controlled studies showed evidence of health improvements, with none reporting evidence of poor health outcomes. The authors comment that “the evidence identified in this review compares favourably with evidence for many other types of socio-structural interventions affecting health”.</p>
(Friedli 2009) Report	<p><b>Mental health, resilience and inequalities</b> [Report from the World Health Organization Regional Office for Europe]. Mental health is fundamental to the resilience, health assets, capabilities and positive adaptation that enable individuals and communities both to cope with adversity and to reach their full potential. Drawing on the literature on health and inequalities, this report argues that improving mental health brings significant benefits for health and quality of life – not only through the absence of mental illness, but because positive mental health is of itself a protective asset, influencing a very wide range of health, social and economic outcomes. But mental health is also a key pathway through which social inequality impacts on health. There is overwhelming evidence that inequality is a key cause of stress in itself and also exacerbates the stress of coping with material deprivation. Mental health itself is produced socially. Opportunities for individuals and communities to retain or achieve social recognition and to stay or become connected contribute significantly to resilience, but are frequent casualties of adverse economic and cultural trends. The presence or absence of mental health is above all a social indicator. Therefore what Europe needs are policies and programmes to support improved mental health for the whole</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	population. Achieving this requires social as well as individual solutions.
(Graveling et al. 2008) Systematic Review	<p><b>A review of workplace interventions that promote mental well-being in the workplace</b> <i>(Extensive literature review from Institute of Occupational Medicine)</i> Looks at of the effectiveness of specific workplace interventions designed to promote or improve the mental well-being (MWB). 66 primary studies were included in the review addressing a broad range of interventions. Key findings:</p> <p><u>Organisational level interventions</u> <u>Changing working/organisational practices to improve mental well-being</u> Conclusion – inconclusive evidence base - currently insufficient evidence to make a judgement about the efficacy of participatory interventions <u>Training managers and supervisors</u> Evidence from high quality RCTs indicate that web based nor conventional didactic training improves MWB in subordinate workers. Concludes there is insufficient evidence for a positive statement regarding the efficacy of such interventions. <u>Changing shift and/or work practices</u> The review concludes that there is some evidence to conclude that making changes to shift practices of tacking time away from the workplace has beneficial impact on MWB and burnout. In one study, changing the shift system was associated with decreases in GHQ-12 scores. This evidence is based on one RCT and one UK based quasi-experimental study. <u>Support/training to improve job skills</u> Some evidence (small scale RCTs) to support the positive impact of psychosocial intervention courses (e.g. to enhance communication skills) in reducing burnout (as measured by the Maslach Burnout Inventory) over the short term. <u>Stress Management Interventions</u> Authors report that the 8 studies reviewed display insufficient consistency to justify recommending specific guidance on this issue. Differences amongst the studies in terms of interventions and populations rule out the possibility of drawing definitive conclusions. However, longer-term interventions do appear to be more effective. <u>Counselling and therapy</u> The studies reviewed suggest that ACT, IPP and computerised CBT impact positively on anxiety and depression in the short term. <u>Exercise and relaxation interventions</u> Evidence based on 4 RCTs. Insufficient evidence to support the use of massage or relaxation based training to improve MWB. One RCT comparing transcendental with meditation with conventional stress management training reported a positive impact on MWB over the longer term. <u>Health promotion interventions</u> One RTC trial reported an online health promotion/lifestyle training package improves MWB for up to 6 months after the package became</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	unavailable. Overall conclusions are that the evidence from this review supports the possibility that tangible benefits could accrue from interventions. However, the mixed nature of the quality of the studies prevents unequivocal statements being made.
(Harvey et al. 2006)  Narrative review	<b>Organizational interventions and mental health in the workplace: a synthesis of international approaches</b> This literature review is somewhat deceptive in that from the title, it appears that the focus is directed at mental health. In fact, the primary focus of the review is on interventions aimed at dealing with work related stress. The authors report limited evidence of rigorous evaluation of interventions to mitigate work related stress. However, it was concluded that interventions targeted at objectively modifying working processes (socio-technical interventions) appear to have positive effects on well-being. Psychosocial interventions were reported as providing a more mixed evidence base, with the authors taking the view that the evidence base is too limited to reach firm conclusions. The authors say, however, that this is not the same thing as classifying psychosocial interventions as ineffective – more research is needed in this area. <ul style="list-style-type: none"><li>• Socio-technical interventions include changing workload and schedules (impacted positively on well-being and performance)</li><li>• Psycho-social interventions include:<ul style="list-style-type: none"><li>• Increasing participation communication and social support</li><li>• Reducing role ambiguity and conflict</li><li>• Enhancing control over work tasks</li></ul></li></ul>
(Kashdan & Rottenberg 2010)  Narrative review	<b>Psychological flexibility as a fundamental aspect of health</b> Literature review exploring the utility and efficacy of the concept of psychological flexibility. Psychological flexibility is not defined. The review suggests that low levels of psychological flexibility are implicated in various psychological conditions that are defined as CHPs, notably anxiety disorders and depression. Appears worth exploring further in relation to individual resilience issues. It appears to be a relatively new concept and the authors comment that no systematic reviews have so far explored the concept. <i>(The overall conclusion appears to be that more research is needed, in particular to determine whether psychological flexibility is an antecedent or successor to the various related CHP conditions).</i>
(Kirkwood et al. 2008)  Report	<b>Foresight Mental Capital and Well-being Project. Mental capital through life: Future challenges</b> Derived from the Foresight project. Mental capital definition: the totality of an individual's cognitive and emotional resources, included their cognitive capability, flexibility and efficiency of learning, emotional intelligence (e.g. empathy and social cognition) and resilience in the face of stress. The extent of an individual's resources reflects his/her basic endowment (genes and early biological programming), and their experiences and education, which take place throughout the life course. Two important components of mental capital are cognitive resilience (individual's successful adaptation and functioning in the face of stress or trauma) and cognitive reserve (individual's resistance to

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>impairment in cognitive processing such as memory, reasoning and attention, which may arise through brain injury or neuropsychiatric disorder or disease). During childhood intellectual functioning, strong attachment behaviour, optimism and active coping styles predispose resilience. In adults who are employed in stressful professions resilience to stress is associated with group bonding, altruism, and effective performance under stress. Positive affectivity or optimism, cognitive reserve, cognitive flexibility and the development of coping strategies also predispose resilience, as can religious coping, social cooperation and inclusion or exclusion. Adverse nutritional factors can accelerate build up of damage (bodily wear and tear, or undermine cognitive reserve) where as beneficial food such as fruit and vegetables, fish, supports the bodies natural protection against damage accumulation. The impact of poor nutrition on cognitive functioning over time may be mediated by inflammatory mechanisms. Exercise generally protects against damage accumulation. Preliminary evidence suggests that exercise programs are beneficial for anxiety disorders. Not enough is known about the optimal parameters of exercise.</p>
(Krupa 2007)  Narrative review	<p><b>Interventions to improve employment outcomes for workers who experience mental illness.</b></p> <p>A review (not systematic) examining a range of employment interventions aimed at improving outcomes for employees experiencing mental health issues. The author organises these interventions into a framework of 7 interventions focusing on individuals. The review does not, unfortunately, make any comments about, or assess the quality of evidence underpinning these interventions. Further investigation is required in order to comment on these issues.</p> <p>The author states (without reference) that knowledge about interventions designed to mitigate the impact of mental illness in a work context is limited by a largely descriptive knowledge base i.e. a prevalence of cross sectional type studies outnumbering potentially more useful longitudinal and randomised study designs.</p> <p>Interventions are described at both the individual and organisational level as follows:</p> <p>Individual:</p> <ul style="list-style-type: none"><li>• Early identification, diagnosis and treatment</li><li>• Assessment and planning</li><li>• Self-awareness counselling</li><li>• Coping skills training</li><li>• Work hardening</li><li>• Reasonable job accommodations</li><li>• Social network development</li></ul> <p>Organisational:</p> <ul style="list-style-type: none"><li>• Routine screening strategies, mainly linked to depression (no further details)</li><li>• Training initiatives aimed at education and awareness</li></ul>



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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
(Lamontagne et al. 2007)  Systematic Review	<b>A systematic review of the job-stress intervention evaluation literature, 1990-2005</b> The aim of the review was to identify models of best practice using systematic review methodology. The authors use a tripartite classification to categorise workplace stress interventions into three category types, as follows: Primary – preventative and pro-active interventions, based on organisational systems approaches e.g. job re-design, workload reduction; secondary – ameliorative measures designed to modify individual's response to stressors e.g. CBT, coping classes; Tertiary – reactive measures designed to treat, compensate and rehabilitate, e.g. return to work assistance, occupational therapy. Included studies were rated as high, moderate or low depending on the extent to which organisational systems approaches were utilised in the intervention. A high classification was assigned to studies where primary intervention was the predominant approach, but also linked to secondary measures. Studies were classified as moderate if primary interventions only were assessed and low if the study little or zero primary interventions. General conclusions: Low rated, individually focused interventions are effective at the individual level but less so at the organisational level; High/moderate level interventions with an organisational focus impact both at the individual and organisational level.
(Lelliott et al. 2008)  Report	<b>Mental health and work</b> [Report by the Royal College of Psychiatrists for the UK National Director for Work and Health]. Wide ranging report on the prevalence of mental health problems, impact and cost, stigma and discrimination, mental health and employment, mental health problems and worklessness, systems services and policy, and the research evidence about what works. Concluded that, despite their high prevalence in the workplace, there has been relatively little research about the effectiveness of interventions that assist people with common mental disorders to remain in work or return to work after a sickness absence. Summarised broadly similar conclusions from two recent reviews (Hill et al. 2007; Seymour & Grove 2005) <ul style="list-style-type: none"><li>• For people who have common mental disorders that are affecting their work, brief individual therapy, mainly cognitive behavioural therapies, in short courses of up to eight weeks may be beneficial (<i>for clinical outcomes</i>). Interventions should be comprehensive and address both individual and organisation-level factors. There is little evidence on organisation-level interventions alone and what there is shows mixed results.</li><li>• When people are off work due to mental disorders an early return to work is aided by line managers keeping in touch at least once every two weeks.</li><li>• Stress management techniques may improve people's ability to cope with stress and to avoid stressful situations at work. However, there is no firm evidence that stress management techniques reduce the prevalence of common mental illness or of sickness absence. Also, no studies have been conducted of the use of stress management in people who have already developed a common mental disorder.</li><li>• Few of the many studies that demonstrate the effectiveness of a range of pharmacological and psychological treatments in treating common mental disorders have measured their impact on employment status, work performance or absenteeism. The few exceptions, which were mostly conducted in the United States, suggest that the overall gain in labour output is much less marked than the reduction</li></ul>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>in symptoms.</p> <ul style="list-style-type: none"> <li>The conclusion of a systematic review, that counselling is effective in alleviating the symptoms of anxiety, stress and depression, and reduces sickness absence rates by 25-50% (McLeod 2001), has been challenged (Henderson et al. 2003; McLeod &amp; Henderson 2003). Its critics contend that most of the studies reviewed have major methodological limitations and that the only true randomised controlled trial showed no benefit of counselling. There is at best an absence of evidence that workplace counselling improves occupational outcomes.</li> </ul>
(MacEachen et al. 2006)	<p><b>Systematic review of the qualitative literature on return to work after injury</b></p> <p>Qualitative systematic review setting out to provide a deeper understanding of the “dimensions, processes and practices of workplace based return to work”. Selection criteria included studies that explored the experiences of key players in the return to work process, studies that used qualitative methods and studies focusing on musculoskeletal and pain related injuries.</p> <p>13 studies were rated as being of sufficient quality for inclusion in the review. A meta-ethnographic approach was used to synthesise data in the selected papers, employing 3 levels of analysis: first order concepts, second order interpretations and third order syntheses (based on the Nat Cen approach to qualitative analysis).</p> <p>7 concepts emerged as important themes across the 13 studies:</p> <ul style="list-style-type: none"> <li>The role of goodwill between participating players – i.e. whether people actually collaborate constructively during the RTW process is associated with goodwill and prevailing organisational culture.</li> <li>Relations between the worker and the system</li> <li>Contact between employer and worker between injury and return to work – several studies identify this early contact time as crucial for developing cooperation, flexibility and credibility.</li> <li>Employer contact with medics – studies revealed that employers found aspects of this process problematic e.g. they are hard to contact, do not promote early RTW etc.</li> <li>Modified work: social, physical and financial dimensions of</li> <li>Role of supervisors in day-to-day relationships underpinning RTW – studies highlighted the crucial role of the supervisor in the success or otherwise of RTW efforts.</li> <li>RTW and organisational environments, particularly economic and organisational – e.g. implementing effective RTW is harder in adverse economic circumstances such as downsizing situation.</li> </ul> <p>3 main findings emerged from an analysis of the above synthesis of the evidence from the studies:</p> <ol style="list-style-type: none"> <li>The scope and complexity of the RTW process – involves more scope and dimensions than were presented in one study</li> <li>The role of trust and goodwill – these are crucial for the success of RTW efforts to succeed</li> <li>The “challenge” of social and communication processes in the RTW effort given the different players involved. Key intermediary players such as rehabilitation providers and workplace supervisors have a potentially key role in facilitating the RTW process.</li> </ol>

**Table 2: Work-relevant mental health complaints**

<b>Authors</b>	<b>Key features</b> ( <i>Reviewers' comments in italic</i> )
	<i>(Although this review focuses on RTW, it begs the question as to if there is any common ground with the way CHPs are handled prior to a RTW situation developing). (See also Table 4).</i>
(Martin et al. 2009) Meta-analysis	<b>Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms.</b> Depression and anxiety are the most common mental disorders associated with work, but are also the most manageable MH conditions resulting from workplace interventions. Meta-analysis investigates the impact of different types of health promotion intervention on depression and anxiety symptoms. MH promotion was defined as wide range of activities designed to have a positive effect on MH. Most interventions in the meta-analysis were individually targeted. Intervention types included: increasing physical activity – aerobic weight training exercise plus behaviour modification; reducing depressive and anxiety symptoms – stress management interventions,; CBT; emotional distress – focusing on understanding causes, developing/implementing problem solving strategies, promoting early work resumption; improving physical/mental health – motivational interviewing; organised health promotion during consultations with occ health physician; beating the blues CBT programme; mailed advice on reducing stress, blood pressure; serum lipids and sick leave refocusing techniques with physiological feedback; transcendental meditation; empowerment programs or employee participation. Results indicated a small but positive effect for depression and anxiety symptoms in the interventions comprising the review, but no effects for composite outcomes based on composite MH measures. Interventions with a direct focus on MH also showed a positive impact on symptoms. Effect sizes were generally small but in the same (positive) direction as similar meta analyses. Authors concluded that the use of a broad range of workplace interventions based on health promotion is effective. Interventions focused on symptoms show similar results to interventions that focused on risk factors.
(Michie & Williams 2003) Systematic Review	<b>Reducing work related psychological ill health and sickness absence: a systematic literature review</b> Authors set the scene by conjecturing that organisational factors impact on levels of workers' psychological ill health. The paper reports on a systematic review of the factors associated with psychological ill health in healthcare and across other work settings. Psychological ill health includes anxiety, depression, emotional exhaustion and psychological distress. The review considered 22 studies focusing on healthcare employment settings in both the UK and other developed countries. Studies in non-healthcare settings were also included due to limited numbers of healthcare specific studies. In healthcare settings (both in the UK and beyond), the authors report a number of organisational factors associated with psychological ill health, including: Long hours; High workloads; Work pressure; Lack of role clarity; Low involvement in decision making/use of skills. A similar picture was reported for non-healthcare work settings, with specific factors associated with psychological ill health including: Work pressure/overload; Conflicting demands; Lack of control over work; Low participation in decision making; Poor social support; Lack of role clarity; Unclear management. The most common factors across all studies were: Work demands (long hours, work demands, pressure); Lack of control over work; Poor managerial support. The authors conclude that the associations between organisational factors and psychological ill health and sickness absence are similar enough across sectors to justify a generic approach to reducing psychological ill health and potentially amenable to change. As the studies reviewed focused mainly on training based interventions, the authors recommend the testing of interventions based on employment practices and management style. They

**Table 2: Work-relevant mental health complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	recommend the deployment of longitudinal/randomised control studies to do this more effectively.
(Nieuwenhuij sen et al. 2008)  Cochrane Review	<p><b>Interventions to improve occupational health in depressed people.</b></p> <p>Cochrane review of RCTs with stated objectives of evaluating the effectiveness of interventions aimed at reducing work disability in employees with depressive disorders. The review focuses exclusively on worker directed interventions i.e. interventions employing treatments for depressive disorders, either pharmacological or psychotherapeutic. The main outcome measure for studies included in the review was days lost because of sickness absence during the follow up period. 11 studies were selected for inclusion in the review.</p> <p>The key finding from the review is that there is some limited evidence that psychodynamic therapy in association with tricyclic antidepressants results in less days lost to sickness absence compared with tricyclic antidepressants alone.</p> <p>The review found no evidence (in terms of reducing numbers of days lost to sickness absence) for the impact of:</p> <ul style="list-style-type: none"> <li>• SSRI medication compared to other anti-depressant medications;</li> <li>• computerised CBT or problem-solving therapy delivered by community psychiatric nurses;</li> <li>• occupational therapy plus care as usual and care as usual alone.</li> </ul> <p><i>(Suggest some caution here as some of these conclusions are based on the results of only one study. In addition, the quality of 7 of the 11 studies was considered to be low).</i></p>
(Olsson et al. 2009)  Original study	<p><b>Identifying factors associated with good health and ill health: not just opposite sides of the same coin.</b></p> <p><i>(A study not a review: however, sample size is randomly drawn and of a very reasonable size).</i></p> <p>Survey based study where the authors investigate the moderating role of Antonovsky's Sense of Coherence (SOC) concept with regard to factors traditionally linked to ill health in previous studies. Key aim was to explore the link between SOC and good health.</p> <p>Authors conclude that work environment factors relating to ill health relate, in an opposite way to good health. They suggest that health as a concept forms a continuum (i.e. good to bad at the extremes). In addition, the authors also conclude that a strong SOC helps individuals better cope with adverse working conditions. In this sense, SOC could be regarded as a form of individual resilience that protect against the impact of adverse work characteristics.</p>
(Schneider 2003)  Narrative Review	<p><b>Is supported employment cost-effective? : a review</b></p> <p>The author presents a review of studies examining the effectiveness of supported employment programmes for individuals with mental health issues. It includes a number of methodologically strong studies utilising randomised controlled trial methodologies and the author concludes that there is little doubt about the efficacy of supported employment initiatives, targeted at clients with mental health issues, based on the Individual Placement and Support model.</p> <p>Considered in terms of employment/workplace interventions aimed at individuals experiencing mental health issues, this paper points to the effectiveness of targeted support, designed explicitly for the purpose of helping clients with (sometimes quite severe) mental health issues survive in open, competitive employment. The key message from this paper appears to be the efficacy of targeted, independent (from the</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	employer) support.
(Seymour & Grove 2005)  Systematic review	<p><b>Workplace interventions for people with common mental health problems: evidence review and recommendations</b></p> <p>This systematic review was undertaken to answer key questions about mental ill health and work using an evidence based approach. The authors make a point of marking key differences between mental ill health and stress, but the latter concept is not ignored in the review given the importance attached to it by many employers.</p> <p>Common mental health problems are those that occur most frequently and are more prevalent, are mostly successfully treated in primary rather than secondary care settings and are at least disabling in terms of stigmatising attitudes and discriminatory practices.</p> <p>The following system of evidence weighting was used in the review:</p> <ul style="list-style-type: none"> <li>• Strong – evidence based on consistent findings in high quality scientific studies.</li> <li>• Moderate – generally consistent findings in fewer, smaller or lower quality scientific studies.</li> <li>• Limited or contradictory – based on findings from one scientific study or inconsistent findings in multiple scientific studies.</li> </ul> <p>The authors drew the following key conclusions:</p> <p><b>Stress</b> – moderate evidence from five papers suggesting stress management interventions yield positive and practical effects. There was moderate evidence supporting the use of multi-modal interventions to help with stress problems are more effective than single method approaches. Limited evidence suggests that individually focused interventions are better than interventions at the organisational level. <i>(However, the nature of the general interface between stress and common mental health problems is unclear).</i></p> <p><b>Retention at work</b> – strong evidence (from 8 studies) indicating the efficacy of individually focused interventions to manage the impact of common mental health problems over interventions that operate at the organisational level. Effective interventions were associated with approaches such as personal support, individual coping and social skills and coping skills training with the most enduring impact associated with multi-modal approaches.</p> <p><b>Rehabilitation</b> – strong evidence (from four studies) showing that the most effective approach is brief individual therapy interventions (max 8 weeks), with most effective approach being CBT, either delivered personally or via computer based systems (significantly more effective than relaxation techniques). Strong effects are seen in people doing high control jobs/roles (no definition of this provided).</p> <p><b>Common mental health problems</b> – strong evidence that CBT interventions are effective, and better than other types of intervention (n=3736 from 2 studies).</p> <p><b>Job related distress</b> – moderate evidence showing brief interventions are effective (two studies n=196).</p> <p><b>Mental health related absenteeism</b> – strong evidence that CBT is an effective intervention to help employees with common mental health based sickness absence.</p> <p><b>Role of key players</b> – moderate evidence that skilling primary care practitioners is effective in retention scenarios (n=1993). Types of interventions in the studies included:</p> <p><b>Preventative</b> – mostly a combination of different approaches. Mainly teaching and skills acquisition sessions with exercise, relaxation, self-</p>

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	<p>study, problem-solving and communication skills. Interventions that included individual training or skills acquisition were found top be the most effective.</p> <p><b>Retention (employees deemed to be at risk from common mental health problems (CHMP))</b> The authors conclude that for retention scenarios, individual support, training, counselling or skilled aimed at self-management are crucial.</p> <p><b>Rehabilitative (employees already experiencing CMHPs)</b> –Strong evidence for the use of CBT for CHMPs for employees in this category. For those already diagnosed with depression, structured psychotherapy was found to be an effective intervention.</p>
(van Oostrom et al. 2009)  Cochrane review	<p><b>Workplace interventions for preventing work disability</b></p> <p>Cochrane review of 6 RCTs of workplace interventions for the prevention of workplace disability stemming from musculoskeletal disorders, common mental health problems such as depression and adjustment disorders. The authors cite references suggesting that low levels of motivation and self-efficacy are potential barriers to return to work. In this review, interventions allude to changes in the workplace or equipment, work design/organisation, working conditions or work environment. The primary outcome indicator was sickness absence period. Data synthesis was based on Cox proportional regression techniques to determine hazard ratios. The meta-analysis was conducted using a random effects model due to heterogeneity in measures such as disability type, duration of sickness absence and other variations in the constituent studies. Authors conclude that workplace interventions are effective to reduce sickness absence for workers with musculoskeletal disorders. However, the same interventions are not effective at improving health outcomes for workers with musculoskeletal disorders. As only one of the 6 selected studies looked at mental health issues, the authors conclude that conclusions about workplace interventions cannot be drawn for this health condition from this review. A secondary conclusion drawn by the authors is that stakeholders in the return to work process should focus on return to work as a primary goal. (<i>see also Table 1</i>)</p>
(Varekamp et al. 2006)  Systematic review	<p><b>How can we help employees with chronic diseases to stay at work? Review of interventions aimed at job retention and based on an empowerment perspective</b></p> <p>Review aimed at identifying that characteristics and effectiveness of job retention interventions. The review identified 9 studies via a literature review (that met the inclusion criteria), and additional studies through contact with subject matter experts. All studies were quantitative, four used a RCT methodology, two a semi or non-randomised control group and three no control groups at all. Most studies reported that job retention measures were effective, and all studies looking at work accommodation interventions reported positive results. In contrast, studies measuring self-efficacy reported mixed results.</p> <p>Intervention methods included:  Assessment, education, group discussion  Psychosocial assessment, education, counselling  Education, peer interaction  Assessment of work barriers and accommodation needs, training, including role-playing  Useful study in terms of this topic.</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
(Waddell & Burton 2004)  Conceptual review	<p><b>Concepts of rehabilitation for the management of common health problems</b></p> <p><i>(This review, undertaken for the Department for Work and Pensions, explored concepts of rehabilitation for common health problems: musculoskeletal, mental health and cardio-respiratory).</i> “The stereotype of disability is a severe medical condition with objective evidence of disease and permanent physical or mental impairment (e.g. blindness, severe or progressive neurological disease, or amputation). In fact, most sickness absence, long-term incapacity for work and premature retirement on medical grounds are now caused by less severe mental health, musculoskeletal and cardio-respiratory conditions. These ‘common health problems’ often consist primarily of symptoms with limited evidence of objective disease or impairment. Importantly, many of them are potentially remediable and long-term incapacity is not inevitable. Rehabilitation has traditionally been a separate, second-stage process, carried out after medical treatment has no more to offer yet recovery remains incomplete: the goal was then to overcome, adapt or compensate for irremediable, permanent impairment. That approach is inappropriate for common health problems, where the obstacles to recovery are often predominantly psychosocial in nature rather than the severity of pathology or impairment. In this situation, rehabilitation must focus instead on identifying and overcoming the health, personal/psychological, and social/occupational obstacles to recovery and (return to) work.</p> <p>This implies that rehabilitation can no longer be a separate, second stage intervention after ‘treatment’ is complete. The evidence shows that the best time for effective rehabilitation is between about 1 and 6+ months off work (the exact limits are unclear). Earlier, most people recover and return to work uneventfully: they do not need any specific rehabilitation intervention and the priority is not to obstruct natural recovery. Later, the obstacles to return to work become more complex and harder to overcome: rehabilitation is more difficult and costly, and has a lower success rate. To take maximum advantage of this window of opportunity and minimize the number going on to long-term incapacity, rehabilitation principles should be an integral part of good clinical and occupational management:</p> <p>....</p> <p>Common health problems are not only matters for health care, but much broader public health issues of ‘health at work’. Sickness absence and return to work are social processes that depend on work-related factors and employer attitudes, process and practice. This requires employers, unions and insurers to re-think occupational management for common health problems: addressing all of the health, personal and occupational dimensions of incapacity, identifying obstacles to return to work, and providing support to overcome them. The same principles are equally applicable to job retention, early return to sustained work and reintegration.</p> <p>This should not obscure the importance of the individual’s own role in the management of common health problems. Rehabilitation is an active process that depends on the participation, motivation and effort of the individual, supported by health care and employers.</p> <p>....</p> <p>Action depends on accepting ownership of the problem. Everyone – workers; employers, unions and insurers; health professionals; government and the taxpayer – has an interest in better outcomes for common health problems. Effective management depends on getting ‘all players onside’ and working together to that common goal. This is partly a matter of perceptions (by all the players). It requires a fundamental</p>

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	shift in the culture of how we perceive and manage common health problems, in health care, in the workplace, and in society. Better management and rehabilitation of common health problems is possible, can be effective, and is likely to be cost-effective.” (pp 3-4). <i>(see also Tables 1, 3 and 4).</i>
(Waddell & Burton 2006)  Best evidence synthesis	<b>Is work good for your health and well-being?</b> <i>(This review for the Department for Work and Pensions covered common health problems in general, not just musculoskeletal problems).</i> “The review focused on adults of working age and the common health problems that account for two-thirds of sickness absence and long-term incapacity (i.e. mild/moderate mental health, musculoskeletal and cardio-respiratory conditions).” (p. vi). <i>For convenience, the section relating to mental health problems is reproduced here verbatim:</i> “* Emotional symptoms and minor psychological morbidity are very common in the working age population: most people cope with these most of the time without health care or sickness absence from work [.....] * People with mental health problems are more likely to be or to become workless (sickness, disability, unemployment),with a risk of a downward spiral of worklessness, deterioration in mental health and consequent reduced chances of gaining employment [.....] * There is a general consensus that work is important in promoting mental health and recovery from mental health problems and that losing one’s job is detrimental [.....] There is limited evidence about the impact of (return to) work on (people with) mild/moderate mental health problems, despite their epidemiological and social importance.However, there is much more evidence on ‘stress’, which may be the best modern exemplar of common mental health problems.” (p. 22) <i>(Findings in respect of musculoskeletal problems are in Table 1, stress in Table 3, and generic issues in Table 4).</i>
(Waddell et al. 2008)  Best evidence synthesis	<b>Vocational rehabilitation: what works, for whom, and when?</b> “This review has demonstrated that there is a strong scientific evidence base for many aspects of vocational rehabilitation. There is a good business case for vocational rehabilitation, and more evidence on cost-benefits than for many health and social policy areas. Common health problems should get high priority, because they account for about two-thirds of long-term sickness absence and incapacity benefits, and much of this should be preventable. Vocational rehabilitation principles and interventions are fundamentally the same for work related and other comparable health conditions, irrespective of whether they are classified as injury or disease. .... Healthcare has a key role, but vocational rehabilitation is not a matter of healthcare alone – the evidence shows that treatment by itself has little impact on work outcomes. Employers also have a key role - there is strong evidence that proactive company approaches to sickness, together with the temporary provision of modified work and accommodations, are effective and cost-effective. (Though there is less evidence on vocational rehabilitation interventions in small and medium enterprises). Overall, the evidence in this review shows that effective vocational rehabilitation depends on work-focused healthcare <i>and</i> accommodating workplaces. <i>Both</i> are necessary: they are inter-dependent



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	<p>and must be coordinated.</p> <p>The concept of early intervention is central to vocational rehabilitation, because the longer anyone is off work, the greater the obstacles to return to work and the more difficult vocational rehabilitation becomes. It is simpler, more effective and cost-effective to prevent people with common health problems going on to long-term sickness absence. A 'stepped-care approach' starts with simple, low-intensity, low-cost interventions which will be adequate for most sick or injured workers, and provides progressively more intensive and structured interventions for those who need additional help to return to work. This approach allocates finite resources most appropriately and efficiently to meet individual needs.</p> <p>Effective vocational rehabilitation depends on communication and coordination between the key players – particularly the individual, healthcare, and the workplace.</p> <p>....</p> <p>There is strong evidence on effective vocational rehabilitation interventions for musculoskeletal conditions. For many years the strongest evidence was on low back pain, but more recent evidence shows that the same principles apply to most people with most common musculoskeletal disorders. Various medical and psychological treatments for anxiety and depression can improve symptoms and quality of life, but there is limited evidence that they improve work outcomes. There is a lack of scientific clarity about 'stress', and little or no evidence on effective interventions for work outcomes. There is an urgent need to improve vocational rehabilitation interventions for mental health problems. 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 and so prevent long-term sickness.</p> <p>Current cardiac rehabilitation programmes focus almost exclusively on clinical and disease outcomes, with little evidence on what helps work outcomes: a change of focus is required. Workers with occupational asthma who are unable to return to their previous jobs need better support and if necessary retraining.” (pp 5-6)</p> <p>“1. Vocational rehabilitation is <i>whatever helps someone with a health problem to stay at, return to and remain in work</i>. It is an idea and an approach as much as an intervention or a service.</p> <p>2. This review has demonstrated that there is now a strong scientific evidence base for many aspects of vocational rehabilitation.</p> <p>3. There is a good business case for vocational rehabilitation, and more evidence on cost-benefits than for many health and social policy areas.</p> <p>4. Common health problems should get high priority, because they account for about two-thirds of long-term sickness absence and incapacity benefits and much of this should be preventable. Return-to-work should be one of the key outcome measures.</p> <p>5. Vocational rehabilitation depends on work-focused healthcare <i>and</i> accommodating workplaces. To make a real and lasting difference, both need to be addressed and coordinated.</p> <p>6. Most people with common health problems can be helped to return to work by following a few basic principles of healthcare and</p>

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	workplace management. This can be done with existing or minimal additional resources, and is low cost or cost-neutral. Policy should be directed to persuading and supporting health professionals and employers to implement these principles.” (p. 8) <i>(This review was a policy document for the UK cross-sector Vocational Rehabilitation Task Group. It covered common health problems in general, not just musculoskeletal problems). (See also Tables 1,3, and 4).</i>

Table 3<sup>13</sup>: Work-relevant stress complaints

<b>Table 3: Work-relevant stress complaints</b>	
<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
(Aust et al. 2010)  Multiple unit study	<p><b>When workplace interventions lead to negative effects: Learning from failures</b></p> <p>Multiple unit study of psychosocial work conditions intervention. Used participative approach to develop interventions on the basis of an initial survey (like management standards) and unit-leaders given access to leadership development. Data extraction on process evaluation is limited to analysis of minutes from working group meetings to implement changes, notes form researchers on meetings and few quantitative questions in a survey.</p> <p>In general, psychosocial work conditions deteriorated in the intervention groups, including on measures of leader-member relationships, and there was no impact of the intervention on indicators of psychological well-being. Findings indicated a differential take up of leadership training, very poor implementation of working groups to establish changes and a rapid drop in motivation for changes.</p> <p>The lack of implementation was blamed for these effects. This may have been because of insufficient follow-up from working groups but also because other units/hierarchical levels did not assist in the implementation of changes. Researchers also blame low intensity leadership coaching as being insufficient to improve leadership and that more sessions were needed (most unit leaders attended three or less sessions). The lack of support for working groups from unit-leaders was also blamed, both in facilitating with organising workshops and helping with implementations.</p> <p>"another important element for participative interventions in the workplace is a clear structure of the intervention process, for example helping a working group to define goals, set deadlines and follow up on them." p 117</p> <p>Also, working groups were not aware a group of consultants (change agents) were available for help.</p> <p>It seems a structured and supportive participative change process that is supported and facilitated by leaders who prioritise the process is required (fundamentals of project management it seems). However, conclusions are limited due to the low quality of process data collected.</p>
(Awa et al. 2010)  Review	<p><b>Burnout prevention: A review of intervention programs</b></p> <p>Evaluation of burnout prevention programs at the workplace or elsewhere "25 primary intervention studies were reviewed. Seventeen (68%) were person directed interventions, 2 (8%) were organization-directed and 6 (24%) were a combination of both interventions types. Eighty percent of all programs led to a reduction in burnout. Person-directed interventions reduced burnout in the short term (6months or less), while a combination of both person and organization-directed interventions had longer lasting positive effects (12 months and over). In all cases,</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>positive intervention effects diminished in the course of time." p 184. Most studies were RCTs (14) or non-equivalent control group designs (9). Most (88% of studies) involved workers or those in vocational training. Two studies involved rehabilitation.</p> <p>Person-directed interventions included cognitive behavioural training, psychotherapy, counselling, adaptive skill training, communication skills training, social support, relaxation exercises or recreational music making amongst others.</p> <p>Organization-directed interventions included work process restructuring, work performance appraisals, work shift readjustments and job evaluation.</p> <p>17 studies registered a statistically reliable decrease in burnout, 1 individually focused study registered a statistically reliable increase in burnout (<i>a weaker study with an odd intervention based on didactic/interactive teaching</i>).</p> <p>Only 2/3 organisational interventions were effective (<i>the ns study was the only RCT</i>), but all 6 combined person- and organisation-directed interventions were (<i>including three RCTs</i>).</p> <p>Organisational and combined interventions appeared to have longer lasting effects. Noted that the only intervention to have an effect over one year included refresher sessions.</p> <p>Suggest combined person/organisation interventions with refresher courses are better.</p>
(Bal & Van Der Velde 2008)	<p><b>Psychological contract breach and job attitudes: A meta-analysis of age as a moderator</b></p> <p>Meta-analysis of 36 studies (N=17,333) of psychological contract breach and job satisfaction. Most of the relationships examined were cross-sectional. There is a consistent negative correlation between psychological contract breach and job satisfaction (<math>r = 0-.43</math> across studies).</p>
Meta-analysis	
(Bambra et al. 2007)	<p><b>The psychosocial and health effects of workplace reorganisation 2. A systematic review of task structuring interventions</b></p> <p>Systematic review of 19 interventions with randomised and non-randomised control groups. Concludes interventions that promote autonomy might be the most effective – although not all interventions reviewed were effective and some of the evidence cited in favour of improving autonomy came from studies that reduced autonomy (<i>hardly the same thing</i>).</p>
Systematic review	
(Bambra et al. 2008b)	<p><b>Shifting schedules: the health effects of reorganizing shift work</b></p> <p>Systematic review of 26 studies of organisational strategies to counteract negative effects of shift work, most of which included a non-equivalent control group. Most interventions had neutral or positive effects - but sample sizes tended to be small and there were some weak designs.</p> <p>Switching from slow (6-7 shifts) to fast (3-4 shifts) rotation was generally associated with benefits (although two studies found some, but inconsistent) negative effects. Authors conclude changing from backward (night, afternoon, morning) to forward rotation (morning, afternoon, night) can be beneficial - one study indicated benefits for cardiovascular functioning and another for health behaviours - but there</p>
Systematic review	

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	was limited evidence for an impact on subjective well-being. Self-scheduling of shifts seemed to have benefits for well-being in all three studies examined. <i>(Therefore, self-scheduling of shifts for shift workers seems to benefit well-being the most and fits well with theories concerning the benefits of worker control).</i>
(Bambra et al. 2008a)  Systematic review	<b>A hard day's night? The effects of compressed working week interventions on the health and work-life balance of shift workers: a systematic review</b> Systematic review of 40 observational studies of compressed working weeks (CWW) specific to shift workers "popular organisational level intervention is changing the hours of shift work by introducing a Compressed Working Week (CWW). The CWW is an alternative work schedule in which the hours worked per day are increased, whilst the days worked are decreased in order to work the standard number of weekly hours in less than five days. The most popular forms of CWW are the 12-hour CWW, the 10-hour CWW and the Ottawa system.18 The 12-hour CWW involves four 12-hour shifts (day, night) over four days with three or four days off. Under a 10-hour CWW, four 10-hour shifts are worked followed by three days off. The Ottawa system consists of three or four 10-hour morning or afternoon shifts spread over four days, then two days off. This is followed by a block of seven eight-hour nights, then six days off" p 765. Data tended to be self-report. Most studies found improvements or no change in health - with only two reporting negative impacts. More studies reported benefits for work-life balance but there were some studies reporting adverse effects for work-life balance. Most studies found no organisational benefits. <i>(Although the evidence based is limited, CWW does not seem a viable working pattern for CHPs).</i>
(Becker & Huselid 2006) (Conceptual review)	<b>Strategic human resources management: Where do we go from here?</b>
(Combs et al. 2006) (Meta-analysis)	<b>How much do high performance work practices matter? a meta-analysis of their effects on organizational performance?</b>
(Delaney & Huselid 1996)	<b>The impact of human resource management practices on perceptions of organizational performance</b>
(Guthrie 2001)	<b>High-involvement work practices, turnover, and productivity: Evidence from New Zealand</b>
(Huselid 1995) (3 empirical)	<b>The impact of human resource management practices on turnover, productivity, and corporate financial performance</b> High performance work systems (HPWS) refer to an integrated system of human resource management practices that have been consistently linked to better firm performance (Becker & Huselid, 2006; Combs et al., 2006). Within these broad parameters, HPWS have been

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
papers)	characterized as comprising several of the following practices (see e.g., Becker & Gerhart, 1996; Combs et al., 2006; Delaney & Huselid, 1996; Guthrie, 2001; Huselid, 1995): high investment and selective recruitment and selection; contingent rewards, based on performance or skills and possibly administered through profit-sharing or employee stock ownership; job design, including self-managing work teams, job rotation, flexible work, and skilled work; decentralized decision making and participation reflected in information sharing, suggestion schemes, attitude assessment, and problem-solving groups; investment in training; formal, internal and merit based career structures; total quality management; job analysis; performance management and appraisal systems; conflict resolution and grievance procedures; human resource planning; and employment security. Conceptually, these practices appear to be related to developing employee skills (e.g., selection, training), empowering employees to use those skills (e.g., job design), motivating employees (e.g., contingent pay), and facilitating information exchange (e.g., Combs et al., 2006). Some of the features of HPWS are consistent with notions of Good Jobs (e.g. autonomy, skill use). There is consistent evidence that HPWS are related to better organizational performance and productivity (Coombs et al., 2006).
(Biron et al. 2006)  Conceptual paper	<p><b>Risk assessment of occupational stress: Extensions of the Clarke and Cooper approach</b></p> <p>Level of risk is calculated based on the exposure level of a hazard and on the level of negative consequences associated with this exposure plus factors in coping. (<i>note unlike Management Standards that assesses exposure only</i>). Indicates exposure to workplace stressors can be conceptualised as chronic (<i>as in Management Standards, but this is a rather than view of stressors as conditions rather than discrete events or chains of events, which is more consistent with transactional models of stress</i>).</p> <p>p 419 "E is the perceived level of stressor (exposure) and C is the correlation (R2) between stressor level and stress outcome (consequences). For measuring the impact of risk factors on a variety of stress outcomes, a regression of stress exposure for each risk factor on stress outcomes is computed and the variance explained in the risk factor (R2) constitutes the perceived level of consequences"</p> <p>Suggest improving this by incorporating coping as so: "The product of the interaction between exposure and coping (EK) could be computed and used in the calculation of the stress consequences: risk" p 421</p> <p>Suggest:</p> <ol style="list-style-type: none"><li>Compute mean exposure level for a group (E) on a standardised 0-10 scale;</li><li>Compute mean level of nonadaptive coping (K)</li><li>Compute the product of risk exposure and nonadaptive coping for each person;</li><li>Run a regression analysis on each outcome, which includes linear, interactive and curvilinear terms (<i>note, this assumes a decent sample size, access to software and statistical analysis skills beyond most people with MScs in occupational psychology or healthcare practitioners</i>)</li><li>Take the percentage of variance accounted for from each regression analysis for each risk factor and its interaction with coping</li><li>Use the output of step e) and multiply by the output of steps a) and b) to get a score from 0-100 for each risk factor</li><li>Rank the risk factors</li></ol> <p>p 422 "Among the advantages of this approach, it allows a consultant or a researcher to compare assessed risk factors within an occupational</p>

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>group and an organization, in order to identify those factors associated with the highest risk and probability of impact on organizational health."</p> <p><i>(Note, this technique is for very technically advanced consultants and large organisations. So while putting coping, exposure and consequence into the judgements are more consonant with theory, the technique is far too advanced for general application. Moreover, the technique is dependent upon a sophisticated and accurate assessment of coping (or at least coping potential). Also, the approach to coding coping presumes some forms of coping are adaptive and others are not, and the coping assessed does not cover the full range of what people do (much in the same way that standardised questionnaires to assess psychosocial hazards do not cover the full range of hazards)</i></p> <p><i>The approach also assesses consequences within organisations. If there is a large degree of ill health within an organisation, then C will be limited due to range restriction in the dependent variables. This might be problematic for the technique. To be fair, the authors note some limitations to the approach. Including coping in the assessment of risk is important to determine what hazards people can self-regulate, but methodologies of this nature are not viable for the target population).</i></p>
(Broughton et al. 2009)	<p><b>Managing stress and sickness absence</b></p> <p>Qualitative evaluation based on extensive data collected through three distinct methods, including 1300 questionnaires, 500 interviews and 9 case studies - mainly focused on MS and sickness absence in relation to SIP2.</p>
Qualitative study	<p>Of relevance to managing/preventing CHPs, the report notes the following.</p> <p>SIP2 included workshop, a telephone helpline, masterclasses, HSE worksite visits. Participants seemed to view the workshop and masterclasses positively, but did not use the helpline preferring to consult websites. Notes that continuing HSE support through such events might be important in helping to embed changes.</p> <p>Barriers to implementation identified included lack of resources, lack of knowledge, lack of commitment. Notes it is difficult to assess concrete impact of the MS.</p> <p>Stakeholders in organisations in SIP2 seemed to have a positive view of MS (cf. Table 3: Tyers et al assessment of SIP1), but noted MS offered little help in managing those that had developed stress-related complaints and for non-work related problems. Transferring knowledge of problems into interventions seemed to be difficult. Noted that SIP2 implementation allowed organisations to be more flexible.</p> <p>Identifies line manager training in H&amp;S policies, plus good H&amp;S policies important for implementation of good management practice.</p> <p>Recognises senior management commitment and resources are difficult to obtain but important for implementation success, especially because of competing priorities and perception that 'hard' financial matters are more pressing. Indicates the importance of issues related to supportive organisational cultures.</p>
(Butts et al. 2009)	<p><b>Individual reactions to high involvement work processes: Investigating the role of empowerment and perceived organizational support</b></p> <p>Cross-sectional survey of 1723 employees. Findings suggest that employee perceptions of high performance work systems (HPWSs) lead to perceived empowerment, which in turn leads to higher job satisfaction, lower job stress symptoms, higher commitment and higher perceived</p>
Original study	

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	performance. The relationships between job stress symptoms, higher commitment and higher perceived performance were stronger when employees perceived high support from the organisation, <i>suggesting HPWS are most effective when accompanied by high levels of support.</i>
(Topa Cantisano et al. 2008) Meta-analysis	<b>Psychological contract breach and outcomes: Combining meta-analysis and structural equation models</b> Meta-analysis of 23 studies (N=4395) of psychological contract breach and job satisfaction. Most or all of the relationships examined were cross-sectional. Perceived psychological contract breach is the perception that expectations concerning mutual obligations and benefits in the exchange relationship between employer and employee have been broken, i.e., what the employee was promised in return for certain obligations was not received. Note, this is not necessarily just about careers, remuneration but can include promises of skill development, interesting work etc. Consistent negative correlation between perceived psychological contract breach and job satisfaction ( $r = -0.38$ ).
(Cass et al. 2002) Meta-analysis	<b>Health and Employment: A review and meta-analysis study (HERMES)</b> Large scale meta-analysis of cross-sectional self-report studies. Therefore good sample size but analysis of methodologically weak research. Concludes supervisor support, job control, job security and working hours all have statistically reliable associations with indicators of health, but these tend to be on the small side ( $l.08   r   l.19$ ).
(Conn et al. 2009) Meta-analysis	<b>Meta-analysis of workplace physical activity interventions</b> Meta-analysis of workplace physical activity interventions ( $n > 38,000$ , $k = 200$ ). Range of interventions included: "Interventions were more often delivered at the workplace (s1) than in other locations (s2). Nearly all of the studies recruited subjects at the worksite (s12). Only 32 papers reported that interventions were delivered during employees' paid time. Most studies used interventionists employed by the research project (s10) instead of workplace employees. Only six studies reported including an organizational-level policy change, such as providing free or reduced memberships to fitness centres not located at the worksite. Twenty-six studies involved workplace employees in designing interventions. Thirty-eight papers reported on interventions that included fitness facilities at the worksite. Supervised exercise was used in 27% of the studies while 80% used motivational or educational sessions." p 332. Significant positive effects were found for physical activity behaviour; fitness; lipids; anthropometric measures (e.g. weight, BMI); work attendance; job stress; and mood. Effects on most variables were substantially heterogeneous because diverse studies were included. A variety of designs were used, including simple pre-post-test designs with no control group. For stronger pre-post test two-group designs, effect sizes were still statistically reliable ( $p < .05$ ), apart from indicators of quality of life (marginal at $p < .10$ ) and job stress, work attendance and job satisfaction. <i>(Therefore, overall although there is evidence that physical activity interventions might improve CHPs, there is no compelling evidence and the variety of potential interventions makes it difficult to specify what should be included. On the other hand, physical activity is good).</i>
(Corbiere & Shen 2006)	<b>A systematic review of psychological return-to-work interventions for people with mental health problems and/or physical injuries</b> Systematic review of 14 psychological return-to-work (RTW) interventions for people with mental health problems and/or physical injuries (mainly MSDs). (Note is general in approach). Only 2 studies focused on mental health, the rest on MSDs. Most studies focused only on



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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
Systematic review	individual and only half had control groups. The most popular interventions were cognitive behavioural, including coping strategies, problem-solving strategies, and belief/attitude adjustments. Generally these were effective in RTW and promoting mental health, including for people with physical problems such as MSDs. "cognitive behavioural RTW interventions were found to be promising for treating mental health problems in people with musculoskeletal injuries, people with adjustment disorders, and even people with other mental health problems. However, the type of CBT used in these studies varied in both length and content, which ranged from improving coping skills to developing problem-solving strategies."p284 Other key interventions include communication between stakeholders and the involvement of each framework level (i.e., individual, group, and organization) in the RTW process, supported by follow-up in the community. Very limited evidence to suggest communication and involvement of stakeholders important because of limited number of studies.
(Corbiere et al. 2009) Systematic review	<b>A systematic review of preventative interventions regarding mental health issues in organization</b> Systematic review of various interventions for work-related stress, including mental health. Identified 24 studies. Quality of studies was high (mainly RCTs or non-equivalent control group design). Interventions mainly included coping or other skills training or changes related to job redesign. Concluded only 42% of studies had positive effects on work-outcome measures (mainly perceptions of the work environment). 67% of the interventions had a positive effect on mental health outcomes. So although interventions are not guaranteed to work, the odds slightly favour an improvement. Conclude that interventions should include supervisor training for preventing mental health problems in the workplace. Also conclude that participatory approaches are more effective, and these could be extended to include families as stakeholders
(Crawford et al. 2010) Narrative review	<b>The healthy safety and health promotion needs of older workers</b> Notes limited evidence base (two studies) on work place health promotion for older workers (who might be a specific age-related risk)
(Danford et al. 2008) Original study	<b>Partnership, high performance work systems and quality of working life</b> Cross-sectional survey of 2577 employees from six establishments. Findings: Job satisfaction associated with perceptions of fair treatment, consultation, job security, team decision making, higher levels of job responsibilities but negatively with workload. Job stress is associated with lower job satisfaction, perceptions of less fair treatment, higher levels of consultation, higher levels of team decision making, less training, higher levels of job responsibilities, higher job demands. <i>(That job satisfaction was controlled in the equations predicting job stress means the overall effects of some aspects HPWSs on stress is unclear, and may be artefacts of shared variance between job stress and satisfaction. Moreover, the authors did not control for the hierarchical nature of the sample (participants within firms), rendering significant tests suspect (probably too liberal).</i>
(Daniels	<b>Stress and well-being are still issues and something still needs to be done: or why agency and interpretation are important for policy</b>

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
2011) Narrative review	<b>and practice</b> Places emotional reactions to work as a key mediator between work and well-being/stress-related symptoms (including some aspects of CHPs). Concludes job characteristics/work environment models are not adequate basis for explaining emotional reactions to work. Instead reviews small evidence base (which includes some powerful longitudinal and diary designs) that suggests people's appraisals of work and events at work for their goals and well-being provides a better explanation. Also reviews a small evidence base indicating discretion over breaks at work and job autonomy/social support used for problem-solving can foster effective coping with adverse work events. Indicates emotional suppression is probably bad for well-being, but its converse – emotional expression – has complex and probably mediated/moderated relationships with well-being that are not understood. Concludes job redesign/organisational level interventions have little evidence to support universal effectiveness. Indicates standardised questionnaires have limited ability to detect psychosocial risks, as psychosocial risks are experienced and described in categories specific to workplaces rather than through researcher pre-defined categories. Indicates assessment might need to expand to include issues around personal goals, appraisals and coping potential. Indicates the way workers shape their own work and interventions need to be attended to. Suggests a number of ancillary interventions, including training in relevant coping (e.g., problem-solving, recovery), management training and changes in managerial reward systems, communities of practice (see organisational learning literature), performance appraisal, more comprehensive involvement of workers in defining and shaping interventions. Workplace should enable workers to pursue personal goals (not at expense of others or organisational goals – hence management and especially performance appraisals are important) and regulate own affective experience and symptoms. Job control and social support identified as important in allowing this self-regulation. Is the only review to consider how to allow individuals with illness/disability to regulate workplace – indicating they should be able to shape their work to make them feel comfortable. (see also table 4)
(de Bloom et al. 2009) Meta-analysis	<b>Do we recover from vacation? Meta-analysis of vacation effects on health and well-being</b> Recovery during vacations based on effort-recovery theory and allostatic load theory - essentially based on psycho-physiological unwinding and recuperation. Examines 7 longitudinal studies, generally with assessment of psychological or general well-being in mainly healthy samples. Vacations had a small positive effect on well-being and related variables ( $d = 0.43$ ) - beneficial impacts were larger on exhaustion and health complaints. There was a fade-out effect, as benefits dissipated over 2 - 4 weeks ( <i>not surprising really</i> ). Only one study assessed vacation experiences but indicated positive vacation experiences and not reflecting negatively about work were related to better well-being after vacation. <i>(Suggest some advice concerning holidays - indicating people should focus on enjoying themselves rather than reflecting on being away and having to return to bad work. If work is generally good, such reflections may be less likely in the first place).</i>
(de Lange et al. 2003) Systematic	<b>“The very best of the millennium”: Longitudinal research and the demand-control-(support) model</b> Review of longitudinal studies of Karasek and Theorell's Demands-Control-Support model. Indicates jobs with high control, high support and low demands are probably best for health (NB findings from Fergusson et al., 2006 meta-analysis: Table 3)

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
review	
(Egan et al. 2009) Systematic review	<p><b>Reviewing evidence on complex social interventions: Appraising implementation in systematic reviews of the healthy effects of organisational-level workplace interventions</b></p> <p>Systematic review of 18 interventions focused on control and participation (including some without control groups, but others did have no randomised control groups). Concluded such interventions can be effective, but not all interventions were effective, not all health indicators changed in the predicted direction and two studies indicated a deterioration in health (<i>Egan et al attributed this to restructuring post hoc</i>)</p>
(Fergusson et al. 2006) Meta-analysis	<p><b>The relative contributions of work conditions and psychological differences to health measures: a meta-analysis with structural equations modelling</b></p> <p>Meta-analysis of 10 longitudinal studies of self-report psychological and physical symptoms and job characteristics. Found self-reports of job characteristics predicted subsequent changes in reports of psychological symptoms only after controlling for baseline symptoms and personality. Found self-reports of job characteristics had no relationship with subsequent reports of physical symptoms after controlling for baseline symptoms and personality. Found negative oriented personality was related to subsequent symptoms (psychological and physical) after controlling for baseline symptoms and job characteristics: Negatively oriented personality had a stronger relationship with symptoms than self-reports of job characteristics. Concluded individually focused interventions need to supplement organisationally focused interventions (<i>this does not imply therapy but could include health promotion and risk communication</i>).</p>
(Franche et al. 2005) Narrative review.	<p><b>Workplace-based return-to-work interventions: Optimizing the role of stakeholders in implementation and research</b></p> <p>Discussion focuses on musculoskeletal disorders (MSD). Notes some work (e.g. high task specialisation, physical work for MSDs) may prevent return to work (RTW). Notes that safety- and people-oriented cultures and senior management teams are associated with RTW programmes. Bureaucracy is associated with fewer RTW programmes.</p> <p>Recommend including multiple stakeholders in RTW interventions - including workers and their families, union representatives, supervisors and corporate managers, healthcare providers, and insurers. Claim it is unreasonable to expect different stakeholders to change their motivations but it is reasonable to accept them to tolerate some deviation from their own preferred position by "[e]stablishing clear parameters of optimal levels of involvement of stakeholders, 2) Increasing communication among stakeholders, 3) Decreasing sources of miscommunication and misinformation, and 4) Increasing stakeholders' awareness of other stakeholders' paradigms" p 531</p> <p>Suggests involving supervisors, given their knowledge of incumbent's work roles, their ability to spot problems and offer support. Suggest enhancing supervisors' roles through relevant training. Note this is all fine provided supervisor targets for work unit performance are adjusted to take into account accommodations - to adjust for this, it is suggested to include disability management practices in supervisors' performance appraisal.</p> <p>Suggests involving insurers through case managers but adds the following conditions: "[f]irst, case managers must have sufficient authority to recommend work restrictions and accommodations in consultation with care providers. Second, case managers must have sufficient time and</p>

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>resources to view the physical work environment, engage the worker and supervisor in collaborative problem-solving, and facilitate individualized accommodations" p 534.</p> <p>Also suggests structured protocols, checklists, guides and workshops might be helpful. Also notes "[s]everal processes in RTW interventions may benefit from formalization: information campaigns about the program, evaluation of workers' functional capacities, regular contact with workers absent from work, worker-oriented follow-up and program evaluation" (p 535)</p> <p>Indicates improving communication between stakeholders, clear articulation of individual priorities and subsequent facilitated interactions are important for programme success. Also indicates workplaces need financial and regulatory motivations to put programmes in place.</p> <p><i>(Generalisability - SAW may be an issue, as might be generalising from MSDs to stress. Little guidance on timing of involvement of stakeholders too).</i></p>
(Gilbody et al. 2006)  Systematic review	<p><b>Can we improve the morale of staff working in psychiatric units? A systematic review</b></p> <p>Examined strategies to improve morale and reduce burnout. Interventions were mainly group administered. Identified 8 intervention studies (3 RCTs, 3 controlled clinical trials, 2 non-equivalent control group designs). Educational interventions designed to enhance skills/competency showed positive effects on at least one outcome of interest. Psychosocial interventions for work-based support for staff with difficulties were effective (one US study, a small UK study was poorly implemented with low managerial support). Concludes organisational interventions show potential, with some positive findings on reducing sickness absence (2 studies) and improving job satisfaction (1 study). Findings limited by short-term follow-ups. Note also indicates importance of multi-component interventions because not all outcomes were shown to change and like in other reviews, there is no rationale to expect some changes but not others.</p>
(Hornung et al. 2008)  Original study	<p><b>Creating flexible work arrangements through idiosyncratic deals</b></p> <p>Cross-sectional survey (n = 887). Found that i-deals (workers negotiating the content of their jobs) to work more flexibly were associated with less work-family conflict and less overtime. But i-deals focused on career/skills development were associated with greater work-family conflict and overtime. Insofar the work-family conflict can be considered implicated in the stress process, the results are relevant to some degree.</p>
(Hornung et al. 2009)  Original study	<p><b>Why supervisors make idiosyncratic deals: antecedents and outcomes of i-deals from a managerial perspective</b></p> <p>Cross-sectional survey of 263 supervisors. Supervisors were more likely to grant career/skills development i-deals and flexible working i-deals to employees they perceived to be higher in initiative. Supervisors were more likely to grant workload reduction i-deals to employees they thought the organisation had unfulfilled obligations towards. Flexible working i-deals were associated with supervisors' perceptions of work-life balance. Constraints were negatively related to flexibility and workload reductions i-deals..</p>
(Hornung et al. 2010)	<p><b>Beyond top-down and bottom-up work redesign: Customizing job content through idiosyncratic deals</b></p> <p>Cross-sectional surveys (study 1, n = 189, study 2 n = 135). Found that task i-deals (workers negotiating the content of their jobs) were associated with positive job characteristics (control, complexity - both studies) and minimisation of stressors (tested in study 2 only). Good</p>

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
Original study	relationships with supervisors were associated with task i-deals. Task i-deals had a positive relationship with work engagement (vigour, dedication and absorption) which was mediated control, complexity and stressors (tested in study 2 only) I-deals related to the content and characteristics of jobs “they should be considered as supplements rather than substitutes for systematic top-down efforts. Systematic efforts to design intrinsically motivating jobs can be improved both by active employee involvement in the broader process and by local negotiations to better align jobs with individual and organizational needs. Task i-deals can also serve as pilot tests for future redesign activities or be used when managers and workers refine broad-scale changes to make them more applicable locally. .... Attention to justice issues is essential to effective use of i-deals” (p. 210)
(Howell et al. 2007) Meta-analysis	<b>Health benefits: Meta-analytically determining the impact of well-being on objective health outcomes</b> Meta-analysis of 150 methodologically strong studies (experimental, ambulatory, longitudinal) of subjective well-being and objective health outcomes. Well-being was associated with better health in healthy samples only across a range of indicators – however, range restriction might explain this and that only a small number of studies looked at unhealthy samples). Well-being was related to better disease/symptom control in unhealthy sample.
(Jordan et al. 2003) Review and empirical study	<b>Beacons of excellence in stress prevention</b> Systematic review to identify examples of good practice and primary case studies. Suggest the following principles of good practice: senior management commitment, participative approach, development of stress management action plan, on-going risk and task assessment, work-related (first line) and worker-related (second line) interventions, ‘wide target’ interventions integrated into wider management initiatives, adequately resourced (financial, human, time) groups responsible for management that are integrated with the wider human resources function and senior management.
(Joyce et al. 2010) Systematic review	<b>Flexible working conditions and their effects on employee health and well-being</b> Examined the effects of flexible working conditions on physical, mental and general health and well-being. Flexible working conditions include self-scheduling/flexibility of shift work, flexitime and overtime, contractual flexibility (partial/gradual retirement, part-time work, fixed term contract). NB physical flexibility (teleworking) not reviewed nor was job sharing. Conclusions are limited by the studies’ designs and reliance on self-reports. 10 controlled before and after studies (NB no RCTs but most studies had non-equivalent control group designs) were included in a narrative review. Self-scheduling of shifts tended to be associated with improvements in health (4 studies - mostly fatigue related, but also other indicators and health behaviours), as was gradual/partial-retirement (2 studies). Other forms of temporal flexibility did not have an effect on outcomes (2 studies - mostly general/mental health). All forms of contractual flexibility other than partial retirement had equivocal or no impact on health. Contractual flexibility - which can relate to a lack of job security - is not recommended for CHPs. Self-scheduling of shifts - which relates to worker control - might be useful.
(Kerr et al.	<b>HSE management standards and stress-related work outcomes</b>

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
2009) Original study	An evaluation of HSE's Indicator Tool based on a cross-sectional self-report survey of over 700 health and social services workers. Each of the six areas has at least one statistically reliable relationship with indicators of psychological well-being after controlling for the other factors and some basic demographics. Therefore, the study does provide some evidence for the Indicator Tool.
(Kroon et al. 2009) Original study	<b>Cross-level effects of high-performance work practices on burnout</b> Cross-sectional survey of 393 employees working in 86 establishments. HPWSs assessed by HR managers working at each establishment. Find HPWSs were associated with higher levels of job demands, which in turn were associated with higher levels of emotional exhaustion. Suggests HPWSs can lead to greater work intensification. Indicates there is no role for procedural justice.
(Krupa 2007) Narrative review	<b>Interventions to improve employment outcomes for workers who experience mental illness</b> Narrative and selective review. Examines employee-directed and employer-level interventions for workers with mental illness (with a focus on depression and anxiety). Notes those that are working may have access to a range of occupational health services that can help with treatment. Specific interventions can include: Early identification/screening systems (may need line manager training to spot problems) Dynamic evaluations of functional capacity that a performed at work or in simulated work environments - enable assessment of capacity in relation to a wide range of factors including task requirements, interpersonal interactions and organisational structures. The dynamic element is meant to capture changes due to recovery, fluctuations in functional status or to identify situations that could provoke a reaction. Self-awareness counselling - to increase understanding or the illness/disability, personal strengths and limitations, and alter the individual's perception that personal efforts can be made to adjust to employment. Other aspects of counselling include reappraisal of work-related issues in a positive manner, gaining awareness of how the work situation may provoke or trigger features of the disability and developing strategies to deal with relapse and other relevant issues. Coping skills training - focused on behavioural competences -- includes stress management, relaxation, energy conservation, assertiveness, social skills, problem-solving training. Disclosure training - focused on competences in revealing aspects of the illness experience in the work context. Disclosure is complex as can affect (perceived) status but can also provide opportunities for accommodations. (Note those with mental ill health may not want to disclose) <i>(note cannot see why an educational package could not be developed for self-awareness, coping skills and disclosure)</i> Work hardening – graded programme of strengthening of cognitive and emotional competences through progressively more complex simulated work (in relation to return to work - might work for real work) Reasonable job accommodations for interpersonal and cognitive demands - notes that accommodations can adverse effects if work of others is affected. Social network development – developing, building an awareness and using natural supports (note depressed individuals do not always want support so training might be necessary)

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	Line manager training on: disabilities associated with mental ill-health, rights and expectations with regard to accommodations, and support provision.
(Kuoppala et al. 2008a)  Systematic review	<b>Work health promotion, job well-being and sickness absences – A systematic review and meta-analysis</b> Systematic review and meta-analysis of 46 studies of work health promotion. Looked at various interventions - including RCTs. Introduce the 'job well-being pyramid' a hierarchical model in which intervention in areas is <i>assumed</i> (my italics) to affect factors higher up the pyramid and that major problems at upper levels can be prevented by treating minor problems at lower levels. <i>Not sure the assumptions stack up to the evidence</i> . One side of the pyramid refers to well-being and illness, one to action and the other to work ability. The well-being side goes (lower to higher) from leadership, work environment, health and safety climate, well-being, illness and accidents. The action side goes from development discussion, health promotion, early rehabilitation and rehabilitation. The workability side goes from workability, job performance, sickness absence, disability pension. Workplace health promotion addresses groups so may have more efficacy than individual interventions. WHP might target individual lifestyles, work contents, workplace health and safety hazards, and work organisation. Conclude that weak to moderate evidence that work health promotion benefits sickness absence, work ability, mental and job well-being but not physical or general well-being. Exercise interventions seem good for overall well-being, mental well-being, workability and sickness absence ( <i>note, the amount of exercise needed to promote physical fitness is not realistic in worksite health promotions - but it may be sufficient to increase mental well-being</i> ). Sickness absence also seems to be reduced by healthy lifestyle interventions and ergonomics. Work redesign seems to increase mental well-being and sickness absence. Conclude education and psychological means alone seem ineffective ( <i>note other reviews conclude cognitive-behavioural coping skills training is effective</i> ). Conclude work health promotion should target both physical and psychosocial environments ( <i>note other reviews conclude targeting the environment alone is insufficient - general conclusion from multiple reviews might be that broad interventions across multiple levels might be more effective</i> ).
(Kuoppala et al. 2008b)  Systematic review	<b>Leadership, job well-being, and health effects – A systematic review and a meta-analysis</b> Systematic review and meta-analysis. Examines leadership (considerative, supportive and transformational leadership all seemingly lumped together under good leadership). Examined 109 studies, of which 94 were cross-sectional. Therefore evidence base is weak. Concludes good leadership is associated with job satisfaction, well-being, decreased risk of sick leave and decreased risk of early retirement ( <i>only two studies examined this though</i> ).
(Lamontagne et al. 2007)  Systematic review	<b>A systematic review of the job-stress intervention evaluation literature 1990-2005</b> Systematic review of intervention studies – but includes studies without control groups (although reports some findings with studies with control groups separately). Concludes all kinds of intervention (individual or organisational-level) can be effective, but combined individual/organisational level interventions might show promise for the best kind of intervention.

**Table 3: Work-relevant stress complaints**

<b>Authors</b>	<b>Key features (Reviewers' comments in italic)</b>
(Leana et al. 2009) Original study	<b>Work process and quality of care in early childhood education: The role of job crafting</b> Examines job crafting – people altering the content/scope of their jobs - as an individual activity, and as a collaborative activity with co-workers. Cross-sectional survey (n = 232). Found that individual and collaborative job crafting was related to individual discretion at work, and supportive supervision and social ties with co-workers were positively related to collaborative job crafting. Found both performance and job satisfaction are positively related to collaborative job crafting but individual crafting is negatively related to job satisfaction.
(Macky & Boxall 2008) Original study	<b>High-involvement work processes, work intensification and employee well-being: A study of New Zealand worker experiences</b> Cross-sectional survey of 775 employees. Multivariate analyses revealed “higher perceived levels of power, information provision, rewards, knowledge and training, and teamwork to be associated with higher job satisfaction. Table 2 also shows increased power to act autonomously to be associated with reduced job-induced stress and fatigue, while receiving rewards tied to performance was associated with lower imbalance between work and non-work life” p 50. Generally indicates components of perceived HPWSs are associated with better well-being. Generally, indices of work demands were associated with lower levels of HPWSs.
(Martin et al. 2009) Meta-analysis	<b>Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms</b> Looks at workplace health promotion. Meta-analysis of 20 intervention/control comparisons (n = 2640) indicating a small beneficial effect on anxiety and depression. Interventions focusing directly on mental health (mainly cognitive-behavioural coping skills training) had a similar effect to interventions focusing on risk factors (e.g. smoking, chronic disease, substance abuse, obesity or inactivity, and poor psychosocial work climate), indicating a broad range of health promotion programmes might be effective ( <i>note indicates a range of approaches are needed</i> ). Long-term follow-up effects are unclear ( <i>note other reviews indicate top-ups are necessary</i> )
(Murta et al. 2007) Systematic review	<b>Process Evaluation in occupational stress management programs: A systematic review</b> Systematic review of 52 studies that included process evaluation of individual and organisational stress management interventions. Concluded “there is insufficient evidence to reliably identify the process predictors of outcomes from SMIs conducted in work organizations. However, there are a number of noteworthy trends: (1) the greater the involvement and support from supervisors and managers, the better the intervention implementation and likely outcomes achieved; (2) the smaller the intervention dose delivered, the smaller the chances of altering organizational climate; (3) the more positively participants perceived the sessions to be and the context in terms of warmth and safe climate, the greater the likelihood of altering job-related stress; and (4) the more frequent the monitoring of participants’ attitudes toward intervention and its effects, the more awareness is raised about personal stress. Perhaps, surprisingly, there was no clear evidence that dose received and attendance were related to outcome.” p 252 <i>Note that the conclusions seem to indicate a high intensity intervention is needed but participants do not necessarily need full exposure to the intervention provided it is high intensity – potentially taking into account individual need with individually focused interventions. These conclusions may not generalise to organisational interventions.</i>
(Nielsen et al. 2007)	<b>Participants’ appraisals of process issues and the effects of stress management interventions</b> No control group, longitudinal study of 538 workers experiencing various interventions - team building, training and education and



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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
Original study	individually tailored programmes. Used limited, single item indicators. Conclude knowledge/information about intervention influences participation in intervention and influence over the content of the intervention. In turn, these influence appraisal of the quality of the intervention. Appraisal and information influence perceptions of positive changes in the workplace, which influence stress outcomes and psychological well-being beneficially.
(Nieuwenhuij sen et al. 2010) Systematic review	<b>Psychosocial work environment and stress-related disorders, a systematic review</b> Reviews contribution of work-related psychosocial risk factors to stress-related disorders (SRDs). Reviewed prospective cohort studies or patient-control studies of workers at risk for SRDs. Seven prospective studies were reviewed. Concluded there was strong evidence that SRDs were predicted by psychosocial risk factors (including job demands, low job control, low co-worker support, low supervisor support, low procedural justice, low relational justice and effort-reward imbalance). Concluded that review suggests SRDs could be prevented by targeting the psychosocial work environment. Noted that more prospective studies required for consistent assessments.
(Ontario Health Quality Council 2010) Narrative review	<b>A framework for public reporting on healthy work environments in Ontario healthcare settings</b> Concerned with a framework for reporting on the quality of work environments in healthcare. Indicates healthy working environment does not just identify hazards but develops capabilities. As well as the usual factors identified in other reviews identifies features of good professional practice environments, which "blend features of a health-promoting workplace with the supports and resources health professionals need to work to their full scope of practice. These factors include communication, collaboration, organizational culture and climate, organizational leadership, nurse manager support and leadership, control over practice, relationships with physicians, patient-centred values, workload, autonomy and decision making and professional development opportunities" p 11. This indicates a wider view of assessment is needed. Notes that better frameworks may include assessments of healthy work environments and their consequences (cf. HSE Indicator Tool), policies with guidance frameworks, mandatory assessments, metrics integrated with strategy and setting targets to improve operational/organisational performance, public reporting of results and support for continuous improvement. These conclusions are based on a review of several healthcare frameworks and singles out the NHS Staff Survey as the best. However, the report does caution that systems can get too complex and unwieldy. The NHS survey also has over 130 items. Does indicate one survey of 20 items that includes global assessments of health, mental health, perceived performance, organisational and job satisfaction, absenteeism, presenteeism, plus indicators of the work environment (presumably mainly single item indicators) Suggest using global indicators such as absence, injury rates. Suggests assessment framework should: be flexible; use metrics that are actionable; leverage existing organisational activities. Suggests senior managers should monitor KPIs chosen for their strategic relevance, that functional managers monitor mid-range indicators (absence, perhaps survey reports) and the HR function monitors the most detailed indicators revealed through observational measures, analysis of performance appraisals on a monthly basis. This indicates a hierarchy of

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	assessment. Suggest the strategic KPIs be presented publicly and annually (in organisational reports), the mid-range indicators be presented to senior management for discussion quarterly and summary reports of the most detailed indicators. Indicates the hierarchy might fit together as follows: "the concept of a safe work environment could include: a single KPI in the top tier (lost time injury rate), four to six indicators in the mid-tier (e.g., lost time injury rate, severity, long-term disability, return to work success rate, WSIB claim costs) and in the most detailed tier, analysis of the mid-level indicators by demographics and injury type" p 34.
(Randall et al. 2007)	<b>Participants' accounts of a stress management intervention</b>
Original study	No control qualitative study of 26 healthcare staff exposed to work reorganisation to manage workloads. Indicates a single intervention might work through various processes, including improving working conditions, by improving colleagues working conditions, improved processes, improved communications, establishing a better organisational culture. These micro-changes appear different for different individuals. Indicates staff participation in the interventions, amount of discussion of participants' needs, visibility of senior management commitment were important considerations in process as well as confidence and legitimacy to change their behaviour as a result of the intervention in response to competing demand on participants' time. Also indicates variable time to be exposed to intervention, with some units noticing changes and benefits before others. Indicates potential importance of staff supporting and managing the intervention as well as as managers supporting and managing the intervention. Indicates variation in contexts important - some people said they did not require their workloads to be managed - thus limiting the impact of the intervention. Others indicated that the nature of some of their critical tasks was such that they could not change their behaviour as required by the intervention. Indicates people can shape the intervention or simply refuse to comply. <i>(Based on interviews with just 26 participants, the conclusions are limited. Specific theory in this paper also lacking as was more exploratory).</i>
(Randall et al. 2009)	<b>'The development of five scales to measure employees' appraisals of organizational-level stress management interventions</b>
Original study	No control longitudinal study of 188 healthcare staff exposed to work reorganisation into teams. Suggest process variables related to implementation of stress management can be captured by the following five factors: <ol style="list-style-type: none"><li>1. Line manager attitudes and actions - line management attitudes and actions during the implementation.</li><li>2. Exposure to intended intervention - how much of the intervention was experienced</li><li>3. Employee involvement - in design and implementation of the intervention.</li><li>4. Employee readiness for change - expectations of and readiness for change.</li><li>5. Intervention history - the extent to which employees already operated in lines with the intervention.</li></ol> However, line manager attitudes were most consistently related to outcomes at T2, but most relationships were weakened by inclusion of T1 controls for outcomes. <i>The extent to which the process variables explain the success of interventions is unclear from this original study.</i>

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(Richardson & Rothstein 2008) Meta-analysis	<b>Effects of occupational stress management intervention programs: A meta-analysis</b> Meta-analysis of randomised control trials (7 cognitive behavioural, 17 relaxation, 5 organisational, 19 multimodal (very few with an organisational component), 7 alternative). Organisational level interventions had no associations with improvements in symptoms. Cognitive behavioural interventions had the strongest association with reduced symptoms. Note small number of studies for most interventions and small overall sample size making it difficult to draw firm conclusions from moderator analyses.
(Rick et al. 2002) Systematic review	<b>Review of existing supporting scientific knowledge to underpin standards of good practice for key work-related stressors – Phase 1</b> This is the review that formed the basis for the Management Standards. Reviewing the best available evidence, with a preference for intervention studies with randomised and non-randomised control groups – although other designs were included – did not indicate a uniform pattern of findings of various stressor categories across nine stressors examined (relating to work demands, work scheduling, control over work processes and skill discretion, the physical environment and social relations at work – including bullying). The reviewers do indicate that understanding of the processes linking the work environment may need to incorporate individual differences, curvilinear and moderator relationships. The report's authors conclude 'The nature of the limited evidence suggests that it is currently not feasible to issue clear and simple directives about which stressors are most harmful, at what threshold they become harmful, how they operate, or what can be done to reduce their levels' (p 164). They suggest a contextually tailored approach to intervention based on understanding how stressors cause problems in each specific organisational context. Implication is that assessment should be equally tailored.
(Rousseau et al. 2006) Conceptual review and theoretical synthesis	<b>I-deals: Idiosyncratic terms in employment relationships</b> Idiosyncratic deals or i-deals - "idiosyncratic employment arrangements are special terms of employment negotiated between individual workers and their employers (present or prospective) that satisfy both parties' needs" (p. 977) or "i-deals refer to voluntary, personalized agreements of a nonstandard nature negotiated between individual employees and their employers regarding terms that benefit each party" (p 979). They can be negotiated during recruitment or when in post. They are mutually negotiated and partially shaped by the worker - so therefore usually require a source of power for the employee (e.g., scarce and valued skills) - they are not favouritism (which does not imply employee power to negotiate) and must benefit both employee and employer. They can include things like authorised flexible working arrangements, increases in job scope and so on. Individuals may need to feel they can reasonably expect to negotiate such deals. <i>Although Rousseau does not acknowledge this, they do lend themselves to individuals negotiating arrangements that allow some degree of accommodation if unwell, or personalised comfort if practicable (cf. the literature on job crafting).</i> However, "because i-deals create differences among co-workers in conditions of employment, failure to recognize and attend to i-deals can exacerbate the injustice their existence might engender, eroding trust and cooperation in the organization" (p 978) Rousseau therefore reasons that i-deals will not be unfair when: i) opportunities for negotiating i-deals are available to all ii) the i-deal also provides benefits for co-workers (e.g. retention of a highly skilled member of staff)

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	Rousseau also indicates open communication to all co-workers on i-deals enhances fairness
(Rubak et al. 2005)  Systematic review	<p><b>Motivational interviewing: a systematic review and meta-analysis</b> Review of motivational interviewing ("directive, client-centered counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence" p 305) - it is about clients recognising and doing something about current or potential problems and is viewed as especially useful for those ambivalent or reluctant to change behaviour. The goal is to increase client's intrinsic motivation to pursue a particular behaviour.</p> <p>Results from 72 randomised control trials analysed. 74% of studies reported benefits, none reported harm. Only individual interviews succeeded. Group and telephone interviews showed no effects. Average level of the interview as 60 minutes. Only 40% of studies with one encounter showed positive effects, but positive effects were found in 87% with more than five encounters - suggesting this is not a one-off technique. All interventions were delivered by healthcare professionals. <i>(None of the studies examined behaviours related to CHPs. So, although the paper suggests motivational interviewing might be effective, conclusions from this study cannot be extended to interventions delivered by supervisors and to behaviours relevant to CHPs)</i></p>
(Ruotsalainen et al. 2008)  Meta-analysis	<p><b>Systematic review of interventions for reducing occupational stress in health care workers</b> Meta-analysis of the effectiveness of interventions (k = 19, n = 2812, healthcare workers mainly nurses) in reducing stress at work among health care workers. Found evidence that person-directed (including cognitive-behavioural training, relaxation training, music-making, therapeutic massage and multicomponent interventions), person-work interface (mobilizing support from colleagues and learning participatory problem solving and decision-making skills) and interventions focused on improving functioning in work tasks (mainly training/knowledge/skills based) can all be effective at reducing at least some symptoms of stress/psychological ill-being. Do not find evidence that any interventions were harmful. <i>The authors refrain from making a statement concerning effect sizes for the different interventions and because they use different effect size indices for different measures it is difficult to ascertain from reading the text.</i> Note "Before large-scale implementation can be advised, larger and better quality trials are needed." p 169</p>
(Semmer 2008)  Report	<p><b>Stress management and well-being interventions in the workplace - Mental capital and well-being: making the most of ourselves in the 21st century. Foresight project. State of Science Review:SR-C6</b> General review - review criteria unclear and combines evidence with sources that put forward an opinion on good practice rather than evidence-based recommendations.</p> <p>Most promising approaches involve: management support; risk analysis; a participatory approach; a combination of person- and organisation-focused interventions. Personal intervention (e.g. stress management training) is more effective if it includes cognitive-behavioural skills training approaches and relaxation, and if there are top-up sessions. Quality of implementation of job/organisational process redesign is important. Also calls for integration of stress management training with organisational culture. <i>(Acknowledges that negative effects of organisational interventions can occur - this may be related to participations and implementation)</i></p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<i>factors).</i>
(Sin & Lyubomirsky 2009) Meta-analysis	<p><b>Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis</b></p> <p>Meta-analysis of interventions and activities to increase positive thoughts and emotions. All studies included control groups and pre and post intervention measures of well-being or depression. Effect on well-being was <math>r = .29</math> (<math>k = 49</math>, <math>n = 4235</math>) and depression <math>r = .31</math> (<math>k = 25</math>, <math>n = 1812</math>), but there was significant variability between studies. Effect sizes were stronger for individual therapy (<math>r = 0.44</math>), followed by group-administered interventions (<math>r = 0.30</math>) followed by self-administered interventions (<math>r = 0.16</math>).</p> <p>Also, some evidence that those who are depressed benefit most from positive psychology interventions (PPIs), but also those who were more motivated to engage with the intervention.</p> <p>Interventions:          "A variety of PPIs have now been found effective, including positive behaviours like engaging in enjoyable activities .... and using one's signature strengths in new ways .... Cognitive strategies, such as replaying positive experiences and self-monitoring instances of well-being, have also been shown to boost happiness and alleviate depression .... Finally, the practice of emotional skills—including mindfulness and acceptance—can have a positive impact on a client's psychological well-being ...." p 482          Suggest combination interventions are likely to be more effective.  <i>(However, therapeutic focus of best interventions, and the smallish effect size for individual administered interventions may limit the applicability of PPIs for CHPs)</i></p>
(Skakon et al. 2010) Systematic review	<p><b>The impact of leaders on employee stress and affective well-being: a systematic review of three decades of empirical research</b></p> <p>Systematic review of 49 studies (43 were cross-sectional limiting evidence base). Transformational leadership and supportive/empowering leadership behaviours had clearest and strongest relationships with worker well-being. Leader well-being was associated with worker well-being but underpinning theoretical processes are unclear.</p>
(Soler et al. 2010) Systematic review	<p><b>A systematic review of selected interventions for worksite health promotion: The assessment of health risks with feedback</b></p> <p>Focuses on Assessment of Health Risks with Feedback (AHRF). Indicates might be effective with and without other components of workplace health promotion.</p> <p>"[R]esults of these reviews indicate that AHRF is useful as a gateway intervention to a broader worksite health promotion program that includes health education lasting &gt; 1 hour or repeating multiple times during 1 year, and that may include an array of health promotion activities." p S237</p> <p>"Most authors in the field agree, though, that there are basic elements of HRAs: the assessment of personal health habits and risk factors (which may be supplemented by biomedical measurements of physiologic health); a quantitative estimation or qualitative assessment of</p>

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	<p>future risk of death and other adverse health outcomes; and provision of feedback in the form of educational messages and counselling that describe ways in which changing one or more behavioural risk factors might alter the risk of disease or death" p S238</p> <p>Can be used as a stand-alone or as a gateway programme in multi-component health promotion, which might involve follow-up assessments</p> <p>Assessment can be done by questionnaire, and risk assessment can be done qualitatively (e.g. indicating certain behaviours are associated with increased health risks). Feedback can be verbal or in writing</p> <p>Analysis of 32 studies with AHRF alone and 51 studies with AHRF plus other components. Minority were RCTs and many pre-post-only designs. Generally did not assess common mental health problems or stress-related problems.</p> <p>For AHRF alone, impact on blood pressure was inconsistent, but most studies found a decrease in cholesterol (which is more likely to be diet- rather than stress-related). Combined interventions were more effective for reductions in blood pressure and cholesterol. Results for absenteeism were not consistent. The effect size was small for single interventions, but there was a consistent reduction in absence for combined interventions. Note absence was usually assessed by self-report, and effect sizes tended to be moderate. Potential adverse effects are listed as: "information received in the feedback portion of AHRF may cause anxiety for the recipient; false positives are likely, particularly with the biometric screenings; some employees may experience the "white coat" syndrome when their blood pressure is being checked; and others may not follow directives for fasting prior to cholesterol checks, leading to overestimates of risk status. Finally, breach of confidentiality is of substantial concern in worksite settings and if it occurs, may have some potential for influencing decision making not just about which programs to offer, but about which benefits to provide." p S255 Lack of participation may also be a barrier to implementation. (To use AHRF or something like it for preventing/managing CHPs is an extrapolation, although evidence with blood pressure and absence is promising. It might be possible to develop something like a web-based tool for self-diagnosis or work unit diagnosis. However, the evidence indicates stronger effects for AHRF with other interventions).</p>
(Tabanelli et al. 2008)  Narrative review	<p><b>Available instruments for measurement of psychosocial factors in the work environment</b></p> <p>Attempt to identify measures of psychosocial hazards. Identified 26 standardised questionnaires and 7 observational methods. Indicates as well as questionnaires, assessment can include: observational checklists, assessment of organisational units as well as single jobs, interviews with supervisors and workers, assessment and development of interventions in a single package through groups working through issues and coming up with solutions, checklists of potential interventions to consider. However, these more in-depth methods tend to require expert administration and none seem to have been developed after the 1990s. Questionnaires may be perceived to be more convenient (<i>but perhaps it is possible for organisations to use methods other than questionnaires themselves with appropriate guidance</i>).</p>
(Takeuchi et al. 2009)  Original study	<p><b>Through the looking glass of a social system: Cross-level effects of high-performance work systems on employees' attitudes</b></p> <p>Argues HPWSs signal organisation demonstrates concern for employees using social information processing and organisational climate literature. Cross-sectional survey of 552 employees in 76 establishments. HPWSs and climate assessed at establishment level with multiple raters. Finds that HPWSs are associated with establishment level concern for employees which in turn is related to job satisfaction (and commitment). <i>Indicates importance of social processes for success for HPWSs (cf. Butts et al., 2009).</i></p>

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(Thomson et al. 2003)  Narrative review with primary data collected	<b>Best practice in rehabilitating employees following absence due to work-related stress</b> Narrative review, case studies and interviews. Identify a number of principles of good practice in rehabilitating after absence due to stress: Early contact with employee when first going off sick to communicate general support rather than discuss treatment/intervention; within 2-4 weeks of absence, there is a referral for health assessment; accurate, sympathetic, employee centred assessment with communication between relevant manager in organisation and health practitioner; employee and line manager involvement, commitment and agreement to rehabilitation plan with regular reviews; access to therapeutic interventions, specifically talking interventions such as CBT; flexible return to work options with assessment and tailoring of work and work conditions to be suitable for return and potential (temporary) changed level of functioning and the returning worker is supported and work conditions monitored and the return to work plan adjusted as necessary depending on length of recovery; written policy of return to work; case management approach to involve various stakeholders; line managers awareness of stress and rehabilitation – perhaps through training; central monitoring of sickness absence patterns.
(Tyers et al. 2009)  Original study	<b>Organisational responses to the HSE management standards for work-related stress</b> Reports a qualitative study of SIP1. Based on interviews with 113 individuals. Many of many findings, the most important to managing and preventing CHPs relate to implementation issues. These are: Securing senior management commitment is important but difficult. Senior managers may have a fear of the process which needs to be overcome. Implementation is more successful where the MS champion is senior but often more junior H&S managers were given the role. A senior manager should engage actively in championing and managing the project (e.g., chairing the steering group, being the source of communication, helping to develop action plans and KPIs for action plans). The senior manager who becomes the champion should have the right political skills to engage people in what can be a difficult, interpersonal process; have sufficient resources - including time; recognise that there are difficulties related to organisational cultures, processes and perceptions of stress and that resistance needs to be overcome. Small steering groups with senior managers were more effective. These should meet regularly and report directly to the Board. Maintaining momentum throughout implementation is important. This requires regular steering group meetings, communicating successes to senior managers and rest of workforce. Multiple communication channels are needed and communication needs to be sustained. In order to get initial momentum, at early stages there is need to identify areas for quick wins and to communicate these. In relation to the Indicator Tool: there were concerns over reputational risks should results become public and especially in relation to the red lighting system and the bullying items. This suggests at a minimum the Indicator Tool needs to be revised. However, other sources raise more fundamental issues about the Indicator Tool. The six areas appeared useful as a framework for action and for developing a stress policy. However, there are other concerns about these six areas raised in other reviews. The Indicator Tool was sometimes adapted. Resistance to implementation could come from adverse perceptions of the Indicator Tool. Focus groups were seen as useful for developing interventions but not for developing specific action plans. However, problems like bullying

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	<p>were difficult to tackle in focus groups; the quality of focus group facilitators were important and line managers were often not the best people to act as facilitators; focus groups needed to have clear agendas and requirement for output to stop them going off track. External advisors (HSE stress partners) seemed to be useful for getting senior management commitment and advising MS champions. However, initial resistance to external help from 'enforcers' needs to be overcome and supportive role developed - although enforcement might help to get MS implementation get back on track by direct communication with most senior manager. External advisors felt involvement over a longer period would have been beneficial.</p> <p>MS process appears to be good at raising awareness of stress, increasing confidence to manage stress-related problems and encourages integration of stress management into management development. MS could be perceived as too rigid - more flexibility might be required. Organisational case studies to show how to implement MS might be useful.</p>
<p>(van Wyk &amp; Pillay-Van Wyk 2010)  Cochrane review</p>	<p><b>Preventive staff-support interventions for health workers (Review)</b></p> <p>Assessed the effects of preventive staff-support interventions to healthcare workers in relation to work-related stress. Included ten RCTs involving 716 participants: Eight studies assessed the effects of training interventions in various stress management techniques on measures of stress and/or job satisfaction, and two studies assessed the effects of management interventions on stress (e.g. multidisciplinary meetings, feedback sessions, etc.), job satisfaction and absenteeism.</p> <p>Because only two management interventions were identified, it was not possible to draw conclusions.</p> <p>"There is strong evidence to support the effectiveness of an intensive, long-term stress management training intervention on reducing job stress and risk of burnout among a wide range of health workers in various settings. Stress management training interventions should therefore include periodic refresher sessions up to 18 months post-intervention to maintain beneficial effects of the training beyond the intervention." p 11</p> <p>However, the nature of the most effective interventions could not be identified because of the heterogeneity of the interventions. Training usually delivered face-to-face. Intensity is measured by frequency and duration of contact. It is not possible to know whether high intensity training delivered virtually would work. (see also Table 4).</p>
<p>(Varekamp et al. 2006)  Systematic review</p>	<p><b>How can we help employees with chronic diseases to stay at work? A review of interventions aimed at job retention and based on an empowerment perspective</b></p> <p>Interventions aimed at job retention for workers with chronic conditions. Some of these use an empowerment perspective. (<i>Not focused on CHPs, so have to extrapolate</i>). There is some evidence for the effectiveness of vocational rehabilitation interventions that pay attention to training in requesting work accommodations and feelings of self-confidence or self-efficacy in dealing with work-related problems.</p> <p>p 88 "The empowerment perspective in health care originates from patient education and self-management practices for chronic diseases. The aim is to provide 'a combination of knowledge, skills and a heightened self-awareness regarding values and needs, so that patients can define and achieve their own goals' It is more of a social than biopsychosocial approach</p>



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	<p>Analysis of 9 studies: Interventions focused on:</p> <ul style="list-style-type: none"><li>• increasing knowledge about the disorder, its consequences, legal rights and work accommodations.</li><li>• increasing understanding of work-related problems or work barriers.</li><li>• increasing feelings of control (general control or perceived self-efficacy for requesting work accommodations).</li><li>• develop coping and social skills.</li><li>• increasing activities aimed at work accommodations.</li></ul> <p>All interventions were training related with some including counselling. Most were individually oriented but some were group oriented. Some included family members. Only five studies assessed job retention, and only three of these had a control group. Only two of these reported better job retention. <i>(Therefore there is only inconsistent evidence that empowerment interventions would work for job retention in relation to CHPs).</i></p>
(Waddell & Burton 2004)  Conceptual review	<p><b>Concepts of rehabilitation for the management of common health problems</b> <i>(This review, undertaken for the Department for Work and Pensions, explored concepts of rehabilitation for common health problems: musculoskeletal, mental health and cardio-respiratory).</i> “The stereotype of disability is a severe medical condition with objective evidence of disease and permanent physical or mental impairment (e.g. blindness, severe or progressive neurological disease, or amputation). In fact, most sickness absence, long-term incapacity for work and premature retirement on medical grounds are now caused by less severe mental health, musculoskeletal and cardio-respiratory conditions. These ‘common health problems’ often consist primarily of symptoms with limited evidence of objective disease or impairment. Importantly, many of them are potentially remediable and long-term incapacity is not inevitable. Rehabilitation has traditionally been a separate, second-stage process, carried out after medical treatment has no more to offer yet recovery remains incomplete: the goal was then to overcome, adapt or compensate for irremediable, permanent impairment. That approach is inappropriate for common health problems, where the obstacles to recovery are often predominantly psychosocial in nature rather than the severity of pathology or impairment. In this situation, rehabilitation must focus instead on identifying and overcoming the health, personal/psychological, and social/occupational obstacles to recovery and (return to) work. This implies that rehabilitation can no longer be a separate, second stage intervention after ‘treatment’ is complete. The evidence shows that the best time for effective rehabilitation is between about 1 and 6+ months off work (the exact limits are unclear). Earlier, most people recover and return to work uneventfully: they do not need any specific rehabilitation intervention and the priority is not to obstruct natural recovery. Later, the obstacles to return to work become more complex and harder to overcome: rehabilitation is more difficult and costly, and has a lower success rate. To take maximum advantage of this window of opportunity and minimize the number going on to long-term incapacity, rehabilitation principles should be an integral part of good clinical and occupational management: Clinical management should provide timely delivery of effective health care, but that alone is not enough. The primary goal of health care is</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>to treat disease and provide symptomatic relief, but too often that fails to address occupational issues. Rehabilitation demands that health care should both relieve symptoms and restore function, and these go hand in hand. Work is not only the goal: work is generally therapeutic and an essential part of rehabilitation. Every health professional who treats patients with common health problems should be interested in and take responsibility for rehabilitation and occupational outcomes. That requires radical change in NHS and health professionals' thinking. Common health problems are not only matters for health care, but much broader public health issues of 'health at work'. Sickness absence and return to work are social processes that depend on work-related factors and employer attitudes, process and practice. This requires employers, unions and insurers to re-think occupational management for common health problems: addressing all of the health, personal and occupational dimensions of incapacity, identifying obstacles to return to work, and providing support to overcome them. The same principles are equally applicable to job retention, early return to sustained work and reintegration. This should not obscure the importance of the individual's own role in the management of common health problems. Rehabilitation is an active process that depends on the participation, motivation and effort of the individual, supported by health care and employers. Better clinical and occupational management and rehabilitation of common health problems is the best way to reduce the number of people going on to long-term incapacity. Even with the best possible management, however, some will always need further help; consideration must also be given to long-term benefit recipients. Social security is then not just about paying benefits: the 'welfare to work' strategy is also about providing support to (re)-enter work. Rehabilitation in a DWP context must address the additional obstacles facing people who are more distanced from the labour market, including the particular problems of the 'hard to help', the disadvantaged and excluded, and those aged &gt; 50-55 years. It must also fit the practicalities of the DWP context, including issues of: early identification of those at risk; recruitment, engagement and retention; incentives, disincentives and control mechanisms. Action depends on accepting ownership of the problem. Everyone – workers; employers, unions and insurers; health professionals; government and the taxpayer – has an interest in better outcomes for common health problems. Effective management depends on getting 'all players onside' and working together to that common goal. This is partly a matter of perceptions (by all the players). It requires a fundamental shift in the culture of how we perceive and manage common health problems, in health care, in the workplace, and in society. Better management and rehabilitation of common health problems is possible, can be effective, and is likely to be cost-effective." (pp 3-4) (See also Tables 1, 2 and 4).</p>
<p>(Waddell &amp; Burton 2006)  Best evidence synthesis</p>	<p><b>Is work good for your health and well-being?</b>  <i>(This review for the Department for Work and Pensions covered common health problems in general, not just musculoskeletal problems).</i>          "The review focused on adults of working age and the common health problems that account for two-thirds of sickness absence and long-term incapacity (i.e. mild/moderate mental health, musculoskeletal and cardio-respiratory conditions)." (p. vi). <i>For convenience, the section relating to stress is reproduced here verbatim and references to source material omitted as indicated by [.....]:</i>          "** Cross-sectional studies show an association between various psychosocial characteristics of work (job satisfaction, job demands/control,</p>

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>effort/reward, social support) and various subjective measures of general health and psychological well-being [.....] The strongest associations are with job satisfaction [.....], and the weakest with social support [.....]. The associations are stronger for subjective perceptions of work than for more objective measures of work organization.</p> <p>* Longitudinal studies support a causal relationship between certain psychosocial characteristics of work (particularly demand and control) and mental health (mainly psychological distress) over time but the effect sizes are generally small. [.....]</p> <p>The conceptual problem is the circularity in stimulus-response definitions: stressors are any (job) demands associated with adverse stress responses; stress responses are any adverse (health) effects attributed to stressors. The practical problem is that stressors and stress responses and the relationship between them are subjective perceptions, self-reported, open to modulation by the mental state identified as 'stress' (whatever its cause), and with confounding of cause and effect. There are no objective or agreed criteria for the definition or measurement of stressors or stress responses, or for the diagnosis of any clinical syndrome of 'stress' [.....]. These conceptual and methodological problems create considerable uncertainty about psychosocial hazards, about psychosocial harms, and about the relationship between them [.....]</p> <p>The underlying problem is the fundamental assumption that work demands/stressors are necessarily a hazard with potential adverse mental health consequences [.....], ignoring or failing to take sufficient account of the possibility that work might also be good for mental health [.....]. It is sometimes argued that this is a matter of quantitative exposure: 'Pressure is part and parcel of all work and helps to keep us motivated. But excessive pressure can lead to stress which undermines performance' (HSE Stress homepage <a href="http://www.hse.gov.uk/stress">www.hse.gov.uk/stress</a> : accessed 24 January 2006). However, there is little evidence for such a dose-response relationship or for any threshold for adverse health effects [.....]. Rather, work involves a complex set of psychosocial characteristics with which the worker interacts to experience beneficial and harmful effects on mental health. Other non-work-related issues can influence how the worker interacts with and copes with work stressors. Positive and negative work characteristics, positive and negative job-worker interactions, and positive and negative effects on the worker's health then all occur simultaneously. The final impact on the worker's health depends on the complex balance between them.</p> <p>A more comprehensive model of mental health at work should embody the following principles:</p> <ul style="list-style-type: none"><li>• Safety at work should be distinguished from health and well-being. Safety is freedom from dangers or risks (Concise Oxford Dictionary). Health and well-being are much broader and more positive concepts.</li><li>• Personal perceptions, cognitions and emotions are central to the experience of 'stress' [.....].</li><li>• 'Stress' is both part of and reflects a wider process of interaction between the person (worker) and their (work) environment [references omitted].</li><li>• Work can have both positive and negative effects on mental health and well-being [.....].</li></ul> <p>This review did not retrieve any direct evidence on the relative balance of beneficial vs. harmful effects of work (of whatever psychosocial characteristics) on mental health and psychological well-being. Any adverse effects of work stressors appear to be comparable in magnitude to those of job insecurity [.....]. Any such effects are smaller than the adverse effects of unemployment ....., social gradients in health</p>

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	[.....]and regional deprivation [.....]on physical and mental health and mortality [.....]. There is no direct evidence on a) how any adverse/beneficial effects of continuing to work compare with the adverse/beneficial effects of moving to sickness absence; b) the balance of adverse or beneficial effects of return to work in people with stress-related health complaints; or c) how any risk of adverse effects from returning to work compares with the adverse effects of prolonged sickness absence. On balance, any adverse effects of work on mental health appear to be outweighed by the beneficial effects of work on well-being and by the likely adverse effects of (long-term) sickness absence or unemployment.” (pp 22-24) ( <i>Findings in respect of musculoskeletal problems are in Table 1, mental health in Table 2, and generic issues in Table 4</i> ).
(Waddell et al. 2008)  Best evidence synthesis	<b>Vocational rehabilitation: what works, for whom, and when?</b> “This review has demonstrated that there is a strong scientific evidence base for many aspects of vocational rehabilitation. There is a good business case for vocational rehabilitation, and more evidence on cost-benefits than for many health and social policy areas. Common health problems should get high priority, because they account for about two-thirds of long-term sickness absence and incapacity benefits, and much of this should be preventable. Vocational rehabilitation principles and interventions are fundamentally the same for work related and other comparable health conditions, irrespective of whether they are classified as injury or disease. .... Healthcare has a key role, but vocational rehabilitation is not a matter of healthcare alone – the evidence shows that treatment by itself has little impact on work outcomes. Employers also have a key role - there is strong evidence that proactive company approaches to sickness, together with the temporary provision of modified work and accommodations, are effective and cost-effective. (Though there is less evidence on vocational rehabilitation interventions in small and medium enterprises). Overall, the evidence in this review shows that effective vocational rehabilitation depends on work-focused healthcare <i>and</i> accommodating workplaces. <i>Both</i> are necessary: they are inter-dependent and must be coordinated. The concept of early intervention is central to vocational rehabilitation, because the longer anyone is off work, the greater the obstacles to return to work and the more difficult vocational rehabilitation becomes. It is simpler, more effective and cost-effective to prevent people with common health problems going on to long-term sickness absence. A ‘stepped-care approach’ starts with simple, low-intensity, low-cost interventions which will be adequate for most sick or injured workers, and provides progressively more intensive and structured interventions for those who need additional help to return to work. This approach allocates finite resources most appropriately and efficiently to meet individual needs. Effective vocational rehabilitation depends on communication and coordination between the key players – particularly the individual, healthcare, and the workplace. .... There is strong evidence on effective vocational rehabilitation interventions for musculoskeletal conditions. For many years the strongest evidence was on low back pain, but more recent evidence shows that the same principles apply to most people with mostcommon

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>musculoskeletal disorders. Various medical and psychological treatments for anxiety and depression can improve symptoms and quality of life, but there is limited evidence that they improve work outcomes. There is a lack of scientific clarity about ‘stress’, and little or no evidence on effective interventions for work outcomes. There is an urgent need to improve vocational rehabilitation interventions for mental health problems. 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 and so prevent long-term sickness. Current cardiac rehabilitation programmes focus almost exclusively on clinical and disease outcomes, with little evidence on what helps work outcomes: a change of focus is required. Workers with occupational asthma who are unable to return to their previous jobs need better support and if necessary retraining.” (pp 5-6)</p> <p>“1. Vocational rehabilitation is <i>whatever helps someone with a health problem to stay at, return to and remain in work</i>. It is an idea and an approach as much as an intervention or a service.</p> <p>2. This review has demonstrated that there is now a strong scientific evidence base for many aspects of vocational rehabilitation.</p> <p>3. There is a good business case for vocational rehabilitation, and more evidence on cost-benefits than for many health and social policy areas.</p> <p>4. Common health problems should get high priority, because they account for about two-thirds of long-term sickness absence and incapacity benefits and much of this should be preventable. Return-to-work should be one of the key outcome measures.</p> <p>5. Vocational rehabilitation depends on work-focused healthcare <i>and</i> accommodating workplaces. To make a real and lasting difference, both need to be addressed and coordinated.</p> <p>6. Most people with common health problems can be helped to return to work by following a few basic principles of healthcare and workplace management. This can be done with existing or minimal additional resources, and is low cost or cost-neutral. Policy should be directed to persuading and supporting health professionals and employers to implement these principles.” (p. 8)</p> <p><i>(This review was a policy document for the UK cross-sector Vocational Rehabilitation Task Group. It covered common health problems in general, not just musculoskeletal problems). (See also Tables 1,2, and 4).</i></p>
(Warr 2007) Conceptual review	<p><b>Work, happiness and unhappiness</b></p> <p>Narrative and conceptual review. Identifies the following features of Good Jobs: job control, skill use, reasonable level of demands, variety in tasks, clarity concerning the future, role and performance, good social contact, pay, physical security, significance to self and society, leadership/supervision, job security and career prospects, fairness in how workers are treated.</p>
(Wu &	<p><b>The role of procedural justice and power distance in the relationship between high performance work systems and employee</b></p>

**Table 3: Work-relevant stress complaints**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
Chaturvedi (2009) Original study	<b>attitudes: A multilevel perspective</b> Argues HPWSs lead to higher perceptions of social justice, based on social exchange theory – argues more positive outcomes arise because HPWSs are perceived to be fair and involving. Cross-sectional survey of 1383 employees from 23 companies, with HPWSs assessed by multiple-raters at the establishment level. Found evidence that HPWSs were associated with job satisfaction and this association was partially mediated by perceptions of procedural justice. <i>Indicates importance of social processes for success for HPWSs (cf. Butts et al., 2009).</i> HPWSs were also associated with commitment.
(Zhao et al. 2007) Meta-analysis	<b>The impact of psychological contract breach on work-related outcomes: A meta-analysis</b> Meta-analysis of 28 studies (N=14,252) of psychological contract breach and job satisfaction. Most of the relationships examined were cross-sectional. There is a consistent negative correlation between psychological contract breach and job satisfaction ( $r = -.45$ across studies). Practically, the authors opine that “managers should not provide unrealistic promises during recruitment, socialization, and routine work interactions ... using counselling programs especially designed to deal with employees’ emotions such as anger, stress, and depression ..... explaining the reasons for unfulfilled promises ..... managers should carefully assess their employees’ needs and make sincere efforts at fulfilling their obligations” (p. 671). <i>The last of these maps on to goal based views of well-being, in which progress and attainment of goals are associated with better well-being.</i>

**Table 4<sup>14</sup>: Generic issues**

<b>Table 4: Generic issues</b>	
<b>Authors</b>	<b>Key features (Reviewers' comments in italic)</b>
(Adler 2009) Narrative review	<b>Engel's bio psychosocial model is still relevant today</b> While not introducing any new theoretical material on the biopsychosocial perspective, this article reviews the basis and background of the BPS model as it relates to the practice and teaching of medicine. Offers a persuasive account of the explanatory usefulness of the BPS model in accounting for a range of phenomena.
(Amicus the Union 2006) Position Statement	<b>Good Work: An Amicus Agenda for Better Jobs</b> Presents an aspirational agenda for workers, employers and government, based on five key elements aimed at improving the quality of working lives: A safe and healthy workplace; Control over the working environment; Secure and interesting work (including support for skills and learning); Fairness and dignity at work; and, a trade union voice. <i>Not a review; cites 19 references. Recognises that work is part of a persons overall well-being.</i>
(Armstrong 2006) Text book	<b>A handbook of human resource management practice</b> Human resource management (HRM) should be integrated with business strategy to enable organisation to realise its goals. HRM therefore should be vertically integrated with overall strategy, horizontally integrated with other parts of the strategy (e.g. operations) and internally consistent with itself so that practices support each other (such consistent HRM practices are sometimes known as 'bundles'). Note the health and safety management comes under HRM - <i>so health and safety need to be aligned with other parts of HRM and the business strategy.</i> Notes that piecemeal initiatives do not constitute a strategy. Perhaps this view reflects 'hard' HRM which emphasises investing in human resources to achieve organisational goals. 'Soft' HRM is more concerned with human relations and development, stressing things like home-work balance, health, safety, involvement, quality of working like. <i>Note that this 'soft' HRM is part of high performance work systems, in which the organisation emphasises so called soft aspects of HRM as a social exchange (psychological contract relevant here) in return for commitment and motivation. Moreover, involvement, autonomy, skill use (characteristics of 'Good Jobs') allow workers to act more quickly and flexibly. There is good evidence that high performance work systems are related to organisational performance (Coombs et al., 2006). One question then becomes how to make 'soft' HRM 'hard'. One approach is regulation, the other and perhaps complementary is establishing a better business case in which performance is emphasised and well-being comes as an ancillary benefit - currently OHS practice emphasises performance as an ancillary benefit. Finally, if there is a</i>

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**Table 4: Generic issues**

**Authors**

**Key features** (*Reviewers' comments in italic*)

*regulatory route (or at least guidance), it is important to ensure there is support available from HSE for implementation - this might be done by appropriately trained inspectors giving advice and helping with implementation of strategies.*

Various theoretical perspectives emphasise that investment in people adds to the value of the firm, either through developing skills, learning and innovation, developing commitment and self-regulation to lower management/supervision costs, flexibility and so on.

An effective HR strategy:

- satisfies business needs,
- is founded on analysis,
- can be turned into action plans that anticipate implementation requirements and problems,
- takes account of the needs of line managers and employees as key stakeholders in the organisation.

Effective HR strategies are more likely to be developed if:

- senior managers understand the strategic imperatives of employing, developing and motivating people;
- line managers and staff are involved in, committed to and co-operate with implementation of HRM.
- the practices underpinning the HR strategy are consistent with each other (e.g., moves to more autonomous working are supported by recruitment and training to ensure workers have the skills to use the autonomy effectively to solve problems etc)

It is important the HR strategy is aligned with the organisational culture as well as the strategy. Note this does not mean abandoning good practices that are universally effective (cf. high performance work systems) but it does mean adapting these practices to suit local conditions.

This adaptation may be a source of advantage for business performance as it cannot easily be imitated by competitors.

In developing and implementing a strategy, it is important to:

- Assess its feasibility - can it be delivered at a reasonable cost and are the intended outcomes realistic;
- Determine its desirability for the organisation e.g. in terms of other activities
- Determine the goals - in other words establish key performance indicators (e.g. reduce absence, sick pay and supervision costs, increase productivity per capita)
- Decide the best means of achieving the goals

Research evidence suggests that working through strategic people management issues leads to identification of various tensions and then leads to an emerging consensus. *Note this is a lot more than senior management 'buy in' and symbolic management as recommended in the Management Standards - it is about senior managers ensuring OHS policies are formed in such a way to achieve business goals - there is an operational emphasis.*

Various barriers to implementation are discussed - some of these may result from different perceptions amongst various stakeholders (HR, staff, line managers) about the role of the HR (read OHS) function. Research evidence indicates factors that increase this gap can include:

- tendency for stakeholders to accept only those practices they perceive relevant to them;



**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<ul style="list-style-type: none"><li>• tendency to inertia for long-serving employees/managers;</li><li>• initiatives that are framed as too complex or abstract;</li><li>• initiatives that are non-routine (i.e. not regularly occurring);</li><li>• initiatives that are seen as unfair, threatening, conflicting with other personal and organisational goals and processes;</li><li>• whether senior management is trusted;</li><li>• whether the organisation has an inert culture/not ready to change;</li><li>• failure to understand the needs for the initiative;</li><li>• initiatives based on poor analysis;</li><li>• failure to recognise the role of line managers in implementing initiatives;</li><li>• failure to recognise initiatives may need supporting processes (cf. training and job design above)</li></ul> <p>To overcome these barriers, it is suggested strategies require:</p> <ul style="list-style-type: none"><li>• thorough analysis of needs and requirements - which includes an assessment of barriers and how to deal with them;</li><li>• enlisted support for the strategy from key stakeholders;</li><li>• action plans;</li><li>• project management of implementation;</li><li>• follow-up and evaluation so that remedial action can be taken as necessary.</li></ul> <p>A strategy review sequence is suggested:</p> <p>Analysis - what is the business strategy, what are the organisations' cultural and operating environment issues that need to be accounted for, what are key HR weaknesses and issues, where are the gaps between what the organisation is doing and what it should be doing</p> <p>Diagnosis - why do the HR weaknesses exist, what are the causes of gaps, what factors (internal or external) are influencing this situation</p> <p>Conclusions and recommendations - how should gaps be bridged, what options are available, which option is recommended and why (note, don't forget feasibility, desirability here and key performance indicators here - see above)</p> <p>Action planning - what actions are needed to implement the strategy, what problems might be anticipated and how might they be dealt with, who takes action and when, how are capable and committed line managers</p> <p>Resource planning - what resources will be needed, how are these to be obtained, how are those with control of resources to be convinced they are required, what other support is required</p> <p>Costs and benefits: What are the costs and benefits to the organisation. How do they satisfy business needs and benefit individuals (<i>I would have thought this should be a check throughout the process at each stage</i>)</p> <p>Note, preparing a strategy document a strategy document could follow the heading of this review sequence, with the cost-benefit analysis</p>

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>placed at the end or costs and benefits analysed reported at each stage. It is suggested that formal policies be drawn up to provide guidelines for action - so policies cannot be too abstract - an overall HR policy will express the overall aims and its underpinning values (e.g. equity, consideration, organisational learning, performance through people, work-life balance, quality of working life, good working conditions - note these should recognise all stakeholders and not solely focus on organisational performance). Specific policies should be based on:</p> <ul style="list-style-type: none"><li>• An understanding of the organisational culture and core values;</li><li>• Analysis of existing practices, formal policies and informal, implicit approaches to managing people;</li><li>• An analysis of the external environment and its influences;</li><li>• An assessment of the adequacy of existing formal and informal arrangements and whether these need replaced or amended;</li><li>• A consideration of the views of various stakeholders (senior and line management, employees and their representatives) on how HR can be improved and whether they are implemented fairly and consistently;</li><li>• Draft policies drawn up from these initial steps which are then discussed with various stakeholders and amended as appropriate;</li><li>• Communication of the policies and guidance notes on their implementation (with supplementary training if appropriate).</li></ul> <p><i>(The importance of line managers is emphasised).</i></p>
(Bambra et al. 2009)  Review of systematic reviews	<p><b>Working for health? Evidence from systematic reviews on the effects on health and health inequalities of organisational changes to the psychosocial work environment</b></p> <p>An umbrella review of reviews aiming to consider and present research findings on the health impacts of organisational changes to the psychosocial work environment. Inclusion criteria: reviews conducted between 200 and 2007 considering organisation interventions only. 7 reviews were identified that met the inclusion criteria, with 3 examining employee control and 4 the impact of changes to the organisation of work. Employee control: one review concluded that the impact of employee discussion groups was mixed and inconclusive. In contrast, another review found a consistent and positive impact on self reported health accruing from committee interventions increasing employee control. The final review found that task structure interventions did not alter levels of employee control, however where there was a reduction in levels of job control, self reported mental health got worse. Changes to the organisation of work: no detrimental impacts were observed following the introduction of initiatives such as compressed working weeks. In terms of shift work changes, switching from slow to fast shift rotation, changing from backward (night, afternoon, morning) to forward rotation (afternoon, morning, night) and self-scheduling of shifts all produced positive effects. Interventions included: Staff discussion groups on improving potentially harmful working conditions; Organisational level work reorganisation – participatory committees, control over hours of work; Task structure work reorganisation – job enrichment, collective coping and decision making, autonomous production groups; Changing from 8 hour, 5 day week to a compressed working week – 12/10 hour, 4 day week; Various changes to shift work schedules The authors conclude that their examination of the review</p>

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	evidence suggests that changes to the psychosocial work environment introduced at the organisational level promote “important and beneficial” impact on health. In terms of policy and practice, the authors conclude that making changes to psychosocial issues in the workplace can yield positive health outcomes.
(Bartley et al. 2005) Report	<b>Work, non-work, job satisfaction and psychological health</b> Outlines a preliminary scoping of available evidence about the relationship between job satisfaction, aspiration, mental health and worklessness. This was based on the recognition that the relationship between work and health and disease goes well beyond specific occupational illnesses and accidents to broader matters. The broader relationship may be understood in terms of three mechanisms: (1) Work which provides fulfilment and allows individuals control over their working lives confers considerable health benefit; (2) Types of job which are lacking in self-direction and control seem to confer far fewer health benefits, and people with such jobs seem to experience consistently higher rates of mortality and morbidity; and, (3) Absence of work in the form of unemployment produces considerable negative health effects. The authors attempted to answer the question ‘Is job satisfaction decreasing?’ and found that between 1991 and 2002, job satisfaction scores declined in the British Household Panel Study. The decline was slightly greater in the older age group. The greatest overall decrease was seen among those in intermediate occupations (clerical, sales and other ‘white-collar’ jobs). The smallest overall decrease was seen among those doing semi-routine and routine jobs.
(Bevan et al. 2007) Report	<b>Fit For Work? Musculoskeletal Disorders and Labour Market Participation</b> Review of recent academic and practitioner research on the relationship between these MSDs and labour market participation, and conducted interviews with over 100 experts in this field from around Europe. The report examines the causes, effects and costs of MSDs in the European workforce and assesses what more can be done by policymakers, health care systems, social welfare regimes, clinicians, employers and by workers themselves to help alleviate the often damaging economic and social consequences of this widespread, but often hidden, problem. Recommendations (for policymakers, employers, clinicians and other stakeholders): <ul style="list-style-type: none"><li>• Better data on MSDs.</li><li>• Active labour market policy must allow workers with MSDs to stay in work.</li><li>• Promote and enforce legislation requiring reasonable workplace accommodations for workers with MSDs.</li><li>• Promote examples of good workplace preventative practice.</li><li>• The EU MSD Directive should recognise pre-existing MSDs.</li><li>• National governments should ensure that primary care physicians are supported in making decisions about work disability.</li><li>• National governments should consider adopting a version of the UK ‘Fit Note’</li><li>• National governments should prioritise access to physical and psychological therapies for workers with MSDs.</li><li>• National governments should implement national care plans for people with MSDs.</li></ul>

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<ul style="list-style-type: none"><li>• Health Technology Assessments (HTAs) should be allowed to take account of the wider societal benefits treatments and therapies for MSDs.</li></ul>
(Bilsker et al. 2005) Report	<p><b>Depression &amp; Work Function: Bridging the gap between mental health care &amp; the workplace</b></p> <p>Review conducted by the Mental Health Evaluation &amp; Community Consultation Unit (MHECCU) at the University of British Columbia for the Depression in the Workplace Collective, and endorsed by the BC Business and Economic Roundtable on Mental Health.</p> <p>The causes and fundamental nature of depression have not been determined. There are two primary models of depression with some scientific support: (1) emphasis on biological factors with some form of neurochemical brain dysfunction; (2) emphasis on psychological factors with some form of distorted cognitive processing is basic to depression. We do not know whether a neurochemical brain dysfunction or biased cognitive style are essential components of depression.</p> <p>Depression is common. Best estimate for one-year prevalence of major depression is 4%. Workforce surveys indicate rates between 6 and 13%. The course of depression has considerable variation between cases. Describing the typical course of depression is not the same as describing the typical course of depression-related impairment; the disability process is influenced by other factors. For example, an individual may remain on the job despite experiencing significant depressive symptoms, or may remain absent from work after most depressive symptoms have resolved.</p> <p>Depression can be effectively treated with medication and psychological therapy (usually CBT). Access to psychotherapy may be limited by cost and availability.</p> <p>The impact of depression is pervasive, affecting virtually all aspects of the depressed person's life. These aspects include: interpersonal function (withdrawal, avoidance or conflict); physiological function (restlessness and fatigue); behavioural function (reduced problem-solving and activity pacing); and cognitive function (reduced concentration and flexibility).</p> <p>Depressed employees describe a 'vicious cycle' and 'downward spiral' of poor morale, decreased job satisfaction, lack of motivation, extremes of emotion and intolerance with others, lack of concentration, confusion and difficulties with decision making, more sickness absences, and higher rates of staff turnover.</p> <p>Being out of work is a powerful contributor to depression. Both unemployment and underemployment (e.g., finding only part-time work) are associated with increased risk of depression onset in subsequent years.</p> <p>Certain kinds of workplace stress are associated with higher frequency of depressive symptoms in employees: "job strain" (high levels of job demand accompanied by low levels of control over workload). Changes in the workplace are seen as significant contributors to depression. Examples of these changes are downsizing, employment uncertainty, work-life imbalance, and increases in workload. At times of significant transformation, there is likely to be an increase in employee distress. The connection between work stress and depression is complicated by two factors: (1) stressors from work and personal life have a synergistic effect on the likelihood of depression, making it difficult to clearly identify the source of stress; (2) personal traits of workers affect their vulnerability to workplace stressors.</p> <p>The transition from employee to patient often heralds the onset of a disconnection between the workplace and healthcare system.</p>

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>Interventions that reduce milder forms of psychological distress may be plausibly seen as preventive for the development of depressive disorders. Stress management interventions are of two types: (1) Reducing the presence or severity of organizational and workplace stressors; (2) Increasing the ability of workers to cope with stress.</p> <p>There is some evidence that stress management programmes can reduce depressive symptomatology (<i>but evidence is lacking for sickness absence</i>).</p> <p>The authors argue for early detection of depression, and rapid access to treatment. They conclude that best practices is:</p> <ul style="list-style-type: none"><li>• Coordinating interventions with the workplace, rather than exclusively relying on external healthcare systems to resolve disability problems</li><li>• Preventing potentially disabling injuries or illnesses</li><li>• Early identification and intervention</li><li>• Early return to work with innovative accommodation techniques</li><li>• Coordination between supervisors, senior management, labour representatives, health practitioners, and insurance providers</li></ul> <p>A chasm has opened between the public healthcare system and the workplace. They have different cultures, communicate poorly, and do not coordinate their priorities for treatment and management of mental health problems. Yet the patients who present to the healthcare system with depression are the employees who demonstrate functional deficits in the workplace. Bridging this chasm through enhanced communication and coordination will substantially benefit the depressed employee's personal health and the nation's corporate health.</p> <p>Depression cannot be treated only as a problem for the individual worker suffering from the condition. It also constitutes a fundamental issue for the employer and co-workers. Depression in the workplace has a significant effect on the productivity and profitability of corporations. Risk factors for depression are found at both the individual and organizational levels and, therefore, successful intervention requires action at both levels. We conclude that a continuum of risk reduction and health promotion, early detection and intervention, and effective disease and disability management will be most effective in managing this complex condition. Research studies concerning the costs associated with depression and programs to improve organizational management of this disorder indicate that a powerful business case can be made for comprehensive intervention.</p>
(Black 2008) Report to UK Government	<p><b>Working for a healthier tomorrow: Dame Carol Black's Review of the health of Britain's working age population</b></p> <p>The subject of this review is the health of people of working age. Three principal objectives are outlined:</p> <ul style="list-style-type: none"><li>• Prevention of illness and promotion of health and well-being</li><li>• Early intervention for those who develop a health condition</li><li>• An improvement in the health of those out of work – so that everyone with the potential to work has the support they need to do so</li></ul> <p>Great progress has been made in improving health and safety at work. A shift in attitudes is necessary to ensure that employers and employees recognise not only the importance of preventing ill-health, but also the key role the workplace can play in promoting health and</p>

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	well-being. Specific recommendations are made about changing perceptions of fitness for work, developing a new model for early intervention, helping workless people, and developing professional expertise for working age health.
(Seymour 2010)  Report	<p><b>Common mental health problems at work - What we now know about successful interventions. A progress review</b></p> <p>The key messages are (in this update to the 2005 BOHRF report):</p> <ul style="list-style-type: none"> <li>• People do not have to be entirely symptom free to remain in or return to work successfully. The evidence suggests that it is important to differentiate occupational goals from clinical goals and understand that the former is not necessarily dependent on the latter. Therefore less emphasis needs to be placed on employees being symptom-free before returning to work.</li> <li>• The workplace is not the only setting for the delivery of appropriate and effective interventions for the management of common mental health problems among working age people. Partnerships between employers, employees and a range of practitioners can help to maximise the retention and rehabilitation of people with common mental health problems.</li> <li>• Different practitioners have valuable and complementary roles to play, in order to achieve positive work outcomes.</li> <li>• Independent case management (ICM) by third party specialists, such as labour experts or employment advisers, is critical to achieving successful outcomes for individuals and organisations where employees are not recovering as expected.</li> <li>• Line managers have a crucial role in supporting employees with common mental health problems to remain in or return to work and they need effective skills development and training to enable them to do so. The line manager has a key role in the liaison between employees with common mental health problems, management and occupational health or primary care practitioners.</li> </ul>
(Boorman 2009)  Report to UK Government	<p><b>Health &amp; Well-being of NHS staff – Interim Report; Health &amp; Well-being of NHS staff – Final Report</b></p> <p>NHS staff have relatively high levels of sickness absence. On average, staff are absent for some 10.7 days a year, more than the public sector as a whole (9.7 days) and the private sector (6.4 days). These levels of sickness absence are reducing, but not as significantly as in other organisations. In the public sector as a whole, sickness absence fell from 9.8 to 9.7 days, while across the private sector it reduced from 7.2 to 6.4 days. Respondents report high levels of presenteeism, with many staff reporting that they come to work when they feel sufficiently unwell to justify staying at home. Many staff report significant levels of stress. Many staff do not believe that senior managers or their employer as an organisation take a positive interest in their health and well-being. Most staff believe that their state of health affects patient care.</p> <p>The key principles underpinning approaches to providing high-quality health and well-being support to NHS staff:</p> <ul style="list-style-type: none"> <li>• focused on prevention and health improvement as well as providing excellent support for staff who present with ill-health and sickness</li> <li>• proactive in tackling the causes of ill-health, both work-related and lifestyle-related, as well as responding effectively to cases presenting for treatment. This should include the provision of early intervention services where these are of clear benefit to individuals, patients and the Trust</li> </ul>

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	<ul style="list-style-type: none"> <li>centred on, and responsive to, staff and their concerns, as well as providing responsive advice to management, with services available to staff through both self-referral and managerial referral</li> <li>holistic, bringing together the variety of initiatives in occupational and public health into a single approach</li> <li>embedded as a core element of Trust business, with appropriate resourcing and routine monitoring and reporting to the board</li> <li>supported by a service specification setting out clear expectations of the service</li> <li>fully connected with wider NHS provision, especially general practice and public health.</li> </ul> <p>Three additional recommendations were added to the Final Report</p> <ul style="list-style-type: none"> <li>all NHS organisations provide staff health and well-being services that are centred on prevention (of both work- related and lifestyle-influenced ill-health), are fully aligned with wider public health policies and initiatives, and are seen as a real and tangible benefit of working in the NHS.</li> <li>all NHS leaders and managers are developed and equipped to recognise the link between staff health and well-being and organisational performance and that their actions are judged in terms of whether they contribute to or undermine staff health and well-being.</li> <li>all NHS Trusts develop and implement strategies for actively improving the health and well-being of their workforce, and particularly for tackling the major health and lifestyle issues that affect their staff and the wider population.</li> </ul>
(Bowling & Beehr 2006)  Meta-analysis	<p><b>Workplace harassment from the victim's perspective: A theoretical model and meta-analysis</b> Workplace harassment is defined as interpersonal behaviour aimed at intentionally harming another employee in the workplace - more common, minor instances “include obscene gestures, dirty looks, threats, yelling, giving the silent treatment, and belittling” (p. 998). In a meta-analysis (not stated but probably mainly cross-sectional, self-report designs), found that harassment was more common in environments characterised by other psychosocial hazards (r's ranging from 0.20 - 0.44, k = 13-25, N = 2733 - 7343). Found that harassment was also linked to indicators of psychological and physical well-being. For indicators of psychological well-being, r varied from -0.18 for life satisfaction to .33 for burnout. r = .25 for the correlation between harassment and physical symptoms.</p>
(Broadbent 2010)  Narrative review	<p><b>Illness perceptions and health: Innovations and clinical applications</b> Author describes interventions from 2 randomised controlled trials (RCT). The aim of the RCTs was to test if illness perceptions interventions could improve functional recovery after a myocardial infarction. The interventions consisted of: 3 half hour sessions with a health psychologist (while still in hospital). The sessions targeted illness perceptions and built up a recovery plan. The trials showed significant differences in illness perceptions between intervention and control group with the intervention participants having a faster return to work rate. Advocates 'patient' drawing</p>
(Burton et al.	<p><b>Management of upper limb disorders and the biopsychosocial model</b></p>

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2008) Best evidence synthesis	<i>(This review was undertaken for HSE and presented as a research Report)</i> The review used a best evidence synthesis to examine the evidence on management strategies for work-relevant upper limb disorders and established the extent to which the biopsychosocial model can be applied. The main results are presented in thematic sections covering classification/diagnosis, epidemiology, associations/risks, and management/treatment, focusing on return to work and taking account of distinctions between non-specific complaints and specific diagnoses. There is considerable uncertainty over classification and diagnosis for upper limb disorders; the inconsistent terminology impacts on studies of their epidemiology, treatment, and management. Upper limb disorders are commonly experienced irrespective of work and can lead to difficulty undertaking everyday tasks; this applies to specific diagnoses as well as non-specific complaints. Work has a limited overall role in the primary causation of upper limb disorders, yet the symptoms are frequently work-relevant (some work tasks will be difficult for people experiencing upper limb symptoms, and may sometimes provoke symptoms that may otherwise not materialize). Management of cases shows more promise than attempts at primary prevention. The biopsychosocial model is certainly appropriate to understand the phenomenon of work-relevant upper limb disorders, and has important implications for their management. Biological considerations should not be ignored, particularly for initial treatment of cases with specific diagnoses, but it is psychosocial factors that are important when developing and implementing work retention and return to work interventions. Implementation of interventions that address the full range of psychosocial issues will require a cultural shift in the way the relationship between upper limb complaints and work is conceived and handled. Neither medical treatment nor ergonomic workplace interventions alone offer an optimal solution; rather, multimodal interventions show considerable promise, particularly for vocational outcomes. Some specific diagnoses may require specific biomedical treatments, but the components of supplementary interventions directed at securing sustained return to work seem to be shared with regional pain disorders. Early return to work, or work retention, is an important goal for most cases and may be facilitated, where necessary, by transitional work arrangements. The emergent evidence indicates that successful management strategies require all the players to be onside and acting in a coordinated fashion, in order to overcome obstacles to recovery and return to work. <i>(See also Table 1).</i>
(Cass et al. 2002) Meta-analysis	<b>Health and Employment: A review and meta-analysis study (HERMES)</b> Large scale meta-analysis of cross-sectional self-report studies. Therefore good sample size but analysis of methodologically weak research. Job satisfaction (often taken to be an indicator of work-related psychological well-being) was found to be associated with other indicators of mental health (1.31   r 1.41).
(Chida & Steptoe 2008) Meta-analysis	<b>Positive psychological well-being and mortality: A quantitative review of prospective observational studies</b> Summarises others' work, and states links between positive affective states and physical health may be explained by behavioural pathways - positive affect may be associated with healthier behaviours (e.g. less smoking, less alcohol consumption, more exercise) and adherence to treatments. It may also be related to physiological processes, as positive affect may have a direct effect of cardiovascular and immune system functioning. <i>Note, there may be reciprocal causation or reinforcement at work here, both at behavioural levels (affect influences exercise which influences affect) and physiological levels (sub-clinical changes in physiology may reduce positive affect).</i> Meta-analysis of positive affect (refers to activated and hedonic affects such as happiness, joy, enthusiasm etc, excludes relaxation) and mortality. Includes only



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	prospective studies. Finds a robust effect of positive affect in reducing mortality in healthy samples (k = 21, N = 36598) and diseased samples (k = 19 N = 15,711). Although there was some evidence of publication bias evident, this was small and possibly does not alter the conclusions. In healthy populations, positive affect is associated with reduced risk of mortality (19% reduction) and CVD mortality especially (29% reduction). Positive affect was associated with decreased mortality in ill samples. In relation to specific illnesses, positive affect did not have a robust protective effect for people with pre-existing CVDs or cancers, but was protective against for patients with renal failure and HIV. <i>(The findings appear not to be specific to dispositions to experience positive affect, rather positive affect per se).</i>
(Chida & Hamer 2008)  Meta-analysis	<b>Chronic psychosocial factors and acute physiological responses to laboratory-induced stress in healthy populations: a quantitative review of 30 years of investigation</b> Meta-analysis of 729 experimental and laboratory studies of acute physiological reactions to stress in healthy populations. Found positive psychological states to be associated with reduced hypothalamic-pituitary-adrenal reactivity. Hostility and aggression associated with increased cardiovascular reactivity, anxiety and negative affect (this is essentially anxiety) were associated with reduced cardiovascular reactivity but reduced cardiovascular recovery, general life stress was associated with poor heart rate or poor blood pressure recovery. However, there was no evidence that job stress per se was associated with changes in acute physiological stress reactions. In general, results tend to indicate affective responses to stressors are important for healthier physiological functioning rather than the work environment being a direct influence.
(Coats & Lehki 2008)  Policy review	<b>'Good work': job quality in a changing economy</b> The quality of employment has an impact on health, life expectancy and life chances. While it is clear that unemployment has a corrosive effect on physical and mental health, there is equally strong evidence to show that a good job is better than a bad job. If we care about the capabilities of individuals to choose a life that they value then we should care about job quality. For the purposes of this discussion good work embraces the following features: -- Employment security; -- Work that is not characterised by monotony and repetition; -- Autonomy, control and task discretion; -- A balance between the efforts workers make and the rewards that they receive; -- Whether the workers have the skills they need to cope with periods of intense pressure; -- Observance of the basic principles of procedural justice; -- Strong workplace relationships (social capital).
(Cole et al. 2005)	<b>Effectiveness of Participatory Ergonomic Interventions: A Systematic Review</b> The objective of this review was to synthesize evidence on the effectiveness of workplace-based participatory ergonomic (PE) interventions in improving health outcomes. Effectiveness was determined by examining quantitative evidence regarding achievement of the desirable

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<b>Authors</b>	<b>Key features (Reviewers' comments in italic)</b>
Systematic Review	<p>consequences, such as reduced levels of musculoskeletal (MSK) pain or discomfort, injuries or claims and time loss. 10 studies were reviewed, no RCT's. The majority of studies identified (without implementation) or implemented (after identification) changes to the physical design of equipment and workplaces. Fewer studies included changes in work tasks, job teams or work organization, the formulation of policies, or specific training. The focus on physical changes may be due to the traditional emphasis of ergonomics and workplace parties on the physical aspects of the work/worker interaction when concerned about MSD, despite the growing literature that indicates a role for psychosocial or work organization factors. 4 studies reported positive effects on musculoskeletal symptoms, and 1 no change. 6 studies reported positive effects on injury claims. 2 studies reported positive effects on sick leave.</p> <p>The authors concluded that taken together these 10 studies provide limited (partial) evidence that PE interventions can have a positive impact on symptoms, in reducing injuries and workers' compensation claims, and on lost days from work or sickness absence. The size of this impact is unclear.</p> <p><i>Inspection of the appended study summary data indicates that while some findings were statistically significant they were probably not meaningful in real-world contexts, because effect sizes were small and sometimes inconsistent.</i></p>
(Conn et al. 2009) Meta-analysis	<p><b>Meta-analysis of workplace physical activity interventions</b></p> <p>Aimed to investigate the relationship between physical activity at work and health outcomes. The key research question was to assess the health outcome impact of interventions designed to increase physical activity in the workplace. Unfortunately, the authors provide very limited information regarding the types of physical activities undertaken by intervention groups. The authors conclude that some interventions improve physical activity in individuals and these changes may [sic] improve selected health outcomes.</p>
(Constable et al. 2009) Report	<p><b>Good Jobs (RR 713)</b></p> <p>Literature review, stakeholder survey, interviews and workshops. The workshop programme provided evidence that the link between good quality jobs, retention and motivation was broadly accepted by many organisations. The survey, meanwhile, illustrated that many employers included key issues such as being valued, autonomy and a pleasant working environment in a definition of a 'Good Job'. Recommendations were made for government policy.</p>
(Côté et al. 2008) Systematic review	<p><b>The burden and determinants of neck pain in workers: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders</b></p> <p>109 articles were included. The annual prevalence of neck pain varied from 27.1% in Norway to 47.8% in Quebec, Canada. Each year, between 11% and 14.1% of workers were limited in their activities because of neck pain. Risk factors associated with neck pain in workers include age, previous musculoskeletal pain, high quantitative job demands, low social support at work, job insecurity, low physical capacity, poor computer workstation design and work posture, sedentary work position, repetitive work and precision work. We found preliminary evidence that gender, occupation, headaches, emotional problems, smoking, poor job satisfaction, awkward work postures, poor physical work environment, and workers' ethnicity may be associated with neck pain. There is evidence that interventions aimed at modifying</p>

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	workstations and worker posture are not effective in reducing the incidence of neck pain in workers. Neck disorders are a significant source of pain and activity limitations in workers. Most neck pain results from complex relationships between individual and workplace risk factors. No prevention strategies have been shown to reduce the incidence of neck pain in workers. <i>(See also Table 1)</i>
(Cox et al. 2009) Report	<p><b>Developing the management standards approach within the context of common health problems in the workplace (RR 687)</b></p> <p>The authors stated that there are theoretical arguments and growing epidemiological and anecdotal evidence to suggest that the risk management approach as expressed in the Management Standards initiative might be of relevance to the management of other common health problems in the workplace. The study focused the key question “can the Management Standards approach be used more widely to address the most common health problems at work?” – a Delphi methodology, plus focused review of the relevant literatures, was used.</p> <p>Epidemiological evidence suggests that there are shared risk factors between the most common health problems (CHP), and that musculoskeletal disorders (MSD) and work-related stress tend to co-occur. Good evidence (<i>not defined</i>) exists to show that there is a shared set of causal factors for these main CHPs. These “psychosocial” factors largely relate to aspects of the design and management of work, work systems and work organisations. Psychosocial factors have an independent and significant role in the aetiology of musculoskeletal disorders. Prospective studies suggest that psychological distress can be a cause as well as an outcome of MSDs, and there are studies that demonstrate that interventions targeting psychosocial factors are also associated with reductions in MSDs. The available evidence regarding a shared causation and co-morbidity supports the possibility of a single (unified) approach to the management of the two main CHPs at work: they share important causal factors and there is some co-morbidity. Two things follow: first, such a unified approach may also be appropriate for other CHPs at work if they also share causal factors and demonstrate co-morbidity, and, second, any such unified approach must be flexible enough to allow for tailoring to particular circumstance. In addition, the physical factors that cause MSDs would still need to be addressed in other ways.</p> <p>The consensus among the experts was that the Management Standards approach works well in principle but less so in practice. The Indicator Tool omits a number of important factors that can impact on work-related health, lacks validity, the assessment can be costly, time consuming, prescriptive and difficult to implement. The overall approach requires additional resources and guidance to be implemented, is not adequately supported by practitioner competencies, and is narrowly focused on stress.</p> <p>The consensus among the experts was that the Management Standards approach can be applied to other CHPs at work, but with caution: it was stressed that it would only be appropriate to combine the assessment of CHPs that have the same causal factors and mechanisms. The expert panel disagreed on whether the Management Standards approach can be used for rehabilitation and return to work.</p> <p>The expert panel expressed views that a broader approach to the management of work-related health can be developed by focusing on good management, placing emphasis on the benefits for organisations, organisational learning and on promoting healthy organisations, promoting organisations’ ownership of the process, strengthening the voice of occupational health and safety professionals, placing emphasis on the positive aspects of work and encouraging a proactive approach.</p> <p><i>(The fundamental concept underlying this report is that common health problems at work are caused by exposure to occupational</i></p>

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	<i>psychosocial factors and that the effect is common across the health problems, leading to 'co-morbidity'. Unfortunately, there seems to have been no clear attempt to distinguish between different manifestations of CHPs – reported symptoms, underlying pathology, sickness absence, disability. For instance, whilst psychosocial factors may influence whether symptoms are reported (as work-relevant) and whether sickness absence is taken, it is difficult to see how they could be responsible for 'generating musculoskeletal pain or causing injury (tissue damage). The scientific evidence favouring shared primary causative mechanisms is inconsistent and the risk factors have small and conflicting effects, so primary prevention through a risk management approach is unlikely to succeed. However, whether the consequences of CHPs (work-relevance) can be reduced through a shared approach is a different question, which was not addressed in this study).</i>
(Daniels 2011)  Narrative review	<b>Stress and well-being are still issues and something still needs to be done: or why agency and interpretation are important for policy and practice</b> Narrative review. Briefly considers affective reactions to work as key mediator between work and well-being and other forms of stress symptoms. Suggests co-existence might partly be explained by common cause (affective experience). ( <i>See also Table 3</i> ).
(de Croon et al. 2005)  Systematic review	<b>The effect of office concepts on worker health and performance: a systematic review of the literature</b> Systematic review of 49 higher quality studies of different types of office work. Build on several other, more specific models of psychological processes, to suggest impact of physical office layout has an impact on psychosocial working conditions (e.g. autonomy), and these psychosocial working conditions partially mediate the impact of physical office layout on short-run indicators of well-being (physical office layout is also thought to have a direct effect on short-run indicators). In turn, short-run indicators influence long-run indicators of health, well-being and performance. Looked at teleworking from home, open-plan offices and desk-sharing. There was insufficient evidence that working from home is beneficial for work characteristics or indicators of well-being There was strong evidence that working in open workplaces reduces the office worker's psychological privacy and there is limited evidence that working in open workplaces intensifies cognitive workload and worsens interpersonal relations. Limited evidence for impacts on communication and autonomy. There was also strong evidence that working in open workplaces reduces job satisfaction but insufficient evidence for an impact on other indicators of well-being. Overall, there is strong evidence that open workplace are detrimental. There was inconsistent evidence was found that desk-sharing improves communication or intensifies cognitive workload, insufficient evidence there is an impact on well-being. "[T]he unfavourable effect of workplace openness implies that, to safeguard the well-being of the office worker, innovative offices should provide sufficient shelter from unwanted acoustic and visual stimuli. To this end, innovative offices should be supplied with an adequate number of enclosed, sound-insulated workstations. In addition, tall, enclosed or frosted glass sound insulating partitions between open workplaces, textile floor covering, acoustic ceiling tiles and printer cabinets might be applied for this purpose. Second, the moderating effect of person-, work- and environment-related variables implies that detrimental office effects might be diminished by the application of

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	measures directed at these variables. Ergonomists might, for instance, prevent unfavourable effects of open and crowded offices by improving lighting and climate conditions. In addition, attention might be paid to the workplace lay-out of high tenure office workers who have a higher need for privacy and low screening-ability, and are engaged in complex work. p 130
(Denson et al. 2009) Meta-analysis	<b>Cognitive appraisals and emotions predict cortisol and immune responses: A meta-analysis of acute laboratory social stressors and emotion inductions</b> Meta-analysis of 80 studies in 66 articles using laboratory based experimental methods (thus rendering effect sizes suspect due to artificial conditions, otherwise this is a strong evidence base). Conclude that appraisals of stressors, specific emotions, cognitive aspects of unpleasant affect (rumination and worry) and social threat are all related to changes in immune responses. Global mood states are not. However, direction of immune response is unclear, with some appraisals/specific emotions being linked to specific types of up-graded immune responses and others to down-graded immune response – however the authors do indicate exposure to stressors or failure to regulate emotions/appraisals to such exposure will adversely effect health. Main conclusion is that specific unpleasant emotional states may have implications for immune functioning and physical stress symptoms.
(EASHAW 2005; EASHAW 2007a; EASHAW 2007b; EASHAW 2009) 4 Reports	<b>Expert forecast on emerging biological/chemical/physical/psychosocial risks related to occupational safety and health</b> This series of four reports from the Risk Observatory of the European Agency for Safety and Health at Work were completed because “the evolution of society and the changing world of work bring new risks and challenges for workers and employers. Indeed, working environments have changed considerably during the last 15 years and are continuing to evolve as a result of changes in the structure of the workforce related to the ageing workforce and increasing participation of women; of changes in the structure of the labour market due to globalisation and growth of the service sector; of new forms of employment and jobs; of the intensification of work; and of the introduction of new technologies and work processes”. <i>These reports represent a type of horizon-scanning initiative, based on expert opinion, the lowest level of evidence.</i>
(EU 2008) Position Statement	<b>European Pact for Mental Health and Well-Being</b> Participants in the EU high-level conference Together For Mental Health And Well-Being held in Brussels issued a consensus statement to acknowledge the importance and relevance of mental health and well-being for the European Union, its Member States, stakeholders and citizens. <ul style="list-style-type: none"><li>• Mental health is a human right. it enables citizens to enjoy well-being, quality of life and health. It promotes learning, working and participation in society.</li><li>• The level of mental health and well-being in the population is a key resource for the success of the EU as a knowledge-based society</li></ul>

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	<p>and economy. it is an important factor for the realisation of the objectives of the Lisbon strategy, on growth and jobs, social cohesion and sustainable development.</p> <ul style="list-style-type: none"><li>• Mental disorders are on the rise in the EU. Today, almost 50 million citizens (about 11% of the population) are estimated to experience mental disorders, with women and men developing and exhibiting different symptoms. depression is already the most prevalent health problem in many EU-Member States.</li><li>• Suicide remains a major cause of death. in the EU, there are about 58,000 suicides per year of which 3/4 are committed by men. Eight Member States are amongst the fifteen countries with the highest male suicide rates in the world.</li><li>• Mental disorders and suicide cause immense suffering for individuals, families and communities, and mental disorders are major cause of disability. They put pressure on health, educational, economic, labour market and social welfare systems across the EU.</li><li>• Complementary action and a combined effort at EU-level can help Member States tackle these challenges by promoting good mental health and well-being in the population, strengthening preventive action and self-help, and providing support to people who experience mental health problems and their families, further to the measures which Member States undertake through health and social services and medical care.</li></ul> <p>Agreement that:</p> <ul style="list-style-type: none"><li>• There is a need for a decisive political step to make mental health and well-being a key priority.</li><li>• Action for mental health and well-being at EU-level needs to be developed by involving the relevant policy makers and stakeholders, including those from the health, education, social and justice sectors, social partners, as well as civil society organisations.</li><li>• People who have experienced mental health problems have valuable expertise and need to play an active role in planning and implementing actions.</li><li>• The mental health and well-being of citizens and groups, including all age groups, different genders, ethnic origins and socio-economic groups, needs to be promoted based on targeted interventions that take into account and are sensitive to the diversity of the European population.</li><li>• There is a need to improve the knowledge base on mental health: by collecting data on the state of mental health in the population and by commissioning research into the epidemiology, causes, determinants and implications of mental health and ill-health, and the possibilities for interventions and best practices in and outside the health and social sectors.</li></ul> <p>They made a call for action in five priority areas. Four of these were: prevention of depression and suicide; mental health in youth and education; mental health of older people; and, combating stigma and social exclusion.</p> <p>The fifth area was mental health in workplace settings.</p> <p>Employment is beneficial to physical and mental health. The mental health and well-being of the workforce is a key resource for productivity and innovation in the EU. The pace and nature of work is changing, leading to pressures on mental health and well-being. action is needed to</p>

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	<p>tackle the steady increase in work absenteeism and incapacity, and to utilize the unused potential for improving productivity that is linked to stress and mental disorders. The workplace plays a central role in the social inclusion of people with mental health problems. Policy makers, social partners and further stakeholders are invited to take action on mental health at the workplace including the following:</p> <ul style="list-style-type: none"> <li>• Improve work organisation, organisational cultures and leadership practices to promote mental well-being at work, including the reconciliation of work and family life</li> <li>• Implement mental health and well-being programmes with risk assessment and prevention programmes for situations that can cause adverse effects on the mental health of workers (stress, abusive behaviour such as violence or harassment at work, alcohol, drugs) and early intervention schemes at workplaces</li> <li>• Provide measures to support the recruitment, retention or rehabilitation and return to work of people with mental health problems or disorders.</li> </ul>
(Faragher et al. 2005) Meta-analysis	<p><b>The relationship between job satisfaction and health: a meta-analysis</b> A systematic review and meta-analysis of 485 studies (n = 267 995). The overall correlation combined across all health measures and job satisfaction was <math>r = 0.37</math>. Job satisfaction was most strongly associated with mental/psychological problems (range of <math>r</math>'s 0.42 - 0.48) The correlation with subjective physical illness was lower (<math>r = 0.29</math>). It was noted that correlations in excess of 0.3 are rare in this context. It was recommended that organisations eradicate work practices that cause most job dissatisfaction to improve employee health. Occupational health clinicians should consider counselling employees with psychological problems to explore ways of gaining greater job satisfaction. (<i>As the authors remarked, the notion that health improvements can be achieved by workplace interventions intended to foster job satisfaction is persuasive: however, the data reviewed were from cross-sectional studies, so longitudinal studies are required</i>).</p>
(Gillespie et al. 2007) Systematic Review	<p><b>Development of a theoretically derived model of resilience through concept analysis</b> Use a concept analysis to review the literature in order to operationalise resilience. Constructs of self-efficacy, hope and coping were defined as attributes or resilience. Conclude that resilience appears to be a process that can be developed at any point in the lifespan and is not an inherent part of personality. This review focuses implications on nursing.</p>
(Hadler 1997b) Editorial	<p><b>Back pain in the workplace: what you lift or how you lift matters far less than whether you lift or when</b> In spite of more than 50 years of concerted effort to diminish task demand, the incidence of compensable back injuries has not wavered. Before we persist for another 50 years in the quest for the "right way to lift," we should consider recent multivariate clinical investigations that suggest alternative approaches. Because task context is at least as important as task content in this regard, it follows that including regional backache under the rubric of "compensable injury" demands reconsideration. Likewise, rather than pursuing the "right way to lift," the more reasonable and humane quest might be for workplaces that are "comfortable when we are well and accommodating when we are ill". (<i>Although the focus is on back injuries, the same notion of comfortable and accommodating might reasonably be expected to apply to other</i></p>

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<i>work-relevant complaints). (See also Table 1).</i>
(Hamilton & CIPD 2010) Guide	<p><b>Work-related stress: what the law says</b></p> <p>This guide provides a consolidated summary of the law in four steps. (The guide focuses on the legal requirements, stressing the need for employers to take appropriate steps (e.g. using the Management Standards) to prevent employees being subjected to work-related stress. A number of dramatic, high-settlement legal cases are used to highlight the financial consequences of employers failing in their duty. Interestingly, these involve failure to accommodate workers with stress complaints as well as failure to prevent stress).</p> <p>Identifying a problem: As an employer you have a legal obligation to try to identify any problems that your organisation might be having with work-related stress. In practice this means using a range of analytic and anecdotal measures to find out what's going on. Engaging employees directly, for instance through safety representatives, will help you understand what their perspective is, and help you identify what might be causing excessive workplace pressure.</p> <p>Preventing harm: The law requires you to actively manage the workplace to try to prevent accidents and ill-health before they happen. The same principles apply to controlling potential causes of work-related stress. The process of risk assessment, as well as being required by law, provides a simple and effective method for preventing the day-today pressure of work from becoming excessive.</p> <p>Protecting individuals: Over and above the legal duties to put preventative measures in place, you have a duty to protect individuals from harm caused by work-related stress. As an employer you are required to take reasonable steps to prevent work-related stress affecting employee health once you are aware that it is affecting them. You are also required to make reasonable adjustments to an employee's work or workplace if their health needs can be defined as a disability.</p> <p>Managing the workplace: Harassment covers a wide range of conduct, ranging from serious crimes (such as sexual assault) to seemingly trivial remarks. It can generally be defined as unwanted conduct that results in, intended or otherwise, the violation of an individual's dignity or creates an intimidating, hostile, degrading, humiliating or offensive environment.</p> <p>Management Standards: The Management Standards approach has been developed by the Health and Safety Executive (HSE) to help reduce the levels of work-related stress reported by British workers. The goal is for you to work with your employees and their representatives to implement the Management Standards by continually improving the way you manage workplace pressures that can result in work-related stress. This will be good for employees and good for business.</p>
(Hanson et al. 2006) Narrative review + model development	<p><b>The costs and benefits of active case management and rehabilitation for musculoskeletal disorders</b></p> <p>'Active case management' describes the goal-oriented approach to achieving specific work retention and return to work outcomes. It is a strategy for supporting individuals (with MSDs) stay in work or return to work. In practice, case managers integrate clinical and occupational management with the needs of the individual to facilitate early return to work (or work retention). There is good international scientific evidence that case management methods are cost-effective through reducing time off work and lost productivity, and reducing healthcare costs. There is even stronger evidence that best-practice rehabilitation approaches have the very important potential to significantly reduce the burden of long-term sickness absence due to musculoskeletal disorders. Many of the factors influencing the adoption of cost-effective case</p>



**Table 4: Generic issues**

<b>Authors</b>	<b>Key features</b> ( <i>Reviewers' comments in italic</i> )
	<p>management and rehabilitation approaches rest with employers, and funders/commissioners of healthcare. It may be easier to integrate these practices into large and medium-sized workplaces, but there is no reason why the same principles cannot be applied to small businesses and the self-employed. It appears to be very timely for the distribution of information to employers and other key players about how effective case management and suitable rehabilitation approaches can be, and how applicable they are to UK settings.</p> <p>An evidence-based model for managing those with MSDs was developed that is widely applicable to all types of industry and business in the UK. It describes the principles to apply in order to integrate case management and rehabilitation with the workplace. There is a clear message in the model for all those involved on what they should do and why, using a staged approach: create the right culture; manage workers with musculoskeletal problems; manage the return to work process; monitor and review the programme effectiveness. The model may be used by all sizes of organisation, and should be suitable for all forms of musculoskeletal disorders. The role of the case manager may be taken by an occupational health professional or the employer (e.g. a line manager). The important points are to respond to the needs of individuals quickly, make appropriate arrangements for them (which may include treatment and workplace changes), and gain agreement from the individual, employer, healthcare provider and case manager as to the individual's planned return to work if absent. The review highlighted the importance of good communication and the need to ensure all the players are onside. (<i>This review for HSE, presented as a Research Report, was supplemented with stakeholder focus groups to assess the model</i>). (See also Table 1).</p>
(Hassan et al. 2009)	<p><b>Health and Well-being at Work in the United Kingdom</b> Literature Review Prepared for the Department of Health as part of the Boorman Review 'NHS Health and Well-being'. The main findings:</p> <ul style="list-style-type: none"> <li>• Health and well-being remain key issues in British workplaces and the NHS.</li> <li>• Poor health and well-being at work lead to significant individual, organisational, economic and societal consequences due to sickness absence.</li> <li>• Health and well-being in the workplace seems a particular challenge to the NHS in England.</li> <li>• The cost of presenteeism should also not be under-estimated.</li> <li>• Workplace health interventions can be effective to address poor health and well-being.</li> </ul>
Grey Literature	
(Hershcovis & Barling 2010)	<p><b>Towards a multi-foci approach to workplace aggression: A meta-analytic review of outcomes from different perpetrators</b> Work place aggression is defined as negative acts perpetrated against an organization or its members and that victims are motivated to avoid. Meta-analysis on mainly cross-sectional self-report studies (k = 3 - 18, N = 407-7474). Finds worse psychological well-being associated with aggressive acts from supervisor (various indicators - job satisfaction, distress, depression and emotional exhaustion r's from  .24  -  .32 ) from co-workers (range of r's  .18  -  .25 ) and organisational outsiders (e.g. customers range of r's  .12  -  .38 ).</p>
Meta-analysis	
(Hill et al. 2007)	<p><b>What works at work?</b> Report by Institute for Employment Studies, commissioned by UK Department for Work and Pensions: reviews the effectiveness of</p>

**Table 4: Generic issues**

<b>Authors</b>	<b>Key features (Reviewers' comments in italic)</b>
Research report	<p>workplace interventions to prevent and manage common health problems</p> <p>The research question was: 'What workplace practices and interventions have been shown to be effective in reducing health related negative work outcomes? Key findings:</p> <ul style="list-style-type: none"><li>• Consistent with the biopsychosocial model, the health condition of the employee is only one of a number of factors in their rehabilitation. One of the key themes to emerge from this research is the importance of addressing multiple barriers in ill-health prevention, management of health problems, and promotion of recovery from ill-health.</li><li>• Interventions which included some form of employer/employee partnership, and/or consultation, demonstrated improved results (compared to those which did not).</li><li>• It is not only the employee's health condition that is important to consider, but also their attitudes and beliefs. Cognitive behavioural approaches are one way of effectively addressing this aspect of health and recovery.</li><li>• Interventions should be comprehensive, addressing both individual- and organisational-level factors. Specific interventions have also been shown to be effective if, for example, organisational interventions are combined with a complementary individual intervention.</li><li>• Improved communication, co-operation and common agreed goals between employers, employees, occupational health providers and primary care professionals can result in faster recovery, less re-occurrence of ill-health, and less time out of work overall.</li><li>• Common mental health problems have been addressed in the workplace using a wide range of intervention types; however, there is only a limited amount of good quality evaluation evidence on the effectiveness of these interventions. The available evidence also mainly relates to individual level intervention types, showing that cognitive behavioural approaches in general, and CBT in particular, can be effective in reducing ill-health and absenteeism. There were contradictory results for organisational-level interventions, although this is largely influenced by the sparseness of good quality data.</li><li>• There was evidence that educational interventions for back pain and musculoskeletal disorders, designed to address an individual's beliefs and attitudes about that pain, were effective. Interventions should also address employees' attitudes and beliefs, as well as. Evidence was also found to suggest the importance of organisational policies and practices, and of employed tackling potential organisational barriers to promoting and maintaining health at work, and promoting recovery through work. The timely provision of modified duties was found to be effective in managing back pain at work and in helping those with back pain to return to work.</li></ul> <p>This review identified very little evidence in relation to the management or rehabilitation of workers with cardio-respiratory health problems in the workplace. <i>(Importantly, whilst a large part of the review concerned health promotion, it argued that improved health outcomes might in principle lead to improved occupational outcomes in the medium to long-term. The conclusions of this review focus on broad principles, similar to Waddell &amp; Burton 2004).</i></p>
(Hoving et al. 2010)	<p><b>Illness perceptions and work participation: a systematic review</b></p> <p>Self-regulatory processes play an important role in mediating between the disease and the health outcomes, and potentially also work</p>

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<b>Authors</b>	<b>Key features</b> ( <i>Reviewers' comments in italic</i> )
Systematic review	outcomes. This systematic review aims to explore the relationship between illness perceptions and work participation in patients with somatic diseases and complaints. Two longitudinal and two cross-sectional studies selected for this review report statistically significant findings for one or more illness perception dimensions in patients with various complaints and illnesses, although some dimensions are significant in one study but not in another. Overall, non-working patients perceived more serious consequences, expected their illness to last a longer time, and reported more symptoms and more emotional responses as a result of their illness. Alternatively, working patients had a stronger belief in the controllability of their condition and a better understanding of their disease. In conclusion, the limited number of studies in this review suggests that illness perceptions play a role in the work participation of people with somatic diseases or complaints, although it is not clear how strong this relationship is and which illness perception dimensions are most useful. Identifying individuals with maladaptive illness perceptions and targeting interventions toward changing these perceptions are promising developments in improving work participation.
(Howell et al. 2007) Meta-analysis	<b>Health benefits: Meta-analytically determining the impact of well-being on objective health outcomes</b> Meta-analysis of 150 methodologically strong studies (experimental, ambulatory, longitudinal) of subjective well-being and objective health outcomes. General finding is that subjective well-being is associated with objective health outcomes ( $r = .14$ ). Importantly, laboratory induced manipulations of positive affect were associated with better objective health indicators ( $r = .17$ ) indicating the relationships cannot simply be attributed to individual dispositions to experience positive affect. <i>Even so, these are small effect sizes but does indicate well-being might mediate the relationship between work and physical health.</i> Well-being was associated with short-term, long-term and disease/symptom control. Some of the strongest relationships were found for immune functioning ( $r = .33$ ) and pain tolerance ( $r = .32$ ). Well-being was not associated with cardiovascular reactivity nor physiological responses, although for older samples well-being was associated with better cardiovascular and physiological functioning. Importantly, well-being was associated with better health in healthy samples only across a range of indicators – however, range restriction might explain this and that only a small number of studies looked at unhealthy samples. Well-being was related to better disease/symptom control in unhealthy sample.
(IOSH 2009) Guidance	<b>Working well - Guidance on promoting health and well-being at work</b> The aim of this guide is to promote a holistic, proactive approach to managing health and well-being issues at work. It also aims to encourage occupational safety and health practitioners to work with others, particularly occupational health and human resource specialists, to improve employees' work performance and reduce sickness absence through: identifying and addressing the causes of workplace injury and ill health, as required by health and safety law; addressing the impact of health on the capacity of employees to work, e.g. support those with disabilities and health conditions, and rehabilitation; promoting healthier lifestyles and therefore making a positive impact on the general health of the workforce. Employers who want their organisations and employees to be 'working well' need to: <ul style="list-style-type: none"> <li>• Ensure a good employee-to-job 'fit', i.e. matching employees' skills and experience to their job requirements.</li> <li>• Take account of organisational values, the 'reality' of the job and the employees' expectations. At performance appraisals, it's useful</li> </ul>

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>to review how the reality of an employee's job may contrast with their expectations and values.</p> <ul style="list-style-type: none"> <li>• Regard well-being as a joint responsibility of management and employees, and make sure your organisation's policy reflects this. Point out the benefits of preserving well-being for both the employer (such as efficiency and increased morale) and employee (e.g. improved health and resilience).</li> <li>• Regard working with a health condition as the norm, as long as appropriate modifications can be made to the workplace and suitable support is put in place. An ageing workforce means this will become more important in the future.</li> <li>• Promote a positive organisational 'climate'. This is about how employees perceive the organisation through its managerial practices, leadership behaviours, how it involves employees and also the reward systems. 'Climate' is also used to describe the tangible outputs of an organisation's health and safety culture, as perceived by employees at a point in time. It can be measured using surveys, supplemented by observations, workshops and focus groups.</li> <li>• Make sure that managers reflect the well-being policy in their actions. This consistency will lead to an increase in employees' trust in the organisation. It's possible to audit this by examining consistency in areas such as selection and recruitment, communication in the organisation, sickness management, performance measurement and flexible working practices.</li> <li>• Monitor holistic well-being. This involves measuring quality of life judgments, physiological health indicators and health beliefs, as well as standard stress indicators, such as those described in the HSE's stress management standards. So, include well-being factors in your stress risk assessment.</li> </ul>
(Jackson et al. 2007)	<p><b>Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review</b></p> <p>Concludes that resilience enables positive adjustment to adversity that can be enhanced through building positive and nurturing relationships, maintaining positivity; developing emotional insight, achieving life balance and spirituality and becoming more reflective.</p>
Narrative review	
(Kuoppala et al. 2008a)	<p><b>Work health promotion, job well-being, and sickness absences--a systematic review and meta-analysis</b></p> <p>A systematic literature analysis to study the association between work health promotion and job well-being, work ability, absenteeism, and early retirement. This systematic review is a part of a large research project studying multiple workplace factors and interventions that may affect workers' health and well-being. There is moderate evidence that work health promotion decreases sickness absences (risk ratio [RR], 0.78; range, 0.10 to 1.57) and work ability (RR, 1.38; range, 1.15 to 1.66). It also seems to increase mental well-being (RR, 1.39; range, 0.98 to 1.91), but not physical well-being. There is no evidence on disability pension. Exercise seems to increase overall well-being (RR, 1.25; range, 1.05 to 1.47) and work ability (RR, 1.38; range, 1.15 to 1.66), but education and psychological methods do not seem to affect well-being or sickness absences. Sickness absences seem to be reduced by activities promoting healthy lifestyle (RR, 0.80; range, 0.74 to 0.93) and ergonomics (RR, 0.72; range, 0.13 to 1.57). it was concluded that work health promotion is valuable on employees' well-being and work</p>
Systematic review + meta-analysis	

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	ability and productive in terms of less sickness absences. Activities involving exercise, lifestyle, and ergonomics are potentially effective. On the other hand, education and psychological means applied alone do not seem effective. Work health promotion should target both physical and psychosocial environments at work.
(Kuoppala et al. 2008b) Systematic review + meta-analysis	<b>Leadership, job well-being, and health effects--a systematic review and a meta-analysis</b> A systematic literature analysis to study the association between leadership and well-being at work and work-related health. These intermediate outcomes are supposed to predict work-related loss of productivity and disability at work. The main search terms were leadership, job satisfaction, well-being, sick leave, and disability pension. There was moderate evidence that leadership is associated with job well-being (risk ratio [RR] 1.40, range 1.36 to 1.57), sick leave (RR 0.73, range 0.70 to 0.89), and disability pension (RR 0.46, range 0.42 to 0.59). The evidence was weak on that leadership is associated with job satisfaction (median RR 2.23, range 1.30 to 3.51) but not with job performance (RR 1.13, range 0.55 to 1.20). It was concluded that there is a relative lack of well-founded prospective studies targeting the association between leadership and employee health, but the few available good studies suggest an important role of leadership on employee job satisfaction, job well-being, sickness absences, and disability pensions. The relationship between leadership and job performance remains unclear.
(Leka et al. 2008) Report	<b>Towards the Development of a European Framework for Psychosocial Risk Management at the Workplace</b> Report published by the Institute of Work, Health and Organisations containing six chapters: (1) Changing world of work: challenges to health and safety management; (2) The impact of psychosocial risks and work-related stress on workers and organisations; (3) Meeting the challenge: the risk management paradigm; (4) Positioning the psychosocial risk management approach; (5) European approaches to psychosocial risk management; (6) The way forward: a European framework for psychosocial risk management (PRIMA-EF). <i>This report appears to form the evidence base for the development Guidance published by PRIMA (Psychosocial Risk Management) about the 'European Framework for Psychosocial Risk Management', although it is not listed in the bibliography of the published guidance (see table entry for PRIMA 2008). However, no evidence reviews are included in that bibliography.</i> <i>The section of this report on impact of psychosocial risks and work-related stress on workers and organisations (Ch. 2) is notable for its statement that "a growing body of evidence demonstrates the association between work-related stress and psychosocial risks in the workplace and antecedents of poor worker physical and mental well-being" (p. 24) but this is supported by a non-systematic review of selected literature, most of which is older and varies in quality. No attempt seems to have been made to grade strength of evidence. Despite this, the authors conclude, "there is substantial scientific evidence to indicate that there is a clear relationship between psychosocial risks and consequences to individuals' physical, mental and social health" (p. 36). A discussion of the application of risk management approach to 'psychosocial hazards' is included, followed by descriptions of implementation and policy required. No evidence of effectiveness is offered, despite references in the document to 'effective management of occupational health and safety' (p. 5, p. 13).</i>
(Lakke et al.	<b>Risk and prognostic factors for non-specific musculoskeletal pain: A synthesis of evidence from systematic reviews classified into ICF</b>

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2009) Systematic review	<b>dimensions</b> Nine systematic reviews were included, addressing a total of 67 factors. High evidence supported increased mobility of the lumbar spine and poor job satisfaction as risk factors for low back pain. There was also high evidence for intense pain during the onset of shoulder and neck pain and being middle aged as risk factors for shoulder pain. High evidence was also found for several factors that were not prognostic factors. For whiplash-associated disorders these factors were older age, being female, having angular deformity of the neck, and having an acute psychological response. Similarly, for persistence of low back pain, high evidence was found for having fear-avoidance beliefs and meagre social support at work. For low back pain, high evidence was found for meagre social support and poor job content at work as not being risk factors.
(Lyubomirsky et al. 2005) Meta-analysis	<b>The benefits of frequent positive affect: Does happiness lead to success?</b> "Positive emotions signify that life is going well, the person's goals are being met, and resources are adequate .... In these circumstances, as Fredrickson has so lucidly described, people are ideally situated to "broaden and build" (Fredrickson 1998; Fredrickson 2001). In other words, because all is going well, individuals can expand their resources and friendships; they can take the opportunity to build their repertoire of skills for future use; or they can rest and relax to rebuild their energy after expending high levels of effort. Fredrickson's model (Fredrickson, 2001) suggests that a critical adaptive purpose of positive emotions is to help prepare the organism for future challenges. Following Fredrickson, we suggest that people experiencing positive emotions take advantage of their time in this state—free from immediate danger and unmarked by recent loss—to seek new goals that they have not yet attained" p 804. <i>(Note, also a review of emotions and cognition indicates positive affect is associated to greater attention to positively valenced information and negative emotions to negatively valenced information, suggesting negative emotions may lead to greater attention being given to symptoms (Daniels et al. 2004; Daniels 2008))</i> Aim to show that happiness leads to favourable life circumstances not the other way round. Concentrates on positive affect (activated, hedonic states) Experimental evidence indicates inducing a positive mood is associated with higher pain tolerance and better immune functioning as indicated by physiological measures. Longitudinal evidence indicates that positive mood is associated with subsequent work outcomes (e.g. career success, $r = .24$ , $k = 11$ , $n = 15080$ ), health (range of psychological and physical indicators, $r = .18$ , $k = 26$ , $n = 27421$ ) and physical well-being and coping ( $.27$ , $k = 10$ , $n = 2999$ ). Also find positive affect is linked to better creativity and problem-solving (which are key to performance in a knowledge intensive economy). The authors do caution that positive affect may not always be functional in all circumstances and for all jobs, and other things matter for success.
(MacEachen et al. 2006) Systematic review	<b>Systematic review of the qualitative literature on return to work after injury</b> Qualitative systematic review setting out to provide a deeper understanding of the "dimensions, processes and practices of workplace based return to work". Selection criteria included studies that explored the experiences of key players in the return to work process, studies that used qualitative methods and studies focusing on musculoskeletal and pain related injuries. 13 studies were rated as being of sufficient quality for inclusion in the review. A meta-ethnographic approach was used to synthesise data in the selected papers, employing 3 levels of analysis: first

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	<p>order concepts, second order interpretations and third order syntheses (based on the Nat Cen approach to qualitative analysis). Seven concepts emerged as important themes across the 13 studies: The role of goodwill between participating players – i.e. whether people actually collaborate constructively during the RTW process is associated with goodwill and prevailing organisational culture; Relations between the worker and the system; Contact between employer and worker between injury and return to work – several studies identify this early contact time as crucial for developing cooperation, flexibility and credibility; Employer contact with medics – studies revealed that employers found aspects of this process problematic e.g. they are hard to contact, do not promote early RTW etc.; Modified work: social, physical and financial dimensions of ; Role of supervisors in day-to-day relationships underpinning RTW – studies highlighted the crucial role of the supervisor in the success or otherwise of RTW efforts.; RTW and organisational environments, particularly economic and organisational – e.g. implementing effective RTW is harder in adverse economic circumstances such as downsizing situation. Three main findings emerged from an analysis of the above synthesis of the evidence from the studies: The scope and complexity of the RTW process – involves more scope and dimensions than were presented in one study; The role of trust and goodwill – these are crucial for the success of RTW efforts to succeed; The “challenge” of social and communication processes in the RTW effort given the different players involved. Key intermediary players such as rehabilitation providers and workplace supervisors have a potentially key role in facilitating the RTW process. Although this review focuses on RTW, it begs the question as to if there is any common ground with the way CHPs are handled prior to a RTW situation developing. (<i>See also Table 2</i>)</p>
(Macfarlane et al. 2009)  Systematic review	<p><b>Evaluation of work-related psychosocial factors and regional musculoskeletal pain: results from a EULAR Task Force</b></p> <p>Back pain - Most of the reviews conducted found evidence for an association between at least two of the psychosocial factors considered and back pain. The most consistent conclusion across reviews was for high job demands, low job satisfaction (four reviews positive out of six for each) and low work support (four reviews positive out of seven). Fewer reviews concluded that there were positive associations with low job demands (two reviews positive out of six) or low job autonomy (one positive review out of five).</p> <p>Neck/shoulder and forearm pain - The most consistent conclusion for neck/shoulder pain related to high work demands (four out of six reviews concluded that there was an association) and low job demands (two from three reviews positive) (table 4). Low work demands included jobs evaluated as monotonous or with insufficient use of skills. A single review found evidence about low work control (out of six reviews). None of six reviews that considered them found sufficient evidence in relation to either low work support or low job satisfaction.</p> <p>Knee pain - Psychosocial factors were considered in only five studies included in the review regarding the association with knee pain, and only one of the cross-sectional studies found a positive association between knee pain and job stress. There was therefore insufficient evidence to conclude that there was a relationship.</p>
(Malik et al. 2010)  Development	<p><b>A toolkit to support human resource practice</b></p> <p>Outlines development of a toolkit for SMEs to manage work-life balance which received a positive evaluation from 400 SMEs. Places special emphasis on monitoring for changes in legislation for work-life balance, ensuring work-life balance and business needs are consonant, involving employees in monitoring work-life balance and evaluating work-life balance initiatives.</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
and evaluation of a toolkit	<p>Part 1: Outlines purpose and content of toolkit</p> <p>Part 2: "Users are presented with information on how they should monitor their WLB orientation across their business, which activities should be involved, and how evaluation can help to refine these" (p. 289)</p> <p>Part 3: Outlines statutory work-life balance policies and includes case study examples. Other information sources was listed in an appendix</p> <p>The 'business case' was presented in a section of the toolkit</p> <p>Clear, non-academic language used - available as a report with an accompanying CD</p> <p>Outlines potential strategies (e.g. compressed working weeks)</p> <p>Recommends SMEs: develop coherent approaches rather than ad hoc arrangements for particular workers and monitor and evaluate these policies. Importantly, monitoring and evaluation is not tied to standardised instruments, but does involve consultation, awareness of different stakeholders and report outline the stages in effective monitoring and evaluation. These are:</p> <p>Outlines checklists, short-run and long-run benefits for monitoring/evaluation - includes consultation in the process</p>
(Marmot 2010)  Policy review	<p><b>Fair society, healthy lives - The Marmot Review</b></p> <p>Detailed, extensive, up to date review of health inequalities, the main effect of which is the health gradient concept. The emphasis of the review appears to be high-level policy interventions, and as such the report does not appear to deal explicitly with common health issues and interventions at the level of the workplace. Key findings from the review are however relevant to the way common health problems unfold at workplace level. Factors that appear to be relevant to interventions aimed to mitigating common health problems include: The social class of employees; Position in the organisational hierarchy and the latitude of control they have over aspects of their job; Levels of reward ; Job security ; The overall "quality" of jobs, including terms and conditions of employment The findings from this review provide an overall context for the development of CHPs. Key questions for consideration: How important a factor is the health gradient in terms of the risk of the development of CHPs? How do health gradient factors relate to other known factors linked to CHPs?</p>
(Mental Health Foundation 2009)  Report	<p><b>Returning to work: The role of depression</b></p> <p>The purpose of this survey study was to examine the role of depression in returning to work after a period of sickness absence. Recommendations were made for employers, and line managers</p> <p>EMPLOYERS</p> <ul style="list-style-type: none"> <li>• Raise the importance of conducting a cost-benefit analysis: Research suggests that when employers are provided with evidence to support the benefits of tailored work adjustments, they are more likely to provide funding interventions. Tools and guidance regarding approaches to cost-benefit analysis could be made available to organisations.</li> <li>• Promote mandatory risk assessment of depression: Given the relationships between depression, sickness absence and intention to leave, it is important to identify those employees returning to work who are at risk for depression. This should be made a key policy by organisations and a part of the risk assessment framework already in place with regards to UK legislation on general health and</li> </ul>



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	<p>safety at work, and the HSE Management Standards for Work-related Stress.</p> <ul style="list-style-type: none"> <li>• Introduce mandatory stress management: In complement to the risk assessment for depression, employers should provide employees returning to work following depression with stress management training to help reduce the risk of depression.</li> <li>• Train mental health first aiders: Mental-health first aiders are colleagues with a genuine interest in common health problems. They are trained to monitor and identify those at risk of depression in partnership with line managers. This assists line managers, and shares the responsibilities of identifying common mental health problems before they result in long-term sick leave.</li> <li>• Colleague buddy-system: As colleague support is important in the promotion of psychological well-being of employees returning from long-term sick leave, mental health first aiders can also be trained to act as ‘buddies’ to provide support and identify any decline in recovery post return to work.</li> <li>• Multidisciplinary OH/HR team: Investment in occupational health psychology professionals ensures early and appropriate psychological interventions and provides support for occupational health and human resources who require additional training to adequately deal with common mental health problems. Investment is required in terms of recruiting staff with specialist training in this area and in supporting their continuing professional development.</li> </ul> <p>LINE MANAGERS</p> <ul style="list-style-type: none"> <li>• Tailored line management training: Evidence from this study suggests that current training and information to line manager in managing return to work and in identifying common health problems may not be effective. Line management training should be tailored and embedded within evidence-based psychological models of intervention such as the Stage of Change model.</li> <li>• Factoring in time for line management to manage depression and return to work processes: By encouraging employers to invest in ‘time windows’ where line managers consult with employees who have workplace/domestic stressors which makes them vulnerable to absence. This could be co-ordinated with Mental Health First Aiders.</li> <li>• Reinforcing legal duty of care: Line managers require additional training and information in employment law since fear of litigation over harassment appears to prevent contact with sick employees. This could include advice on appropriate interventions in partnership with occupational health.</li> </ul>
(NICE 2009)	<b>Promoting mental well-being through productive and healthy working conditions: guidance for employers.</b>
Public Health Guidance	<p>Work has an important role in promoting mental well-being. It is an important determinant of self-esteem and identity. It can provide a sense of fulfilment and opportunities for social interaction. For most people, work provides their main source of income. Work can also have negative effects on mental health, particularly in the form of stress. Work-related stress is defined as ‘the adverse reaction people have to excessive pressure or other types of demand placed upon them’. Although pressure can motivate employees and encourage enhanced performance, when pressure exceeds an employee’s ability to cope, it becomes a negative force in the form of stress. Working environments that pose risks for mental well-being put high demands on a person without giving them sufficient control and support to manage those</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>demands. A perceived imbalance between the effort required and the rewards of the job can lead to stress. A sense of injustice and unfairness arising from management processes or personal relationships can also increase stress and risks to mental health. Other stressful conditions include physical factors such as material hazards, noise, dust and dirt.</p> <p>Stress is not a medical condition, but research shows that prolonged stress is linked to psychological conditions such as anxiety and depression as well as physical conditions such as heart disease, back pain and headache.</p> <p>Recommendations</p> <ul style="list-style-type: none"><li>• strategic and coordinated approach to promoting employees' mental well-being. Adopt an organisation-wide approach to promoting the mental well-being of all employees, working in partnership with them. This approach should integrate the promotion of mental well-being into all policies and practices concerned with managing people, including those related to employment rights and working conditions.</li><li>• assessing opportunities for promoting employees' mental well-being and managing risks. Ensuring systems are in place for assessing and monitoring the mental well-being of employees so that areas for improvement can be identified and risks caused by work and working conditions addressed. This could include using employee attitude surveys and information about absence rates, staff turnover and investment in training and development, and providing feedback and open communication.</li><li>• flexible working. If reasonably practical, provide employees with opportunities for flexible working according to their needs and aspirations in both their personal and working lives. Different options for flexible working include part-time working, home-working, job sharing and flexitime. Such opportunities can enhance employees' sense of control and promote engagement and job satisfaction.</li><li>• the role of line managers. Strengthen the role of line managers in promoting the mental well-being of employees through supportive leadership style and management practices.</li><li>• supporting micro, small and medium-sized businesses. Collaborate with micro, small and medium-sized businesses and offer advice and a range of support and services. This could include access to occupational health services (including counselling support and stress management training).</li></ul> <p>There is evidence to suggest that investment in healthy working practices and the health and well-being of employees improves productivity and is cost effective for businesses and wider society. Research suggests that successful organisations share the characteristics of a healthy working environment</p>
(Ng & Feldman 2008) Meta-analysis	<p><b>Long work hours: A social identity perspective on meta-analysis data</b></p> <p>Meta-analysis of hours worked and various correlates (seems to use cross-sectional, self-report data). Finds reliable associations between hours worked and job stress (<math>r = .13</math>, <math>k = 23</math>, <math>n = 16268</math>), mental strain (<math>r = .06</math>, <math>k = 38</math>, <math>n = 21280</math>). There was no association with physical health complaints (<math>r = .00</math>, <math>k = 29</math>, <math>n = 16367</math>). Found that various psychosocial hazards (role conflict, performance pressures, overload) were associated with hours worked, indicating some characteristics of poor jobs tend to go together.</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
(Novack et al. 2007) Conceptual review	<b>Psychosomatic medicine: the scientific foundation of the biopsychosocial model</b> Comprehensive overview of the physiological and psychological mechanisms underpinning the BPS perspective, written from a medical standpoint. Useful as a point of reference that underpins the robustness of the scientific understanding of the BPS model and justifies it as more complete perspective than the bio-medical model alone.
(Okunribido 2009) Report	<b>Lower limb musculoskeletal disorders - scoping work to help inform advice and research planning. (HSE Research Report: RR 706)</b> This work was commissioned to examine more closely the nature and extent of workplace lower limb musculoskeletal disorders and injuries (LLD) and the causal agents with the aim of informing evidence based guidance and advice for workers and employers. LLDs, particularly knee conditions, are a problem in many workplaces and they tend to be associated with conditions ( <i>actually reports of symptoms</i> ) in other areas of the body. Both acute and ( <i>so-called</i> ) overuse injuries may be suffered by workers, although overuse injuries tend to be more common. There are consequences of occupationally caused LLD for society, the economy and industry in terms of lost working time, medical treatment and hospitalisation, decreased ability to carry out the work, and effects on quality of life. The particular impact depends on the condition and the number of joints affected. The risk factors for LLD are not specific to any of the sites of the lower extremities and they are also associated with disorders in other regions of the body such as the upper limb and torso. There is appreciable evidence of a causal association for kneeling/squatting, climbing stairs or ladders, heavy lifting, walking/standing, and slips and trips hazards as risk factors for LLD. The evidence of a causal association is plausible but less clear for jumps from height (e.g., from a vehicle's bed or cabin to the ground), driving and sitting. There is appreciable evidence for implementation of workplace redesign/modification initiatives, implementation of protection equipment and participatory programmes as interventions for control and prevention of LLD risks, and it was possible to identify useful strategies that may be applied. Further work is recommended to clarify the inter-relationships between injury/pain at different regions of the body; to provide more detailed measures of workplace ergonomics risk exposures; to determine the suitability of existing control strategies and prevention interventions that have been proposed against conditions in other regions of the body (back and upper limbs); to explore the benefits of exercise regimes and coping programmes for those with a condition; and to identify strategies other than regulation that would aid increased awareness of the problems in workplaces and encourage commitment of employers. ( <i>The review looks at a wide range of risk factors (physical, personal and occupational) but the majority of the studies reviewed were not prospective, thus limiting conclusions about cause-effect: the odds ratios tended to be modest. LLDs clearly can be work-relevant, and the review found some evidence that modified work could be effective for reducing lower limb symptoms – overall the findings suggest that comfortable and accommodating work should be beneficial in respect of lower limb complaints</i> ). (See also Table 1).
(Okunribido	<b>Ageing and work-related musculoskeletal disorders - A review of the recent literature (HSE Research Report: RR 799)</b>

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<b>Authors</b>	<b>Key features (Reviewers' comments in italic)</b>
& Wynn 2010)  Report	<p>Aim was to review of the recent literature concerning ageing and occupational musculoskeletal disorders (MSD), and to carry out scoping activities to inform the formulation of future policy or guidance and provision of advice. The authors concluded that attitudes towards ageing and work are changing. More employers regard older workers as a valuable asset and are willing to keep current employees on for longer periods past the usual retirement age. However, while many do now appreciate the value of older workers, only a few workplaces actually implement measures, to support and increase their retention of older workers. Age is not an independent risk factor for work-related MSD. Older workers are more susceptible to work-related MSD than younger workers because of decreased functional capacity. The propensity for injury is related more to the difference between the demands of work and the worker's physical work capacity (or work ability) rather than their age. An older workforce has implications for the health and safety responsibilities of employers. These include providing additional support for worker requirements, changing the workplace attitudes towards ageing, providing a positive knowledge base, adjusting the workplace design and accommodations and improving worker/employer relationships (co-operation).</p> <p><i>16 studies were included in the tables of 'Risk factors for work-related MSD/injuries in populations of workers including aged workers'. Of these, 10 were cross-sectional and 6 were prospective. 15 used only subjective, self-report measures, and only 1 used any type of objective/clinical assessment.</i></p> <p><i>6 studies were included in the tables of 'Risk factors for post MSD injury outcomes in populations of industrial workers'. Of these, 4 were cross-sectional and 2 were prospective. All 6 used only subjective, self-report measures, and none used any type of objective/clinical assessment.</i></p>
(Packham & Webster 2009)  Report	<p><b>Psychosocial working conditions in Britain in 2009</b></p> <p>This report presents analysis of 2009 data from an annual series of surveys on psychosocial working conditions which began in 2004. These surveys were set up to monitor changes in the psychosocial working conditions of Demand, Control, Managerial Support, Peer Support, Role, Relationships and Change in British workplaces.</p> <p>The survey results from 2004 to 2009 indicate that psychosocial working conditions have not generally changed over this period to any great extent, although the scores on the Change scale and on Managerial Support show a significant upward trend (i.e. an improvement). In the 2007 report it appeared that an improvement in population level working conditions may be emerging, however the 2008 and 2009 results do not show a continuation of that trend. There is no longer a downward trend in the number of employees reporting that their job is very or extremely stressful and little change in the number of employees aware of stress initiatives in their workplace or reporting discussions about stress with their line managers.</p>
(Palmer et al. 2010)  Report	<p><b>Reducing the impact of occupationally-related musculoskeletal disorders - Arthritis Research UK: technical report</b></p> <p>Use of a targeted literature review to: identify the leading musculoskeletal reasons for sickness absence in working aged people; estimate the approximate burden of sickness absence attributed to musculoskeletal causes in Great Britain, and the approximate associated economic costs; identify effective measures to prevent sickness absence and health-related job loss arising from musculoskeletal causes among British workers; explore how best to manage musculoskeletal illness and disease in British workers, with a focus on measures that can be applied in</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>the workplace and community to reduce sickness absence and health-related job loss.</p> <p>Conclusions</p> <ul style="list-style-type: none"> <li>• National statistics on MSD-related sickness absence are fragmentary, incomplete, and lacking in important diagnostic detail; information on trends is rather limited. Statistics fail to count presenteeism, or to consider health-related job loss in any meaningful way, or to inform understanding about health inequalities in MSD-related adverse vocational outcomes.</li> <li>• The peer-reviewed literature on interventions to reduce adverse employment outcomes of musculoskeletal illness is reasonably large. However, there is a want of relevant studies from the UK, and of studies on upper limb pain and health-related job loss. Studies to date have mostly been small and many have had key methodological limitations that could be remediated in better quality studies. Most interventions are reported as having positive benefits, but such benefits seem fairly modest and there is evidence of publication bias (i.e. true effects could be smaller still): better quality and larger studies show less evidence of benefit than smaller and lower quality studies. Studies that include an economic evaluation are few in number and so far do not prove or disprove a net cost benefit. No intervention can be endorsed as clearly superior to others. However: Very resource intensive approaches showed little or no evidence of benefit. Studies involving the setting of graded tasks were somewhat more positive than other studies (the evidence base is not sufficient to support firm recommendations). Quite a lot of evidence suggests that approaches geared solely at the individual (e.g. exercise therapy) produce only modest, if any, benefits. Although interventions involving the workplace were not clearly superior overall, the only two larger high quality studies involving workplace modifications and occupational health input showed the biggest effects on return to work.</li> </ul>
(Palthe & Kossek 2003)	<p><b>Subcultures and employment modes: Translating HR strategy into practice</b></p> <p>Based on literature review. Argue that HR strategies can be tailored to suit different sub-cultures in an organisation. (Note at least different sub-cultures need to be taken into account)</p>
Conceptual review	
(PRIMA 2008)	<p><b>The European Framework for Psychosocial Risk Management: PRIMA-EF</b></p> <p>The book was first published by the Institute of Work, Health and Organisations and guidance based on this was published in a separate report. Earlier publications from the same authors formed the basis for this (see Table entry for Leka et al 2008 – Table 4). The guidance is accompanied by 10 two-page information sheets: Psychosocial Risk Management - European Framework: Key Aspects; Psychosocial Risk Management - European Framework: Enterprise Level; Psychosocial Risk Management - European Framework: Macro Policy Level; Making Social Dialogue successful for Psychosocial Risk Management; The Perception of Psychosocial Risk Factors among European Stakeholders; Corporate Social Responsibility and Psychosocial Risk Management at Work; European and International Standards Related to Psychosocial Risks at Work; Monitoring Psychosocial Risks at Work; Best Practice in Work-related Stress Management Interventions; and, Best Practice</p>
Report & Book	

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<b>Authors</b>	<b>Key features (Reviewers' comments in italic)</b>
	<p>in Workplace Violence and Bullying Interventions.</p> <p><i>The overall guidance package (including information sheets) describes psychosocial risk at four levels: societal factors, organisational factors, individual working factors, and individual characteristics. Advice is provided that to prevent and manage psychosocial risks at the workplace and their negative impact, preventive action or interventions should be implemented that are primarily directed at sources of risk at the workplace and the organisational level but are supplemented by actions directed at the individual workers, their skills, abilities and capacities. Guidance about preventive actions and interventions is limited to a small range of approaches such as 'improving autonomy, control and organisational resources' and 'improving coping capacity, providing information and training' (both p. 33).</i></p>
(Robson et al. 2010) Report	<p><b>A systematic review of the effectiveness of training &amp; education for the protection of workers (for the Institute for Work &amp; Health, IWH &amp; National Institute for Occupational Safety and Health NIOSH)</b></p> <p>This review found a lack of high quality randomized trials in the area of OHS training effectiveness. Twenty-two randomized trials were identified through the search and relevance screening. Of these, 14 were considered of sufficient methodological quality to proceed to final evidence syntheses. The trials comprised a wide range of study populations, interventions and outcomes. The modest number of trials available, plus their heterogeneity, limited the ability of the review to draw more definitive conclusions. This was particularly the case for the effect of training (versus control) on Knowledge, and on Attitudes &amp; Beliefs, and on the relative effect of higher versus lower engagement training on each of Knowledge, Attitudes &amp; Beliefs and Health. In contrast, there were sufficient higher quality studies to meaningfully examine the size and consistency of training's effects on OHS Behaviours and on Health. With regard to Behaviours, the review found strong evidence of training's effectiveness. The conclusion was based on six studies, three of which involved training directed at ergonomic hazards and three of which involved training directed at other types of hazards. Most involved one or two training sessions. The median effect size in the body of evidence was considered large by the review team: standardized mean difference (SMD) = +1.09. There were also enough higher quality studies to meaningfully examine the size and consistency of the effects of OHS training on category of Health. Interventions involved one to three sessions and were directed at a variety of OHS hazards. The data in this review show inconsistent and small effects of OHS training on Health. Therefore, the review team considered the evidence insufficient to conclude whether OHS training has or does not have an effect on Health. Though a lack of studies prevented a meaningful examination of the size of training's effects on Knowledge and Attitudes &amp; Beliefs, the review's preliminary findings on Knowledge and Attitudes &amp; Beliefs are consistent with the evidence on Behaviours. The respective effects observed on Knowledge and Attitudes &amp; Beliefs in the higher quality studies are positive and sizeable: median SMDs equal to +2.52 and + 0.84, respectively. This is expected, since knowledge, attitudes and beliefs mediate the effect of training on behaviours. Current learning theory suggests that high engagement training, which involves an application of knowledge and skills in a work-like setting, will have a greater impact on workers than low or medium engagement training. There was a sufficient number of higher quality studies examining this contrast with behaviour as an outcome; effects were consistent, but very small. The review team concluded there is insufficient evidence of high engagement training (single session) having a greater impact on OHS- related behaviours compared to low/medium engagement training (single session). These results should not be generalised to training involving a large number of training</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>sessions.</p> <ul style="list-style-type: none"><li>• Conclusions</li><li>• There is strong evidence for the effectiveness of training on worker OHS behaviours. The size and direction of the effects observed to date for knowledge and attitudes and beliefs are consistent with the evidence on behaviours.</li><li>• There is insufficient evidence of the effectiveness of training on health (i.e. injuries, symptoms), because there are inconsistent and small effects. The inconsistency arises from finding both negative and small, positive effects in the training versus control studies. No large, positive effects are observed in these studies.</li><li>• There is insufficient evidence that high engagement training is more effective than medium/low engagement training on knowledge, attitudes or health.</li><li>• There is insufficient evidence that a single session of high engagement training has a greater effect than a single session of low or medium engagement training on behaviours. The observed effects are very small.</li></ul> <p>Key Message for stakeholders</p> <ul style="list-style-type: none"><li>• Current evidence indicates positive associations between OHS training and the knowledge and attitudes of workers. However, OHS training as a lone intervention has not been demonstrated to have an impact on health (e.g. injuries, symptoms).</li></ul>
(RCP 2008)	<p><b>Mental Health and Work</b></p> <p>This report was commissioned by the cross government Health Work and Well-being Programme</p> <p>Report People with mental health problems can be divided into three broad groups:</p> <ol style="list-style-type: none"><li>1. At any one time, one-sixth of the working age population of Great Britain experience symptoms associated with mental ill health such as sleep problems, fatigue, irritability and worry that do not meet criteria for a diagnosis of a mental disorder but which can affect a person's ability to function adequately.</li><li>2. A further one-sixth of the working age population have symptoms that by virtue of their nature, severity and duration do meet diagnostic criteria. These common mental disorders would be treated should they come to the attention of a healthcare professional. The commonest of these disorders are depression, anxiety or a mix of the two.</li><li>3. The most recent national survey found that about 0.5% of the population has a probable psychotic illness and the generally accepted estimate is that between 1% and 2% of the population will have a severe mental illness, such as schizophrenia, bipolar disorder or severe depression, which requires more intensive, and often continuing, treatment and care during their lifetime.</li></ol> <p>Factors that affect the prevalence of mental health problems: Compared with those who do not have a disorder, people aged 16 to 74 with a common mental disorder are more likely to be women (59%) and to be aged between 35 and 54 (45% compared with 38%). They are also more often disadvantaged socially in that they are more likely to be separated or divorced (14% compared with 7%), to live alone (20% compared with 16%) or as a one parent family (9% compared with 4%), to have no formal qualification (31% compared with 27%), to come</p>

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<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>from Social Class V (7% compared with 5%) and to be a tenant of a local authority or a housing association (26% compared with 15%) (Singleton et al, 2000). Because of these associations, there are more people with mental health problems in areas of the country that have high levels of social and economic deprivation. This is reflected in greatly increased rates of presentation and treatment of mental disorders in both primary and secondary care in socially deprived areas and, in particular, in deprived inner city area. In keeping with this, rates of claims for Incapacity Benefits on grounds of mental and behavioural disorders are highest in urban areas.</p> <p>Association between mental health and physical health: People with mental health problems are more likely to develop physical health problems and vice versa. Furthermore, people with mental health problems can present to their GP or employer complaining of physical symptoms that have no physical cause. This can sometimes lead to missed or delayed detection of the underlying mental health problem. The interaction between physical and mental health is complex and it is often difficult to determine the direction of causal relationships.</p> <p>Treatment and outcomes: Many people who develop a common mental disorder do not seek help from healthcare services or if they do their mental health problem is not detected. Surprisingly little is known about the course of the mental health problem and the longer term outcome for this group of people. For those whose mental health problems are detected, there are drug and psychotherapeutic treatments that are effective for many people at both shortening the duration of the disorder and in reducing the likelihood of relapse.</p>
(Sainsbury et al. 2008)  Report	<p><b>Mental health and employment (Research Report No 513 to Department for Work and Pensions)</b></p> <p>This report presents findings of a qualitative research project commissioned by the Department for Work and Pensions (DWP) to investigate the relationship between mental health and employment. The study drew on the accounts of 60 current or former IB recipients and 52 representatives of employing organisations to explore understandings of mental health, the experience and impact of mental health conditions in the workplace, and transitions out of and into work for people with experience of mental ill health. In drawing out the implications for policy seeking to help people with mental health conditions enter or stay in work, the findings indicate that, while there are important roles for employers and government, salient activities and responses go beyond the remit of these parties, to include medical practitioners and also society more broadly. The findings point to the importance of increasing ‘mental health literacy’ among individuals experiencing mental ill health, their employers and the wider population. Lack of understanding, misconceptions and a reluctance to discuss mental health contributed to the negative employment experiences and outcomes for some people in this study, underlining the importance of initiatives already underway to increase public and employer understandings of mental illness and how to promote mental well-being. The complex factors underlying the mental ill health of many people in the study highlight a need for employers to take a broad understanding of mental health that encompasses both medical and social influences on well-being. The accounts of employers involved in the study demonstrated a willingness to employ individuals experiencing mental health conditions and that (particularly in larger organisations) effective support and adjustments can be facilitated. For many, these views were based on their past experiences of employing people with mental health conditions, and their intentions to continue to do so. Amongst employers with little past experience, most said that they would be willing to try this in the future, depending on the type of work, and the type of mental health condition. However, the retention strategies of employers can only be implemented where an employee’s mental health condition is known about. Enhanced mental health literacy would hopefully</p>



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	encourage individuals to talk to their employer about any difficulties they experience, but at the same time, employers may gain greater confidence in recognising the indications of a mental health condition and so broaching this topic where a member staff seems unwell. Early identification and intervention of this type might enable responses and adjustments to be made sooner, thus preventing prolonged sickness absence or ultimate job loss. There are already resources in existence that give advice to employers on recognising the indications of stress or more acute mental ill health in employees. A systematic awareness-raising campaign to bring these resources to the attention of managers, particularly in small and medium-sized organisations, might increase knowledge and confidence in recognising and responding to employees experiencing mental health conditions. The study findings also support the case for initiatives currently under way that aim to increase access to occupational health services for small and medium-sized employers.
(Sanderson & Andrews 2006)  General review	<b>Common mental disorders in the workforce: recent findings from descriptive and social epidemiology</b> <i>(Reviews epidemiological surveys (but still tends to use self-reports)).</i> Prevalence: "As in the general population, simple phobia was the most common disorder in the workforce, followed by depression. Variation by occupation was examined in 3 of the studies, with 2 finding minimal significant differences by standard occupational classifications ... [with] lower rates of depression among professionals and craftspeople and higher rates among clerical or sales workers and labourers. Higher rates of most anxiety disorders were reported for clerical workers, whereas lower rates were reported for professionals, managers, and craftspeople" p 65. Highest participation rates in the labour force were for people with depression, simple phobia, social phobia, and generalised anxiety disorder. Most of these people worked full time. "The tendency of people with depression to continue to come to work despite their illness represents a hidden cost of depression" ..... contributing factors could also include a lack of recognition that depression is the cause of ill health or fear of stigma if the reasons for sick leave were to be disclosed. Both these situations could be addressed by mental health literacy interventions that encourage recognition of symptoms and treatment seeking" p 71 Sickness absence There were no consistent patterns of associations between mental health problems across studies with sickness absence, but there were more consistent associations between mental health problems and days in which performance was reduced - especially for anxiety and depression. Suggests underemployment is associated with depression, but this cannot be explained by people with depression seeking less demanding work. Reinforces conclusions that low control, high demands, low social support are associated with increased risk of anxiety and depression ( <i>note: this is the basis of the Management Standards, and is an oversimplification</i> ), but adds effort-reward imbalance (where rewards are broadly conceived in terms of job security, career progression as well as pay) and work-place justice (procedural relating to fairness of procedures and relational relating to considerate interpersonal treatment). Conclusions concerning atypical employment contracts (e.g. fixed term, seasonal) were not clear cut ( <i>note other sources consider job security an important aspect of good work and high performance work</i> ).

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	"Interventions can include encouraging employee control over timing of work tasks, redesigning jobs to reduce time pressures, and clarifying expected duties and outcomes. Regarding the effort–reward model, restoring a balance between efforts and rewards may have positive mental health consequences. Possible interventions are additional reward schemes, supervisor training in transmitting praise for good work, clear pathways to promotion, and access to training for career development .... As for organizational justice, the fairness and transparency of decision-making processes was most consistently related to onset of significant depressive and anxiety symptoms. Interventions can include allowing clarification and additional information, ensuring adequate representation by affected parties, adequately justifying decisions, and communicating to staff the information used to make a decision so that they are informed of its completeness and accuracy" pp 71-72 <i>Note: these recommendations are for the kind of interventions that should follow from Management Standards style approaches, and therefore do not take into account individual variability and coping potentials – so whilst they are sensible by themselves they are probably insufficient without other forms of intervention (e.g. training).</i>
(Savolainen 2000) Original study	<p><b>Towards a new workplace culture: Development strategies for employer-employee relations</b></p> <p>Qualitative longitudinal case study based on interviews and documentary analysis of three organisations. Suggests that good HR implementation is based on an incremental cognitive changes which is a leader driven and learning process. Incremental cognitive change leads to increasing trust and cooperation. HR implementation requires visible leadership and good leadership skills.</p> <p>Indicates change needs a clear signal that something is wrong or needs to done (<i>note and this is relevant for the organisation and probably its performance - a clear link needs to be made between current performance, potential improvements and the need for a specific initiative</i>).</p> <p>Indicates resistance comes from specific stakeholders or institutionalised practices and needs to be overcome. This opposition might lead to changes in implementation or strategy (<i>note, indicates importance of consultation</i>).</p> <p>Top management involvement in implementing the strategy seems to be important in developing the strategy. Internal experts and consultants were also important for over-coming resistance. Time was taken to build trust, to change mindsets and involve stakeholders.</p> <p>Persistence was mentioned as a key facilitator.</p> <p>Not that implementation although leader-driven is highly interactive.</p>
(Schulte & Vainio 2010) Discussion paper	<p><b>Well-being at work – overview and perspective</b></p> <p>This paper provides an overview of and perspective on the concept of well-being at work. Well-being is a term that reflects not only on one's health but satisfaction with work and life. Well-being is a summative concept that characterizes the quality of working lives, including occupational safety and health aspects, and it may be a major determinant of productivity at the individual, enterprise and societal levels. Based on a review of the literature and a recent conference, we suggest a model linking workforce well-being, productivity, and population well-being. To appraise the validity of the model, we consider five questions: (i) is there a robust and usable definition of workplace well-being? (ii) have the variables that influence well-being been aptly described and can they be measured and used in risk assessments? (iii) what is the nature of evidence that well-being is linked to productivity? (iv) what is the state of knowledge on the effectiveness of interventions to promote workplace well-being? and (v) should interventions aimed at improving well-being at work focus on more than</p>

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	work-related factors?
(Shaw et al. 2007) Report	<p><b>A staged approach to reducing musculoskeletal disorders (MSDs) in the workplace: A long term follow-up (HSE Research Report: RR 545)</b></p> <p>Behaviour is a crucial factor in the reduction of many of today's most widespread diseases and health problems, including MSDs. Most interventions aimed at reducing MSDs focus on the physical aspects of the work environment and the job task, rather than tackling 'psychological' factors such as risk perception or management commitment. Such an approach overlooks important psychosocial influences, which have been found to be associated with MSDs.</p> <p>Recent research by the authors attempted to improve the efficacy of interventions by applying the stage of change model to the workplace. This study investigated whether the positive findings seen at 6 months persist over the long term, the authors conducted a longer-term follow-up of the interventions at 15 months post-intervention and at 20 months post-intervention. The effectiveness of tailored compared to standard interventions was measured in terms of: stage of change and self-reported musculoskeletal discomfort.</p> <p>Both the quantitative and qualitative findings of this work support previous calls for the application of the stage of change approach to occupational health and safety, suggesting that scope exists for improving the success of health and safety interventions by tailoring advice according to stage change. By focusing on the attitudes, beliefs, and behavioural intentions that underpin an individual's current stage, tailored approaches can increase the uptake, implementation, and maintenance of risk-reducing measures.</p>
(Tompa et al. 2008) Systematic review	<p><b>A systematic review of disability management interventions with economic evaluations</b></p> <p>A systematic literature review of disability management interventions to answer the question: "what is the credible evidence that incremental investment in disability management interventions is worth undertaking?" There was strong evidence supporting the economic merits of multi-sector disability management interventions. For stratification by intervention components, there was moderate evidence for interventions that included an education component, moderate evidence for those with physiotherapy, limited evidence for those with a behavioural component, and moderate evidence for those with a work/vocational rehabilitation component. For stratification by intervention features, there was moderate evidence for interventions that included a work accommodation offer, contact between health care provider and workplace, early contact with worker by workplace, ergonomic work site visits, and interventions with a return-to-work coordinator. It was concluded that there was credible evidence supporting the financial benefits of disability management interventions for one industry cluster and several intervention components and features.</p>
(Tompa et al. 2009) Systematic review	<p><b>A systematic review of occupational health and safety interventions with economic analyses</b></p> <p>A systematic review of the occupational health and safety intervention literature to synthesize evidence on financial merits of such interventions. There was strong evidence that ergonomic and other musculoskeletal injury prevention interventions in manufacturing and warehousing are worth undertaking in terms of their financial merits. There was strong evidence that multi-sector disability management interventions are worth undertaking. While the economic evaluation of interventions in this literature warrants further expansion, there were</p>

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	sufficient studies to identify strong, moderate, and limited evidence in certain industry-intervention clusters. The review also provided insights into how the methodological quality of economic evaluations in this literature could be improved.
(Tomba et al. 2010) Systematic review	<b>A systematic review of workplace ergonomic interventions with economic analyses</b> A systematic review of workplace ergonomic interventions with economic evaluations, to answer the question: "what is the credible evidence that incremental investment in ergonomic interventions is worth undertaking?" Past efforts to synthesize evidence from this literature have focused on effectiveness, whereas this study synthesizes evidence on the cost-effectiveness/financial merits of such interventions. In the manufacturing and warehousing sector strong evidence was found in support of the financial merits of ergonomic interventions from a firm perspective. In the administrative support and health care sectors moderate evidence was found. In the transportation sector limited evidence, and in remaining sectors insufficient evidence was found. Often only a small part of the overall evaluation of many studies focused on evaluating their cost-effectiveness.
(van Wyk & Pillay-Van Wyk 2010) Cochrane review	<b>Preventive staff-support interventions for health workers</b> Cochrane systematic review included ten studies (n=716 subjects). None assessed the effects of support groups for health workers. Eight studies assessed the effects of training interventions in various stress management techniques on measures of stress and/or job satisfaction, and two studies assessed the effects of management interventions on stress, job satisfaction and absenteeism (one assessed an intervention involving process consultation for nurse managers to improve their problem solving ability in interdisciplinary staff teams, and the other assessed the effect of an intervention aimed at improving managers ability to manage organisational change on job satisfaction). Of the two studies that assessed the effects of stress management training interventions on job satisfaction, neither - using low and moderate levels of intensity in training interventions, respectively - demonstrated a positive effect of the intervention on job satisfaction over the short (less than one month after the intervention) or medium term (between one and six months after the intervention). The results of one study show no difference in job satisfaction among nurses and nurse aides who received four sessions of mindfulness training; and, the results of the second show no difference in job satisfaction between health workers who received six sessions of stress management training post-intervention. The single study of a change management intervention demonstrated a small beneficial effect on job satisfaction among the intervention group on 30-week follow-up measure after the intervention, compared to the control group. The authors concluded there is insufficient evidence for the effectiveness of stress management training interventions to reduce job stress and prevent burnout among healthcare workers beyond the intervention period. Low quality evidence suggests that longer-term interventions with refresher or booster sessions may have more sustained positive effect, but this needs to be rigorously evaluated in further trials. (See also Table 3).
(Waddell & Aylward 2010)	<b>Models of sickness and disability applied to common health problems</b> Advocates a biopsychosocial approach to sickness and disability, and suggests we all inevitably take such an approach. Healthcare helps to control symptoms (and disease) and relieve suffering, but management of common health problems is not a matter for healthcare alone. Employers have responsibilities to accommodate people with common health problems and take a proactive approach. people with common

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<b>Authors</b>	<b>Key features</b> ( <i>Reviewers' comments in italic</i> )
Conceptual review	health problems have a responsibility too – they must decide whether their health condition is such that it would be unreasonable to expect them to work. Social policy should support all these stakeholders to adopt the best solutions. Much sickness absence and disability due to common health problems should be preventable. Better management can be achieved, but only by a fundamental change in culture and by all players working towards common goals.
(Waddell & Burton 2004) Conceptual review	<b>Concepts of rehabilitation for the management of common health problems</b> <i>(This review, undertaken for the Department for Work and Pensions, explored concepts of rehabilitation for common health problems in general, not just musculoskeletal problems).</i> “The stereotype of disability is a severe medical condition with objective evidence of disease and permanent physical or mental impairment (e.g. blindness, severe or progressive neurological disease, or amputation). In fact, most sickness absence, long-term incapacity for work and premature retirement on medical grounds are now caused by less severe mental health, musculoskeletal and cardio-respiratory conditions. These ‘common health problems’ often consist primarily of symptoms with limited evidence of objective disease or impairment. Importantly, many of them are potentially remediable and long-term incapacity is not inevitable. Rehabilitation has traditionally been a separate, second-stage process, carried out after medical treatment has no more to offer yet recovery remains incomplete: the goal was then to overcome, adapt or compensate for irremediable, permanent impairment. That approach is inappropriate for common health problems, where the obstacles to recovery are often predominantly psychosocial in nature rather than the severity of pathology or impairment. In this situation, rehabilitation must focus instead on identifying and overcoming the health, personal/psychological, and social/occupational obstacles to recovery and (return to) work. This implies that rehabilitation can no longer be a separate, second stage intervention after ‘treatment’ is complete. The evidence shows that the best time for effective rehabilitation is between about 1 and 6+ months off work (the exact limits are unclear). Earlier, most people recover and return to work uneventfully: they do not need any specific rehabilitation intervention and the priority is not to obstruct natural recovery. Later, the obstacles to return to work become more complex and harder to overcome: rehabilitation is more difficult and costly, and has a lower success rate. To take maximum advantage of this window of opportunity and minimize the number going on to long-term incapacity, rehabilitation principles should be an integral part of good clinical and occupational management: .... Common health problems are not only matters for health care, but much broader public health issues of ‘health at work’. Sickness absence and return to work are social processes that depend on work-related factors and employer attitudes, process and practice. This requires employers, unions and insurers to re-think occupational management for common health problems: addressing all of the health, personal and occupational dimensions of incapacity, identifying obstacles to return to work, and providing support to overcome them. The same principles are equally applicable to job retention, early return to sustained work and reintegration. This should not obscure the importance of the individual’s own role in the management of common health problems. Rehabilitation is an active process that depends on the participation, motivation and effort of the individual, supported by health care and employers.

**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>....</p> <p>Action depends on accepting ownership of the problem. Everyone – workers; employers, unions and insurers; health professionals; government and the taxpayer – has an interest in better outcomes for common health problems. Effective management depends on getting ‘all players onside’ and working together to that common goal. This is partly a matter of perceptions (by all the players). It requires a fundamental shift in the culture of how we perceive and manage common health problems, in health care, in the workplace, and in society. Better management and rehabilitation of common health problems is possible, can be effective, and is likely to be cost-effective.” (pp 3-4). (See also Tables 2, 3 and 4).</p>
(Waddell & Burton 2006)	<p><b>Is work good for your health and well-being?</b> (This comprehensive review was conducted for the Department for Work and Pensions to answer a key question regarding the relationship between work and health). “The review focused on adults of working age and the common health problems that account for two-thirds of sickness absence and long-term incapacity (i.e. mild/moderate mental health, musculoskeletal and cardio-respiratory conditions).” (p. vi). <i>For convenience, the main findings are reproduced here verbatim.</i></p>
Best evidence synthesis	<p>“<b>Work:</b> The generally accepted theoretical framework about work and well-being is based on extensive background evidence:</p> <ul style="list-style-type: none"><li>• Employment is generally the most important means of obtaining adequate economic resources, which are essential for material well-being and full participation in today’s society;</li><li>• Work meets important psychosocial needs in societies where employment is the norm;</li><li>• Work is central to individual identity, social roles and social status;</li><li>• Employment and socio-economic status are the main drivers of social gradients in physical and mental health and mortality;</li><li>• Various physical and psychosocial aspects of work can also be hazards and pose a risk to health.</li></ul> <p><b>Unemployment:</b> Conversely, there is a strong association between worklessness and poor health. This may be partly a health selection effect, but it is also to a large extent cause and effect. There is strong evidence that unemployment is generally harmful to health, including:</p> <ul style="list-style-type: none"><li>• higher mortality;</li><li>• poorer general health, long-standing illness, limiting longstanding illness;</li><li>• poorer mental health, psychological distress, minor psychological/psychiatric morbidity;</li><li>• higher medical consultation, medication consumption and hospital admission rates.</li></ul> <p><b>Re-employment:</b> There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is more or less comparable to the adverse effects of job loss.</p> <p><b>Work for sick and disabled people:</b> There is a broad consensus across multiple disciplines, disability groups, employers, unions, insurers and all political parties, based on extensive clinical experience and on principles of fairness and social justice. When their health condition permits, sick and disabled people (particularly those with ‘common health problems’) should be encouraged and supported to remain in or to</p>

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Authors	<i>Key features (Reviewers' comments in italic)</i>
	<p>(re)-enter work as soon as possible because it:</p> <ul style="list-style-type: none"> <li>• is therapeutic;</li> <li>• helps to promote recovery and rehabilitation;</li> <li>• leads to better health outcomes;</li> <li>• minimises the harmful physical, mental and social effects of long-term sickness absence;</li> <li>• reduces the risk of long-term incapacity;</li> <li>• promotes full participation in society, independence and human rights;</li> <li>• reduces poverty;</li> <li>• improves quality of life and well-being.</li> </ul> <p><u>Health after moving off social security benefits:</u> Claimants who move off benefits and (re)-enter work generally experience improvements in income, socio-economic status, mental and general health, and well-being. Those who move off benefits but do not enter work are more likely to report deterioration in health and well-being.</p> <p><u>Provisos:</u> Although the balance of the evidence is that work is generally good for health and well-being, for most people, there are three major provisos:</p> <ol style="list-style-type: none"> <li>1. These findings are about average or group effects and should apply to most people to a greater or lesser extent; however, a minority of people may experience contrary health effects from work(lessness);</li> <li>2. Beneficial health effects depend on the nature and quality of work (though there is insufficient evidence to define the physical and psychosocial characteristics of jobs and workplaces that are ‘good’ for health);</li> <li>3. The social context must be taken into account, particularly social gradients in health and regional deprivation.</li> </ol> <p><u>Conclusion</u></p> <p>There is a strong evidence base showing that work is generally good for physical and mental health and well-being. Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment. That is true for healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. The provisos are that account must be taken of the nature and quality of work and its social context; jobs should be safe and accommodating. Overall, the beneficial effects of work outweigh the risks of work, and are greater than the harmful effects of long-term unemployment or prolonged sickness absence. Work is generally good for health and well-being.” (pp vii-ix) (<i>Findings in respect of musculoskeletal problems are in Table 1, mental health are in Table 2, and stress in Table 3</i>).</p>
(Waddell et al. 2008)	<p><b>Vocational rehabilitation: what works, for whom, and when?</b></p> <p>“This review has demonstrated that there is a strong scientific evidence base for many aspects of vocational rehabilitation. There is a good business case for vocational rehabilitation, and more evidence on cost-benefits than for many health and social policy areas.</p>
Best evidence	<p>Common health problems should get high priority, because they account for about two-thirds of long-term sickness absence and incapacity</p>

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<b>Authors</b>	<b>Key features (Reviewers' comments in italic)</b>
synthesis	<p>benefits, and much of this should be preventable. Vocational rehabilitation principles and interventions are fundamentally the same for work related and other comparable health conditions, irrespective of whether they are classified as injury or disease. ....</p> <p>Healthcare has a key role, but vocational rehabilitation is not a matter of healthcare alone – the evidence shows that treatment by itself has little impact on work outcomes. Employers also have a key role - there is strong evidence that proactive company approaches to sickness, together with the temporary provision of modified work and accommodations, are effective and cost-effective. (Though there is less evidence on vocational rehabilitation interventions in small and medium enterprises). Overall, the evidence in this review shows that effective vocational rehabilitation depends on work-focused healthcare <i>and</i> accommodating workplaces. <i>Both</i> are necessary: they are inter-dependent and must be coordinated.</p> <p>The concept of early intervention is central to vocational rehabilitation, because the longer anyone is off work, the greater the obstacles to return to work and the more difficult vocational rehabilitation becomes. It is simpler, more effective and cost-effective to prevent people with common health problems going on to long-term sickness absence. A ‘stepped-care approach’ starts with simple, low-intensity, low-cost interventions which will be adequate for most sick or injured workers, and provides progressively more intensive and structured interventions for those who need additional help to return to work. This approach allocates finite resources most appropriately and efficiently to meet individual needs.</p> <p>Effective vocational rehabilitation depends on communication and coordination between the key players – particularly the individual, healthcare, and the workplace.</p> <p>....</p> <p>There is strong evidence on effective vocational rehabilitation interventions for musculoskeletal conditions. For many years the strongest evidence was on low back pain, but more recent evidence shows that the same principles apply to most people with mostcommon musculoskeletal disorders. Various medical and psychological treatments for anxiety and depression can improve symptoms and quality of life, but there is limited evidence that they improve work outcomes. There is a lack of scientific clarity about ‘stress’, and little or no evidence on effective interventions for work outcomes. There is an urgent need to improve vocational rehabilitation interventions for mental health problems. 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 and so prevent long-term sickness.</p> <p>Current cardiac rehabilitation programmes focus almost exclusively on clinical and disease outcomes, with little evidence on what helps work outcomes: a change of focus is required. Workers with occupational asthma who are unable to return to their previous jobs need better support and if necessary retraining.” (pp 5-6)</p> <p>“1. Vocational rehabilitation is <i>whatever helps someone with a health problem to stay at, return to and remain in work</i>. It is an idea and an approach as much as an intervention or a service.</p> <p>2. This review has demonstrated that there is now a strong scientific evidence base for many aspects of vocational rehabilitation.</p>



**Table 4: Generic issues**

<i>Authors</i>	<i>Key features (Reviewers' comments in italic)</i>
	<p>3. There is a good business case for vocational rehabilitation, and more evidence on cost-benefits than for many health and social policy areas.</p> <p>4. Common health problems should get high priority, because they account for about two-thirds of long-term sickness absence and incapacity benefits and much of this should be preventable. Return-to-work should be one of the key outcome measures.</p> <p>5. Vocational rehabilitation depends on work-focused healthcare <i>and</i> accommodating workplaces. To make a real and lasting difference, both need to be addressed and coordinated.</p> <p>6. Most people with common health problems can be helped to return to work by following a few basic principles of healthcare and workplace management. This can be done with existing or minimal additional resources, and is low cost or cost-neutral. Policy should be directed to persuading and supporting health professionals and employers to implement these principles.” (p. 8) <i>(This review was a policy document for the UK cross-sector Vocational Rehabilitation Task Group. It covered common health problems in general, not just musculoskeletal problems). (See also Tables 1, 2, 3).</i></p>
(Willness et al. 2007)  Meta-analysis	<p><b>A meta-analysis of the antecedents and consequences of workplace sexual harassment</b> Meta-analysis of sexual harassment. “In psychological terms, [sexual harassment] can be defined as “unwanted sex-related behaviour at work that is appraised by the recipient as offensive, exceeding her resources, or threatening her well-being” (Fitzgerald et al. 1999). Includes gender harassment, unwanted sexual attention and sexual coercion - "there are three aspects of organizational climate that are of particular importance, including perceived risk to victims for complaining, a lack of sanctions against offenders, and the perception that one’s complaints will not be taken serious" p 131 Climate was associated with sexual harassment <math>r = .33</math> (<math>k = 21</math>, <math>n = 55,529</math>). Based on primarily self-report and cross-sectional data, sexual harassment had reliable associations at around .20 with most indicators of psychological well-being (range 1.18 - 1.211), physical health (<math>r = -.21</math>) and productivity(<math>r = -.20</math>). (<math>k = 6 - 29</math>, <math>n = 4076 - 45,880</math>) Organizational practices to establish a climate to reduce sexual harassment include formal written guidelines for behaviour, procedures for filing grievances and investigating complaints, and education and training programs, as well as implementation, prevention, and enforcement practices.</p>
(WHO 2004)  Report	<p><b>Prevention of mental disorders: effective interventions and policy options</b> Prevention aims at “reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society” Key messages:</p> <ul style="list-style-type: none"><li>• Prevention of mental disorders is a public health priority</li><li>• Mental disorders have multiple determinants; prevention needs to be a multipronged effort</li><li>• Effective prevention can reduce the risk of mental disorders</li><li>• Implementation should be guided by available evidence</li></ul>

**Table 4: Generic issues**

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**Key features** (*Reviewers' comments in italic*)

- Successful programmes and policies should be made widely available
- Knowledge on evidence for effectiveness needs further expansion
- Prevention needs to be sensitive to culture and to resources available across countries
- Population-based outcomes require human and financial investments
- Effective prevention requires intersectoral linkages
- Protecting human rights is a major strategy to prevent mental disorders

Mental disorder prevention targets those determinants that have a causal influence, predisposing to the onset of mental disorders. Risk factors are associated with an increased probability of onset, greater severity and longer duration of major health problems. Protective factors refer to conditions that improve people's resistance to risk factors and disorders. They have been defined as those factors that modify, ameliorate or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome. Mostly, individual protective factors are identical to features of positive mental health, such as self-esteem, emotional resilience, positive thinking, problem-solving and social skills, stress management skills and feelings of mastery. For this reason, preventive interventions aiming to strengthen protective factors overlap largely with mental health promotion.

There is strong evidence on risk and protective factors and their links to the development of mental disorders. Both risk and protective factors can be individual, family-related, social, economic and environmental in nature. Mostly it is the cumulative effect of the presence of multiple risk factors, the lack of protective factors and the interplay of risk and protective situations that predisposes individuals to move from a mentally healthy condition to increased vulnerability, then to a mental problem and finally to a full-blown disorder.

Interventions to prevent mental ill-health aim to counteract risk factors and reinforce protective factors along the lifespan in order to disrupt those processes that contribute to human mental dysfunction. The more influence individual factors have on the development of mental disorders and mental health the greater the preventive effect that can be expected when they are addressed successfully.

*Despite offering the conclusion that mental disorders can be prevented no evidence from systematic reviews, or well-designed studies, is provided.*

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## Project Definitions

### **Accommodating (workplace)**

Good work can be defined by a number of characteristics that apply to work in general. What constitutes a good job, however, relies on local workplace circumstances and the perceptions of the individual worker and may or may not include all the characteristics of good work. For the purposes of the present project, a good job is one that is both comfortable and accommodating. Accommodation takes place at the individual level, perhaps under facilitative workplace policies. It seems that the features that make a workplace 'accommodating' include the following ideas:

An accommodating job/workplace:

- Is flexible enough to allow and offer temporary helpful individual-level changes when a worker is experiencing complaints and is having short-term difficulty with coping.
- Can offer changes in a variety of domains: work organisation, job tasks, job demands, etc. Allows worker to achieve an acceptable work-life balance.
- Facilitates individuals perceiving themselves as in control of their work conditions.

> *Accommodation*: (North American equivalent of *adjustment*) the process and implementation of changes to a job that enable a person with a disability to perform the job productively and/or to the environment in which the job is accomplished.

(NIDMAR  
2000)

> *Adjustment*: any modification or adaptation to work to meet an employee's health needs, whether or not they are disabled.

(HSE 2004)

> *Transitional work*: allows an employee with temporary restrictions to work in a modified, alternative, or reduced-hours capacity, for a defined period of time, while recuperating from an illness or injury [See also Modified Work].

(University of California San Francisco Medical Centre 2010: website)

> *Restrictions*: focus on what the person cannot or should not do, and describe the restrictions in work activities considered necessary for the person to stay at, or return to, their job. Usually prescribed clinically as part of treatment or rehabilitation, but when safety-critical may serve as a medical directive. Restrictions for CHPs should be imposed on a temporary basis, and may be modified with progress.

> *Modified work*: also referred to as transitional work arrangements, flexible working arrangements, adjustments, restrictions, or accommodations. These are changes to the individual's usual work tasks, equipment or organisation for the specific purpose of facilitating (early) return to work; it does not imply that work was the primary cause of the health problem. Work modification can be achieved, when required, through the use of ergonomics principles with input from the worker concerned.

(Waddell et al. 2008)

### **Comfortable (job)**

Good work can be defined by a number of characteristics that apply to work in general. What constitutes a *good job*, however, relies on local workplace circumstances and the perceptions of the individual worker and may or may not include all the characteristics of good work. For the purposes of the present project, a good job is one that is both comfortable and accommodating. The level of intervention to ensure a workplace is comfortable is usually at the group or

organisational level, but must also involve the individual. It seems that the features that make a job 'comfortable' include the following ideas:

- Reduces the probability of work-relevant common health problems and dissatisfaction with work, a good job subsumes this but also increases the probability for workers to progress towards personal goals and values that will give them satisfaction or to engage in activities they find intrinsically enjoyable. There is no implication in the concept of a comfortable job or good work that all individuals will find the same characteristics of the job either comfortable or not.
- Facilitates well-being
- Goes beyond safety, and the need to prevent harms.
- Takes account of physical and psychosocial comfort/needs.
- Minimises discomfort (both perceived and actual) and promotes well-being.
- Fosters job satisfaction.
- Reduces the likelihood of complaints (about symptoms, the job, and the organisation), and may (in principle) reduce the incidence of episodes of complaints (both physical and mental).
- Is different to an 'accommodating workplace' which describes the ability of the worker or his/her manager to change the work environment to respond when complaints are present
- Likely to involve group level intervention, or organisation wide.

### **Common health problems (CHP)**

CHPs are the categories of health complaints that occur most frequently across the population. They are typified by symptoms more than pathology, and tend to be recurrent in nature. Collectively they account for most loss of productivity, sickness absence, care seeking and health-related benefit claims. CHPs have several key features:

- Their ubiquity is consistently reported by multiple players: workers, employers and medical practitioners.
- They involve the report (e.g. to line manager, company occupational health, GP, or other healthcare provider) of one or more symptoms, yet in most instances there is limited objective evidence of injury, disease or impairment.
- Management of symptomatic episodes should be achievable and long-term problems are not inevitable.
- Evidence for occupational causation is contentious, inconsistent, or lacking, leading to ongoing debate. However, CHPs may temporarily reduce the person's ability to work: that is, they may be work-relevant but are not usually solely due to work.
- In occupational terms, the consequences are more important than any (assumed) pathology: with the right support, most people can remain active and stay at work or achieve early and sustained return from sickness absence.

(Waddell & Burton 2004; Waddell & Burton 2006; HSE 2009; Cox et al. 2009; CIPD 2009; Waddell & Aylward 2010)

For the purposes of this project three work-relevant CHPs predominate:

### **Musculoskeletal complaints (as a common health problem)**



The primary complaint is local or regional pain or discomfort that may or may not be associated with apparent injury and may or may not result in limitation or disability. This definition includes a wide variety of diagnostic labels including age-related musculoskeletal changes. It excludes major trauma and serious disease states that may also result in discomfort and disability, and may require particular healthcare and workplace interventions.

(based on (Hanson et al. 2006))

### **Mental health complaints (as a common health problem)**

Mental health refers to how we think, feel, and behave. There are a variety of types of mental illness, each of which can occur with varying severity. The most common mental illnesses are depression, anxiety or combination of the two. Severity ranges from mild distress (sub-clinical) to severe. When these problems are mild or moderate the individual may have short-term difficulties coping with everyday activities and work, but long-term consequences and disability are not expected. Mental health symptoms, in some form, are present in about a third of the working age population at any point in time. About 17% would meet diagnostic criteria, although only 6% seek healthcare, indicating that the majority of cases self-manage. Most mild to moderate mental health problems are short-term (with possible recurrence), and when healthcare is involved it is usually primary care services.

(Seymour & Grove 2005; Waddell et al. 2008) (HSE 2010: Stress & Mental Health at Work website)

### **Stress complaints (as a common health problem)**

The subjective experience of a constellation of complaints that usually include, but are not limited to: physiological features, e.g. headaches, gastric upset; cardiovascular problems; behavioural features, e.g. reduced activity, sickness absence; cognitive features, e.g. worry, being distracted or forgetful; emotional features, e.g. fear, low mood. The person usually associates these complaints with perception of adverse life and/or working conditions and feels unable to cope with them. This may be accompanied by a diminished sense of subjective well-being. This approach transcends ambiguity where the term 'stress' can refer to both cause and consequence. Yet, it is consistent with HSE's formal definition of work related stress as: "The adverse reaction people have to excessive pressures or other types of demand placed on them at work."

(Cox 1978)

### **Comorbidity v concurrent/coexisting complaints**

A significant proportion of people experiencing a CHP also report complaints associated with other CHPs, and healthcare providers may give the person multiple labels. In effect the person has concurrent complaints (perhaps physical and mental). The term 'concurrent' and 'coexisting' are preferred over comorbidity since they simply describe co-occurrence of a number of symptoms without making any assumptions about shared causation or pathology. The clinical concept of 'comorbidity' is useful for treatment and prognostic purposes, but can be ambiguous since it refers to the occurrence of two or more independent diseases, the compound effects of two or more diseases, and the co-occurrence of causally related conditions in the same person. For the purposes of this project (which is geared toward the needs of the workplace) the term 'comorbidity' is therefore less accurate than concurrent or coexistence.

### **Good Jobs**

See definition for comfortable jobs

### **Management**

In relation to CHPs ‘management’ refers to the process and techniques of managing workers/employees, and includes a variety of aspects such as supervision, control, oversight, administration. This means standards for management describe minimum features that contribute to providing a comfortable and accommodating workplace with respect to both physical and psychosocial aspects. These should be integrated with, but not limited to, contemporary human resource management approaches and may often involve aspects of operations management.

(Mackay et al. 2004)

Management is distinguished from leadership and supervision:

- A. Management v leadership - leadership and management are two distinctive and complementary systems of action, both being necessary. Management is about budgeting and planning, organising and staffing, controlling and problem solving. Leadership is more about setting a direction, a vision of the future, aligning people, motivating and inspiring.

(Kotter 1998)

- B. Supervision - coordination by someone taking responsibility for the work of others, including planning, scheduling, allocating, instructing and monitoring actions.

(Mintzberg 1979)

The term ‘management’ is often used in a clinical context (e.g. symptom management, disease or condition management). For the purposes of this project (which is geared toward the needs of the workplace) the term ‘tackling’ is used instead – viz., tackling common health complaints or problems. (See also ‘Tackling’).

### **Prevention**

This is a complex topic. For CHPs there are at least three potential targets for prevention: injury or onset of symptoms; the consequences of injury or symptoms; long-term disability. (1) Prevention of injury and ill health at work requires avoidance or reduction of known causative agents (risk factors), and this works well when there is a direct and sizeable causal relationship between the exposure and the outcome. However, for CHPs, there is inconsistent evidence supporting the majority of purported risk factors, and those that are well documented frequently have small effect-sizes, which logically will compromise the magnitude of preventive interventions. (2) Given that many CHPs occur irrespective of occupational exposures it is pertinent to concentrate on limiting the undesirable consequences (e.g. episodes, concurrent problems, disability, and work loss). Much of this undesirability has to do with how bothersome the symptoms experienced are to the individual, and how well they feel able to cope (self-manage). (3) In order to try and prevent long-term problems it seems reasonable to encourage early reporting of symptoms with the intention of avoiding more significant problems. Whilst encouraging early reporting can lead to early intervention, injudicious warnings can exacerbate the problem through overemphasis of risk with the inadvertent consequence of increasing the incidence of complaints, attribution, and claims.

Given that primary prevention of CHPs is mostly infeasible while reducing deleterious consequences is quite realistic, the most comprehensive approach to prevention in CHPs appears to require two major components: (1) provision of a comfortable work environment that reduces the frequency of cases (episodes) of work-relevant CHPs and the constellation of related symptoms (irrespective of cause); and (2) provision of accommodation when required in order to facilitate workability. This shifts the emphasis to the potentially realistic and achievable goal of minimising the impact of CHPs on workers. This is not to imply that primary prevention through risk control has no role, rather it is recognition that primary workplace prevention of CHPs has severe limitations in and of itself.

(Burton et al. 2006; Burton et al. 2008; Kendall et al. 2009)

**Supportive (workplaces)**

See definition for accommodating (workplaces)

**Tackling**

Refers to dealing with the work–relevant aspects of a health problem. This means taking the steps necessary to help the person stay at work or return to work: it includes identifying obstacles, developing a plan, and taking appropriate action. It necessitates a combination of work-focused healthcare and workplace facilitation, and requires all the players to be onside and acting.

(Kendall et al. 2009)

**Units of intervention**

Refers to the various targets for interventions and how they are delivered. Whilst an approach or framework for intervention may have a common overall goal and shared principles, different situations and people will require different tools. The unit of intervention variously may be the individuals who are subjects of an intervention (workers) or persons delivering the intervention (e.g. line managers, health professionals, organisations). The intervention target may be a group or organisation, e.g. all line managers, all employees, or all members of a department. For some interventions (e.g. culture change), the unit of intervention may be societal.

**Well-being**

The subjective state of being healthy, happy, contented, comfortable, and satisfied with one’s quality of life. It includes physical, material, social, emotional (‘happiness’), and development and activity dimensions. At the general level these factors make for a ‘good life’, although these are always specific to the person and their context. They usually include identification with meaningful activities and work, a sense of satisfaction with life and work, and a sense of moving toward future goals.

(Felce & Perry 1995; Danna & Griffin 1999; Diener 2000; Waddell & Burton 2006; Warr 2007)

### 9.3. PROJECT GLOSSARY

**Activity:**

This is the execution of a task or action by an individual, and applies to the full spectrum of self-care, domestic, social, recreational, mobility, communication, productivity and work. Activity limitations are difficulties an individual may have in executing activities. In contrast, participation is involvement in a life situation, and participation restrictions are problems an individual may experience in involvement in life situations. Both activity and participation are qualified by performance (describes what an individual does in his or her current environment) and capacity (describes an individual's ability to execute a task or an action). For CHPs, where there is little or no impairment present, the focus is on overall level of function that includes activity and participation. Participation in work is an important activity with social, economic and health effects.

(WHO 2001)

**Barriers v obstacles:** Aspects of the person, the workplace and the context can act as impediments (physical and psychosocial) to staying at work or returning to work with a health problem. The clinical literature more often describes them as 'obstacles', the disability rights and social policy literatures as 'barriers'. A barrier can be seen as something constructed to prevent access, whereas an obstacle is something that happens to be in the way: barriers need to be dismantled whilst obstacles can more readily be overcome. Workplace interventions are able to overcome obstacles; dismantling barriers may depend more on systems and society. The preferred term for the present project focuses on obstacles.

(Waddell et al. 2008)

**Biopsychosocial:** refers to the concept that biological, psychological, and social factors combine to play a significant role in human functioning; and, these need to be treated or managed as interlinked systems.

(Burton et al. 2008)

**Bothersomeness:** causing annoyance and inconvenience. In respect of CHPs, the lack of reliability for recalling subjective symptoms interferes with measures of severity. This means, for example, that the symptom may be perceived as less of a problem during the day than during the night. One way to overcome this is to include a measure that asks how much bother the symptom causes. There is evidence that this yields a measure of symptoms relevant to CHPs (e.g. asthma, back pain) that is more sensitive to detecting change.

(Steen et al. 1994; Dunn & Croft 2005)

**Case management:** a goal-oriented approach to achieving specific work retention and return to work outcomes. Active case management is usually undertaken by someone designated as a 'case manager'. Case managers use a range of methods and techniques including, but not limited to, a screening and intake process; assessment; planning; service arrangement; and, monitoring and evaluation of outcome. Case managers provide coordination, facilitate communication, and work collaboratively with treatment providers, the employee, and the workplace to ensure an early and sustainable return to work.

(Hanson et al. 2006)

**Compliance:** Adherence to practices required by formal CHP-related guidance.

**Good Work:** Always desirable, de facto minimum standard of 'good' and safe. Enabled by factors operating at a mainly at societal level. Good work does not always produce 'good job', this also requires:

- a) *Comfortable jobs:* are subjective. Comfortableness varies between individuals and across time. Mitigate unavoidable unpleasant/uncomfortable aspects of jobs (e.g.

coping, resilience). Intervention is mainly at group level, but may involve individual level interventions. Outcome of interest is reduced complaints of problems (symptoms)

- b) *Accommodating workplaces*: facilitate coping with temporary symptoms, allow stay at work, maintenance of work habits, job routine, etc. Key is worker-line manager relationship. Intervention is predominantly at the individual level. Outcome of interest is productivity and reduced work loss.

**Conceptual Model**: a model representation of related concepts which are formed after a conceptualisation process.

(Duan and Cruz 2011)

**Culture**: the collective beliefs, values, attitudes, accepted ways of behaving, rituals, symbols, stories, artefacts, power and social structures and controls that characterise a particular social group over time. These beliefs need not be shared by everyone within a 'culture', but are recognised as prevailing norms. The group may range from 'western society', to a social class, a locality, or a particular work force. Within organisations, these same aspects of culture reinforce underpinning values, attitudes and beliefs. Shared perceptions in themselves form the concept of 'climate' – and can be assessed in relation to safety and potentially in relation to management of common health problems and well-being. (Also see 'organisational culture').

(Johnson 1987; Zohar 2000; Waddell & Burton 2004; Schein 2004)

**Effectiveness and Efficacy**: exist on a continuum. Efficacy refers to whether an intervention produces the expected result under ideal circumstances. Effectiveness refers to the degree of beneficial effect in "real world" settings.

(Godwin et al. 2003)

**Employment v work**: work involves the application of physical or mental effort, skills, knowledge or other personal resources, usually involves commitment over time, and has connotations of effort and a need to labour or exert oneself: work is not only 'a job' or paid employment, but includes unpaid or voluntary work, education and training, family responsibilities and caring. Employment is typically a contractual relationship between the individual worker and an employer over time for remuneration, as a socially acceptable means of earning a living. It involves a specific set of technical and social tasks located within a certain physical and social context. The present project will use the term work in the context of employment.

(Warr 1987; OECD 2003; Dodu 2005; Waddell & Burton 2006)

**Framework**: conceptual structure that integrates sets of ideas, principles, agreements and rules to allow more comprehensive development of practical actions and processes aimed at achieving desired outcomes. A framework is not a theory or scientific model: these are terms applied to explanations of why a phenomenon occurs and usually include specific predictions.

(based on Merriam-Webster dictionary; Encarta dictionary)

**Health**: comprises physical and mental well being, and (despite philosophical debate) is usually operationalised in terms of the absence of symptoms, illness and morbidity.

(WHO 1948; Danna & Griffin 1999; WHO 2004)

**Health and wellbeing cultural maturity**: Important organisational cultural characteristic that determine an organisation's degree of readiness to manage well-being at work.

**Iatrogenic**: refers to inadvertent adverse effects, complications or outcomes caused by or resulting from medical treatment or advice, usually given by a healthcare professional.

(based on Wikipedia 2011)

**Intervention:** Actions intended to bring about changes in (a) knowledge, attitude or behaviour at an individual level, (b) the work environment at the group level (c) and/or systems and culture at the organisational level.

*Active interventions:* Intervention that require the target audience to take action.

*Passive interventions:* Interventions that affect knowledge/raise the awareness of their target audience without necessarily requiring them to take action.

**Job satisfaction:** is how people feel about their jobs and different aspects of their jobs. It is the extent to which people like (satisfaction) or dislike (dissatisfaction) their jobs and their work. As it is generally assessed, job satisfaction is an attitudinal variable. A widely used research definition is “a pleasurable or positive emotional state resulting from the appraisal of one’s job or job experiences”.

(Locke 1976; Spector 1997)

**Module:** Self-contained segment of the toolkit. Depending on the organisation’s status with respect to CHP management, modules can be used on a stand-alone basis or in conjunction with other modules for more comprehensive CHP management.

**Natural history:** refers to the natural clinical course or trajectory of a disease or disorder (or an episode of such) if left untampered. For many CHP the natural history tends to be an untidy, rather unpredictable series of discrete episodes that may or may not be linked.

(based on Wikipedia 2011)

**Obstacles v barriers:** Aspects of the person, the workplace and the context can act as impediments to staying at work or returning to work with a health problem. The clinical literature more often describes them as ‘obstacles’, the disability rights and social policy literatures as ‘barriers’. A barrier can be seen as something constructed to prevent access, whereas an obstacle is something that happens to be in the way: barriers need to be dismantled whilst obstacles can more readily be overcome. Workplace interventions are able to overcome obstacles; dismantling barriers may depend more on systems and society. The preferred term for the present project focuses on obstacles.

(Waddell et al. 2008)

**Organisational culture:** Comprises four major elements existing at different levels of awareness: basic assumptions; values; norms and artefacts shared by organisational members and which influence individual and collective behaviours. (Also see ‘culture’).

(Johnson 1987; Cummings & Huse 1989; Schein 2004; Arnold 2005)

**Pain:** is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(IASP 1994)

**Participation:** is involvement in a life situation, and applies to the full spectrum of self-care, domestic, social, recreational, mobility, communication, productivity and work. Participation restrictions are problems an individual may experience in involvement in life situations. In contrast, activity is the execution of a task or action by an individual, and activity limitations are difficulties an individual may have in executing activities. Both activity and participation are qualified by performance (describes what an individual does in his or her current environment) and capacity (describes an individual’s ability to execute a task or an action). For CHPs, where

there is little or no impairment present, the focus is on overall level of function that includes activity and participation. Participation in work is an important activity with social, economic and health effects.

(WHO 2001)

**Players v stakeholders:** The term ‘players’ is used to denote individuals or groups whose active involvement in the stay at work/return to work process is essential for its effectiveness. The term ‘stakeholders’ refers to individuals or groups having an interest in the outcome of the process: they may or may not be active players.

(Waddell et al. 2008)

**Psychosocial:** refers to the interaction between the person (subjective experiences, beliefs, emotions, behaviour, etc) and their social environment (significant others, healthcare providers, people at the workplace, funders, etc), and how this influences their behaviour (what they do).

(Kendall et al. 1997; Burton et al. 2008)

**Quality of life:** is individuals’ perception of their position in life in the context of the culture and value system in which they live and in relation to their own goals, expectations, standards and concerns.

(The WHOQOL Group 1995)

**Return to work v stay at work:** (good) work is beneficial and prolonged sickness absence is detrimental, so helping people stay at work or to achieve early return after sickness absence is desirable. The stay at work (SAW) philosophy is focused on helping the individual (or workforce) to remain at work when experiencing a health problem, with the aim of preventing unnecessary sickness absence (both present and future). Return to work (RTW) is the process of returning to the workplace following sickness absence, the goal being sustained return to usual tasks in the same job (accepting that will not always be possible). Whilst SAW is the conceptually preferred option, the RTW process should not be ignored. The psychosocial obstacles to both SAW and RTW have shared characteristics so tools applicable for one will help with the other.

(HSE 2004; Waddell et al. 2008; Kendall et al. 2009)

**Risk:** is a judgement involving something potentially damaging or harmful that is possible and may also be probable. It usually involves consideration of multiple factors, and may be complex. This means risk is invariably expressed qualitatively as ‘likelihood’ and not quantitatively as probability. Risk in the workplace does not apply to circumstances that a worker may find unpleasant or uncomfortable. This is consistent with the standard HSE definition that risk is “the likelihood that a hazard will cause a specified harm to someone or something”.

(HSE 2010)

A ‘risk assessment’ involves identifying hazards in a working environment and related working activities to evaluate the extent of risk (of harm occurring). A hazard is something with the potential to cause harm. Risk is the likelihood of potential harm being realised – the extent of risk will depend on the likelihood of that harm occurring, the potential severity of that harm and the size of the population that might be affected.

(HSC 2000)

**Risk management:** Risk management is a process that involves assessing the risks that arise in your workplace, putting sensible health and safety measures in place to control them and then making sure they work in practice. It is accepted that risk has a large subjective component and can be socially constructed, meaning the risk management process needs to be sensitive to the views of multiple stakeholders and not driven solely by judgements of scientific/technological experts.

(Royal Society 1992; HSE 2010)

**Stakeholders v players:** The term ‘players’ is used to denote individuals or groups whose active involvement in the stay at work/return to work process is essential for its effectiveness. The term ‘stakeholders’ refers to individuals or groups who have an interest in the outcome of the process – but who may or may not be active players

(Waddell et al. 2008)

**Stay at work v return to work:** (good) work is beneficial and prolonged sickness absence is detrimental, so helping people stay at work or to achieve early return after sickness absence is desirable. The stay at work (SAW) philosophy is focused on helping the individual (or workforce) to remain at work when experiencing a health problem, with the aim of preventing unnecessary sickness absence (both present and future). Return to work (RTW) is the process of returning to the workplace following sickness absence, the goal being sustained return to usual tasks in the same job (accepting that will not always be possible). Whilst SAW is the conceptually preferred option, the RTW process should not be ignored. The psychosocial obstacles to both SAW and RTW have shared characteristics so tools applicable for one will help with the other.

(HSE 2004; Waddell et al. 2008; Kendall et al. 2009)

**Toolbox/toolkit:** is an accessible collection of resources for a common purpose that is practical and usable. It has an identified set of aims and may contain information and advice or other resources applicable to specific areas or activity.

(Encarta dictionary)

**Vocational rehabilitation:** is whatever helps someone with a health problem to stay at, return to and remain in work. This broad description covers routine healthcare and workplace management in addition to more structured vocational rehabilitation interventions.

(Waddell et al. 2008)

**Work v employment:** work involves the application of physical or mental effort, skills, knowledge or other personal resources, usually involves commitment over time, and has connotations of effort and a need to labour or exert oneself - work is not only ‘a job’ or paid employment, but includes unpaid or voluntary work, education and training, family responsibilities and caring. Employment is typically a contractual relationship between the individual worker and an employer over time for remuneration, as a socially acceptable means of earning a living. It involves a specific set of technical and social tasks located within a certain physical and social context. The present project will use the term work in the context of employment.

(Warr 1987; OECD 2003; Dodu 2005; Waddell & Burton 2006)

**Work-relevant:** refers to health complaints/disorders that, irrespective of cause, are experienced at the workplace to a greater or lesser extent, and which in turn impact on the performance of a worker. Most available evidence pertains to paid work and employment; however the idea likely applies equally to all forms of productive activity. The term work-related tends to be taken to imply a causal relationship between work and health that often may not be the case.

(Burton et al. 2008)

**Worker involvement:** tends to be management-initiated rather than employee-initiated and can include involvement at multiple layers and in many different ways. It may be considered as the reflection of the degree of input that workers have into decisions that affect them.

(Lancaster et al. 2001; Cameron et al. 2006; Armstrong et al. 2010)

**Work-life balance:** is about individuals balancing their daily (un)paid work commitments with their personal life responsibilities and non-work activities. Work-life balance within a business



environment requires the commitment of employers to ensure that corresponding policies and practices are used in a planned and coordinated way to help all employees balance the relationship between their work and family obligations. Personal life challenges, aspirations and expectations can affect an individual's intentions, abilities and desires of how and when they wish to work. These in turn can influence their decisions in how they may wish to spend their time fulfilling their work and personal life commitments at various stages of their lives. To accommodate these choices employers can plan and organise the working arrangements of their staff to suit their operational needs.

(Malik 2007; Malik et al. 2010)

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## 10. APPENDIX 2

### 10.1. STAKEHOLDER SURVEY

#### INTRODUCTION

The purpose of this Appendix is to describe the results of a scoping exercise to identify the views of various stakeholders: end users and experts. End users are defined as those people responsible or involved in service implementation and delivery, and include HR professionals and general managers. Experts are defined as those with specialised knowledge of common health problems (CHPs), either through contributions to relevant research, policy development, policy implementation or through professional and specialised work around CHPs (e.g., medical practitioners specialising in CHPs, insurers, legal advisors). A list of experts in CHPs were identified *ex ante* rather than generated from responses to the survey.

The aims of the survey are two-fold.

First, our intention is to understand the dominant views of various groups. To this end, the results are presented with the sample as a whole but with various other breakdowns. The results, as appropriate, present experts' and end users' views separately. Within experts, we differentiate between academics/researchers, policy makers, industry representatives (unions, professional bodies) and specialised service providers (e.g. medical practitioners). Within end users, we differentiate responses from: small and medium sized enterprises from larger organisations; high emotion regulation sectors vs. low emotion regulation sectors (i.e., retail, wholesale, hotels, restaurants, banking, finance, insurance, public administration, education, health and other services on the one hand versus agriculture, fishing, energy and water utilities, manufacturing, construction, transport and communications on the other); and low physical demands sectors vs. high physical demands sectors (i.e., retail, wholesale, hotels, restaurants, banking, finance, insurance, public administration, education and other services on the one hand agriculture, fishing, energy and water utilities, manufacturing, construction, transport, communications and health on the other).

The second aim was to examine the data for good ideas or different perspectives on CHPs from the views of the various stakeholders.

To ensure coverage of all relevant stakeholders, a web-based questionnaire survey was used. The purpose was not to achieve representativeness, rather representation of various stakeholders to ensure different stakeholders' views would be represented. So as not to pre-impose the research team's views and to acknowledge the potential for detailed and sophisticated answers to questions from those involved with understanding, preventing or managing CHP, we used an open-ended questionnaire.

#### METHOD

##### QUESTIONNAIRE DEVELOPMENT

The questionnaire was developed iteratively. A first draft was developed by Kevin Daniels (KD) and Jenny Lunt (JL). This was circulated to the rest of the project team and amended accordingly, rechecked by the whole team, and so on until there was agreement that the questionnaire covered appropriate material and was phrased appropriately. The questionnaire was then trialled on a small number of people to check further its appropriateness and that the

questionnaire would generate useful data. These pilot participants included two small business owners (one agriculture, one retail), an experienced and qualified health and safety professional (IOSH membership, MA in safety law, PhD in safety psychology, five years experience in academic research, over 25 years experience in high hazard sectors), a public sector manager with a Chartered Institute of Personnel and Development accredited Masters in human resources management, and a professor of human resources management. After checking the answers of the pilot participants and their experiences with the questionnaire, further amendments were made. The questionnaire was then checked with HSE Steering Group and further amendments made. The final questionnaire is shown later in this appendix.

#### PROCEDURE AND SAMPLE

A web based version of the questionnaire was administered to 110 experts and 4334 end users. These were sampled from the Health and Safety Laboratory's (HSL) marketing data-base of experts and the Health and Safety Executive's (HSE) MINT database. Participants were given two weeks to respond to the survey. In total, 218 end users responded and 28 experts. Note that these response rates are low (5% and 25%) and neither the end user or expert sampling frame can claim to be representative. Therefore, although a broad range of end users and experts responded to the survey, the results are not representative of either the UK end user or expert population.

On average, the end user sample were 48.86 years of age (SD = 8.91) and 62.1%<sup>15</sup> ( $N = 136$ ) were male. Some 30.9% worked in small and medium sized enterprises (SMEs) (i.e.  $\leq 250$  people;  $N = 67$ ). The modal value for organisational size was  $>1000$  people (48.4%;  $N = 106$ ). The breakdown of the end user sample by sector is shown in table 1 and their main focus of activity with respect to CHPs in table 2.

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<sup>15</sup> Note that all percentages given relate to participants that responded to questions. Data that are missing are excluded from the calculations. This facilitates interpretation, as it allows comparisons amongst responses. The raw numbers (N) for each answer are given to indicate absolute frequency of responses.

**Appendix 2 Table 1.** End users' sectors.

	Percentage	<i>N</i>
Agriculture/Fishing	.5	1
Manufacturing	29.2	63
Retail/wholesale	2.8	6
Transport	4.6	10
Banking, finance or insurance	.5	1
Public administration/Local Government	17.6	38
Energy or water	6.5	14
Construction	4.6	10
Catering/hotels/restaurants	.5	1
Communications	0	0
Other private sector services	14.8	32
Health/social work	18.5	40

*NB 2 participants did not answer this question*

**Appendix 2 Table 2.** End users' focus of activity with respect to CHPs.

	Percentage	<i>N</i>
General or functional manager	42.	86
Delivering occupational health services in the organisation you work for	30.2	62
Independent occupational health consultancy	5.9	12
Developing or implementing Government policy	2.0	4
Employee representative (e.g. Trade Union)	4.4	9
Insurer	0	0
Human Resources Management	3.4	7
Medical practitioner	7.	15
Research	2.	2
Developing advice for a professional body	2.	2
Legal advisor	1.	1

*NB 13 participants did not answer this question*

**Appendix 2 Table 3.** Experts' focus of activity with respect to CHPs.

	Percentage	<i>N</i>
General or functional manager	11.1	3
Delivering occupational health services in the organisation you work for	7.4	2
Independent occupational health consultancy	11.1	3
Developing or implementing Government policy	7.4	2
Medical practitioner	7.4	2
Research	40.7	11
Developing advice for a professional body	11.1	3
Legal advisor	3.7	1

Although the representation of different sectors is uneven, there is no dominance of sectors that might be considered to be at high risk for mental health and stress-related CHPs, and there is no dominance of sectors that might be considered to be at high risk for MSDs. The vast majority of the end users occupy more general management functions or delivery of occupational health services. Even so, interpretation of the results is bounded by the small numbers in some industries.

On average, the expert sample were 48.28 years of age ( $SD = 8.25$ ) and 59.3% ( $N = 16$ ) were male. The breakdown of the expert sample by their main focus of activity with respect to CHPs is in table 3.

As might be expected, the majority of experts work in research, with most of the rest based in policy/advice development, policy/advice implementation or service delivery. Note neither the expert or end user sample included representation from insurers, although legal advisors were included in both samples. Therefore, there is representation of experts from across the research to application. Even so, interpretation of the results is bounded by the small numbers of some experts and the dominance of researchers in this sample. The expert sample is also small. Whilst this might be reflective of a relatively small number of experts in this area and in the sampling frame relative to end users, and the survey represents some expert views, the interpretation of the results are bounded by the small number of experts.

## ANALYSIS

For the open ended questions, data were analysed by template analysis (King, 2004). An initial template was generated by KD and JL. This was then checked by the rest of the project team and the HSE steering group. This initial template is shown in later in this appendix. The highest level represents each question on the survey. Secondary codes represent higher level answers that group the most detailed primary codes. Data were coded at HSL (by David Fox, DF). A miscellaneous category was added for text that did not appear to be covered by the template.

A sub-sample of questionnaires (15 end users, 14 experts) was second coded by KD. KD examined each excerpt of text from the questionnaire coded by DF and decided whether he



agreed with DF's coding of that excerpt. In total, from the 29 questionnaires coded, some 258 excerpts of text were coded. At the level of the primary, detailed codes, the average inter-rater agreement for each question between DF and KD was 78% (range 45% to 100%). Across all 258 excerpts of text, the inter-rater agreement was 78% for the primary, detailed codes. At the level of the secondary, higher order codes, the average inter-rater agreement for each question was 86% (range 73% to 100%). Across all 258 excerpts of text, the inter agreement was 86% for the secondary, higher order codes. Given the higher levels of agreement for the secondary, higher order codes, analysis was conducted first at this level, with the primary, detailed codes used to illustrate detail when reporting findings for the more superordinate codes.

At the end of DF's coding, KD and JL or DF examined the miscellaneous category for each question. Based on assessment of the number of excerpts of text categorised as 'miscellaneous'; whether discernible themes could be detected in the miscellaneous categories; and a consensual judgement on whether particular excerpts of text were useful for the purposes of the survey and fitted the emergent, discernible themes; the miscellaneous category was either ignored or the template modified accordingly. The revised template is shown later in this appendix. KD also read through all questionnaires, and extracted quotes considered to be especially useful for understanding CHPs or stakeholders' perceptions of CHPs.

## RESULTS

### TO WHAT EXTENT ARE COMMON HEALTH PROBLEMS PERCEIVED TO BE A PROBLEM IN THE UK WORKING POPULATION?

Participants were asked to rate the following item: “Overall, to what extent do you think common health problems are a problem in the UK working population?” Responses to this question were made on a five-point Likert-type scale (1 = *not a problem at all*, 2 = *a very minor problem*, 3 = *a moderate problem*, 4 = *a significant problem*, 5 = *a major problem*). Participants were then asked an open ended question asking them to explain their reasoning.

The end user sample reported an average value of 3.68 (SD = 0.82). This corresponds roughly to end users considering CHPs to be a ‘moderate problem’ to ‘significant problem’. The expert sample reported an average value of 4.14 (SD = 0.59). This corresponds roughly to end users considering CHPs to be a ‘significant problem’. The difference between the two samples was statistically reliable ( $t = 3.77$ ,  $p < .005$ )<sup>16</sup>. It is not surprising those with a particular interest or focus on CHPs consider the problem to be more significant than others. Of course, this question or these statistics cannot and do not indicate which group has the more accurate perception. An analysis of experts’ views indicated no significant differences between stakeholders in the groups of research, policy, industry/employee representation and service delivery ( $F = 0.54$ ,  $df = 3/27$ , ns). The various groups had mean values on this item of 4.00 to 4.40.

Most experts cited the reason for CHPs being a problem was concerned with impact (71%,  $N = 20$ ), especially with regard to impact on productivity and absence (some 64% [ $N = 18$ ] of the total expert sample). For example<sup>17</sup>:

*Common Health problems are a significant issue because problems such as musculoskeletal disorders, stress and anxiety and so on are a major cause of sickness / absence from the workplace and in turn cause further stress and financial hardship (expert 24)*

*Poorly managed chronic disease causes recurrent sickness absence and regular hospital / GP visits resulting in unpredictable attendance and reduced productivity presenteeism results in under performance at work due to the disease or consequences of medication (expert 6).*

For end users, there was significant variation by organisational size ( $F = 2.68$ ,  $df = 5/210$ ,  $p < .05$ ). Tukey’s Honestly Significant Difference Test indicated that participants from organisations with five or fewer workers rated this item significantly lower than participants from organisations with 51-250 workers and over 1000 workers ( $p < .05$ ). The average rating given by participants from organisations with five or fewer workers on this item was 2.89 (roughly equivalent to a moderate problem). The next lowest rating was 3.50 (a moderate to significant problem), and was given by participants from organisations with 6 to 50 workers. Overall then, the experience of participants from the smallest organisations is that CHPs are less of a problem from those in larger organisations, including larger SMEs.

There were no differences in responses to this item between participants from high and low emotion regulation sectors ( $t = 1.26$ , ns). There was however a difference between participants from high physical demands and low physical demands sectors ( $t = 3.36$ ,  $p < .005$ ). Those from

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<sup>16</sup> Note all t-tests reported do not assume equal variances.

<sup>17</sup> Quotes from the comments are reproduced exactly as typed by participants.

high physical demands sectors scored lower on this item on average ( $M = 3.53$ ) than those from low physical demands sectors ( $M = 3.89$ ).

Because of the small numbers, it was not possible to discern a dominant reason or reasons why participants from the smallest organisations rated CHPs on average as a moderate problem. However, for the larger organisations ( $> 5$  employees), it was evident that participants considered CHPs to be a problem because of their occurrence (42%,  $N = 86$ ) and because of their impact (28%,  $N = 57$ ). Some 31% ( $N = 64$ ) of those from larger organisations considered the occurrence of CHPs to be a problem because of their frequency, rather than because they are enduring:

*They represent the majority reasons given for absence (end user 15)*

*In discussions with other H&S professionals the most common areas for concern tend to be around MSDs and workplace pressure (stress) (end user 25)*

Of those from larger organisations citing the impact of CHPs in their answers, just under half (44%,  $N = 90$ ) quoted impact on the organisation through factors such as absence and just over half (54%,  $N = 111$ ) quoted impact on the person. The following quotes illustrate both views:

*Affects ability to work so increases short term/frequency and long term absence. Affects an individual's quality of life that has an impact on their ability to cope at work (end user 18)*

*The accumulative and long-term effects of mental health and musculoskeletal complaints make them important issues. They harm individuals at work but the harm continues into their private activities and retirement after work. The impact on work itself is mainly due to the longer absences (end user 22)*

Notions of frequency and impact dominated the reasons given by participants from both high and low physical demands sectors (frequency mentioned by 45% [ $N = 40$ ] of those from low physical demands sectors, 39% [ $N = 51$ ] from high physical demands sectors; impact mentioned by 33% [ $N = 29$ ] from low physical demands sectors, 30% [ $N = 39$ ] from high physical demands sectors).

#### WHICH OF THE THREE MAJOR CLASSES OF CHPs ARE PERCEIVED TO BE THE MOST DIFFICULT TO MANAGE?

Participants were asked to indicate which out of MSDs, mental health or stress-related CHPs were the most difficult to manage. They were then asked to explain their reasons for giving this answer.

Some 64.5% ( $N = 137$ ) of end users and 55.6% ( $N = 15$ ) of experts rated mental health problems as the most difficult to manage. In second place for both groups were stress-related CHPs (28.0% [ $N = 60$ ] of end users 40.7% [ $N = 11$ ] of experts respectively). For both end users and experts, MSDs were rated as the most difficult by very few participants (7.4% [ $N = 16$ ] and 3.7% [ $N = 1$ ] respectively). There were no differences between different types of expert ( $\chi^2 = 2.10$ , ns)<sup>18</sup>. There were no differences between experts and end users ( $\chi^2 = 2.14$ , ns). Neither were there any differences participants from organisations of different sizes ( $\chi^2 = 11.18$ , ns),

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<sup>18</sup> Note significance of all  $\chi^2$  tests are based on exact tests or Monte Carlo simulations to prevent problems with small expected cell counts.

high emotion versus low emotion regulation sectors ( $\chi^2 = 1.11$ , ns), or high physical demands versus low physical demands sectors ( $\chi^2 = 3.76$ , ns).

In the minds of some participants, stress and mental health are very closely related, as illustrated in the following quotes:

*I am not sure you can distinguish between anxiety & depression and stress. In my understanding most who suffer stress report anxiety & depression. Whatever you call it, it is difficult to manage (expert 26)*

*I would rank mental health and stress related problems equally and they are difficult to manage as they are not always evident (end user 25)*

*It's a toss up between mental health and stress, which may be part of the same thing. Management can be intolerant, and the availability of sensible support may be both scarce and costly (end user 77)*

*(Distinction between 2nd [mental health] and 3rd options [stress] a little artificial I think). Such mental health issues are multicausal and often affected by non-work issues (outside the control of the employer), and can dominate an individual's whole outlook on their life, making attempts at intervention harder as they may become unable to help themselves (end user 165)*

Some 79% ( $N = 22$ ) of experts gave their reasoning for their answer as related to the complexity of CHPs. For experts, this related to both the complexity of CHPs themselves but also difficulty in managing CHPs:

*There is still considerable stigma and lack of understanding of mental health problems, particularly in workplace settings. There is much confusion on how best to manage them. And there are problems both with mental health problems not being taken seriously and with people claiming to have mental health problems as a way of getting preferential treatment (expert 27)*

*There is often a work design, management or organisation modification that lends itself to addressing physical complaints. Such cannot always be said, or is not so immediately obvious, in relation to stress (expert 1)*

*Once anxiety has been triggered, it's very difficult for the individual suffering from it to control/manage that particular physiological response when faced by work conflict or stress. Stress, depression and anxiety (particularly anxiety) is highly stigmatised - this is because the person suffering from it has a mental/behaviour reaction that others find difficult to separate from that person's personality/character. Even when a colleague or line manager is aware that the person's response is anxiety related, it is difficult to empathise with them (or even offer support) as usually they are caught-up in that response (expert 5)*

Some 68% ( $N = 137$ ) of end users gave their reasoning for their answer as related to the complexity of CHPs. For end users, although there was no one dominant, detailed theme, more referred to difficulty in managing CHPs than any other specific theme (43% [ $N = 59$ ] of those noting CHPs' complexity)

*Stress can be work-related, non-work-related or a combination of both. Identifying the stressors is key and, depending upon what they are, can be managed to a degree. The management of mental health problems such as anxiety and depression are considered more difficult to manage due lack of knowledge of the best ways of managing them (end user 24)*

*There are often adaptations you can make to roles to help with MSDs or stress, however deeper mental health issues are often chronic with no identifiable cause or triggers and so harder to manage in the longer term (end user 47)*

## EFFECTIVE PREVENTION OF CHPS

Participants were asked what they thought were the best approaches to preventing CHPs. The majority of experts stated they thought job/organisation focused interventions would be the best means of preventing CHPs (57%,  $N = 16$ ), with those endorsing such primary prevention being evenly split between interventions focused on changing organisational cultures or leadership, changing the work environment or being led by a risk assessment/management process:

*A mind-set change in top leadership is required. This is where HSE and other government bodies should focus their efforts - and not individual organisations, where their efforts are a drop in the ocean (expert 15)*

*For preventing common health problems in the workplace, the best approaches should focus on creating working conditions that promote 'good work'. Providing flexibility, control and autonomy over work and offering social support are a few key pieces to good work. In addition, following ergonomic best practice can help prevent common health problems - particularly for musculoskeletal conditions (expert 10)*

*Adopting a risk assessment approach as outlined in HSG65 and other HSE guidance, and following the management standards for tackling work related stress (expert 28)*

The next most frequently mentioned category of preventive strategies was person-focused interventions (21%,  $N = 6$ ), with training accounting for half of these responses, Even then, there were links made to primary prevention through line manager training:

*Effective training, implementation and then retraining for issues such as MSDs and back pain. Awareness raising for managers and staff on the issues surrounding mental health problems and anxiety etc followed up be effective training for managers in how to deal with these issues at work. Effective training for managers in particular on how to recognise and deal with staff who are suffering from stress alongside work to improve the capacity and capability of line managers so that they recognise the impact their behaviour has on staff and how to manage them more efficiently (expert 17)*

There were no discernible differences between stakeholders in the groups of research, policy, industry/employee representation and service delivery.

In contrast to experts, end users' modal category of answer related to person-focused interventions (35%,  $N = 74$ ), followed by information focused and job/organisational focused (24%,  $N = 51$  each). The most popular person-focused interventions related to managerial/human resource management (HR) support (35%,  $N = 26$  of those that endorsed person-focused interventions) and training (24%,  $N = 18$ , of those that endorsed person-focused interventions). Example endorsements of managerial/HR support are:

*I think applying good people-management skills is essential together with genuine consultation & open & honest communication (end user 32)*

*Regular workplace appraisals or impromptu meetings from management if they notice a problem with an individual, also annual health screening by occ health (end user 109)*

*Having a cooperative and joined up team of Supervisors, Human Resources Personnel and good Occupational Health (end user 45)*

*make yourself and site management easily approachable and able to discuss workplace tasks or procedures that may be causing these problems. this would require some specific training for myself and site managers (end user 12)*

These last two quotes illustrate the importance some end users placed on an organisationally proactive approach to providing support, either through the provision of a coherent and coordinated support system (end user 45) or through management training (end user 12).

In relation to training, end users also showed awareness of inter-linking personal training with other forms of intervention:

*pro-active approach e.g. helping employees to improve resilience-(coping strategies) risk assessment and training for MSK risk (end user 98)*

*Informing people of the hazards through training, awareness campaigns and notices. Ensuring managers know how to recognise the symptoms of stress at an early stage then having systems in place such as counselling which can alleviate the situation (end user 163)*

Of those end users that endorsed information focused interventions, 72% ( $N = 37$ ) thought that information provision and education were the most effective strategies. However, end users did not think that information provision/education should focus on just one group:

*by providing an effective education program for the workforce so that they are much more aware of the issues. Providing sufficient information to supervisors and managers so that they know how to spot the early signs and to deal with them effectively (end user 11)*

*Education and guidance for employees and employers (end user 180)*

Of those end users that endorsed job/organisation change, many (43%,  $N = 22$ ) endorsed the risk assessment/management approach. A smaller number focused on changing organisational cultures or leadership (33%,  $N = 17$  of those that endorsed job/organisational change) and an even smaller number endorsed changes to the work environment (25%,  $N = 13$  of those that endorsed job/organisational change). However, as apparent in the following three quotes, amongst those that endorsed job/organisation change there was some recognition of desirable inter-connections between different preventive interventions:

*Good risk assessment, with actions closed off. Development of a just-culture in which people are likely to speak up. Management training, so that managers recognise the risks, communicate effectively and involve the workforce in putting solutions in place. Leading indicators. Audits (all levels) (end user 20)*

*having a company culture that allows/encourages a good work life balance - provides employees with opportunities for exercise and relaxation and avoids stress. Ensure that*

*work-based risks that can contribute to health problems (e.g. computer use, sedentary job, manual handling etc.) are minimised as much as possible (end user 174)*

*1. reducing exposure to the relevant hazards that may be perceived as causing or aggravating these common conditions e.g. physical work load and handling challenges, stressors in the work place such as the demands, control, role ambiguity, conflict, lack of resources both technical and human, etc 2. education and training about what is normal in the population/ age related and that it is OK to come to work with some of these conditions 3. for mental health condition -- good management style is essential to preventing and managing stress related conditions at work (end user 169)*

Person-focused interventions were more popular from end users in smaller organisations ( $\leq 500$  employees, 40%,  $N = 37$ ) than in larger organisations (31%,  $N = 38$ ), and were the most popular in physically demanding sectors (39%,  $N = 51$ ). However, in sectors with high demands for emotion regulation, job/organisation focused interventions (30%,  $N = 23$ ) were slightly more popular than person-focused interventions (29%,  $N = 22$ ). In no case did participants in these segments/sectors refer to special circumstances in their organisation or sector when answering this question however, excepting one participant from the public sector who stated the public sector needed to be more flexible in its approach (end user 71).

#### EFFECTIVE MANAGEMENT OF CHPS

Participants were asked to describe what they thought was the best approach or approaches to managing people with common health problems in the workplace. For experts, the most popular answered related to job/organisation focused interventions (39%,  $N = 11$ ) followed by person-focused interventions (29%,  $N = 8$ ). There were no discernible differences between stakeholders in the groups of research, policy, industry/employee representation and service delivery.

Of those experts endorsing job/organisation focused interventions, just over half (55%,  $N = 6$ ) endorsed favoured either work reorganisation or work adjustment. This perspective is illustrated in the following quotes:

*A continual programme of psychosocial risk management that has a dual focus on risk assessment and risk reduction. The HSE Management Standards approach offers an ideal tool for such activities (end user 1)*

*Employers need to be flexible in allowing those suffering from common health problems. This may include allowing working at home flexible hours and change in job role during periods of severe symptoms (expert 25)*

*Management of health problems has to be in the context of the individual's health beliefs, but the emphasis should be on timely rehabilitation using a biopsychosocial approach, including modifications to work where appropriate (end user 18)*

This last quote illustrates a connection with person-focused approaches too. Of those experts who endorsed person-focused interventions, no-one specific approach was clearly more frequently endorsed than the others. However, some experts identified sources of intervention external to the organisations, whilst others considered internal support to be important:

*Having an effective Employee Assistance Programme. Having a route outside of line management to report problems. Intervening early and treating people with dignity. (expert 23)*

*For physical problems: prompt accurate diagnoses and the biopsychosocial approach I am not sure that mental health problems can or should be managed in the workplace without far greater training and resources for doing so. Similarly so for stress, if you consider it somehow different (expert 3)*

*It is all about improving the effectiveness, capacity and capability of line managers together with improving the understanding of senior managers (expert 17)*

This divergence of views may indicate a lack of consensus amongst experts on who is best placed to manage common health problems.

For end users, person-focused interventions were endorsed most frequently (48%,  $N = 105$ ), followed in second place by 19% ( $N = 41$ ) of participants who did not provide an answer relevant to the question (e.g., blank response, statement that the answer was covered in the previous question on prevention, very generic statement, e.g., “ensuring the employee stays within work”, end user 128). Person-focused interventions were the most frequently mentioned form of intervention named by participants from smaller organisations ( $\leq 500$  employees, 55%,  $N = 51$ ), larger organisations (47%,  $N = 58$ ), physically demanding sectors (51%,  $N = 66$ ) and sectors with high demands for emotion regulation (49%,  $N = 37$ ). No participant justified his/her response to his/her organisation’s size or sector however. Amongst the end users that endorsed person-focused interventions, the most frequently mentioned solution related to referral to a medical practitioner/occupational health service (38% of those that endorsed person-focused interventions,  $N = 40$ ). The second most frequently endorsed solutions related to management/HR support. Of the next four quotes, the first two are illustrative of referral, and the second two of management/HR support:

*An on-site occupational health service provider working in close liaison with HR to identify sickness absence details, root causes and trends - then identifying & taking actions to improve the situation (end user 24)*

*Any MSDs issues - either via management and or self referral to OH, then see GP. The best way to this is via the multidisciplinary team approach, that is the employee, OH, H & safety and HR/management. Fast tracking medical care that is private scheme of referring workers to the physiotherapy while waiting to get on the physio list from the NHS (GP). Same things for the mental health issues. Some workplace has an OH with CBT skills and we need to encourage this behaviour (end user 116)*

*informed managers and leaders who can support staff and refer to Occupational Health if required (end user 98)*

*good company framework that line managers can work within to support management of individuals. Access to information and advice for managers. Regular contact and open relationship between line managers and employees. Having access to specialist services e.g. occupational health assessment (end user 174)*

All of the above quotes again indicate awareness of end users of the interconnectedness of different forms of intervention.

## SOURCES OF ADVICE AND GUIDANCE



Participants were asked to identify sources of advice and guidance concerning CHPs. Experts mentioned many sources<sup>19</sup>, with over half identifying the HSE specifically (54%,  $N = 15$ ). Some 46% ( $N = 13$ ) of the experts mentioned bespoke professional advice, with consultancies, which include occupational health services, making up the bulk of these responses (77%,  $N = 10$  of those who identified bespoke professional advice). Publicly accessible information was identified by 36%,  $N = 10$  of experts, with most of these (60%,  $N = 6$  of those who identified publicly accessible information) mentioning the internet. Peer reviewed scientific journal publications were mentioned by no experts, although a small number (11%,  $N = 3$ ) mentioned reviews published by NICE, HSE and BORHF. There were no discernible differences between stakeholders in the groups of research, policy, industry/employee representation and service delivery.

End users too mentioned many sources of advice. However, bespoke professional advice was the most frequently mentioned (63%,  $N = 132$ ) with some 46% ( $N = 97$ ) of the total sample identifying consultancies including occupational health services. The next most frequently mentioned sources of advice were Government sources, excluding the NHS (48%,  $N = 101$ ). The bulk of these responses referred to HSE, which made up 44% ( $N = 92$ ) of the total sample. A similar pattern emerged when examining participants from organisations of different sizes and participants from different sectors.

For smaller ( $\leq 500$  employees) and larger organisations, the proportions were different. Participants from smaller organisations mentioned bespoke professional advice less frequently (58%,  $N = 55$ ) than participants from larger organisations (67%,  $N = 76$ ). In both cases, consultants including occupational health services were the main source of professional advice mentioned (38%,  $N = 36$  of total sample from smaller organisations, 52%,  $N = 59$  of total sample from larger organisations). In contrast, participants from SMEs mentioned Government sources of guidance more frequently (54%,  $N = 51$ ) especially HSE (49%,  $N = 47$  of total sample from SMEs). Corresponding figures for larger organisations were 44% ( $N = 50$ ) and 41% ( $N = 46$ ) respectively. These results may reflect larger organisations' greater access to specialised and external resources.

Participants from high physical demands sectors and high emotion regulation demands sectors reported roughly equal proportions of use of bespoke professional advice (53%,  $N = 68$  and 59%,  $N = 46$  respectively) and use of Government sources other than the NHS (56%,  $N = 72$  and 51%,  $N = 40$  respectively). For both these high risk sectors, use of bespoke professional advice is slightly lower than in the whole sample and use of Government sources other than the NHS is slightly higher than in the general sample.

#### CHARACTERISTICS OF GOOD ADVICE AND GUIDANCE.

Participants were asked three questions relevant to the provision of good advice and guidance on preventing or managing CHPs. Participants were asked how they would like to see current guidance improved, what the characteristics of useful advice and guidance are, and what the characteristics of poor advice and guidance are.

In relation to the characteristics of improving advice and guidance, experts were evenly divided on how current advice and guidance could be improved, with 29% ( $N = 8$ ) indicating current advice and guidance need to be more enticing, and most especially more user centred (50%,  $N =$

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<sup>19</sup> In this section, many of the percentages sum to greater than 100% as participants often listed several sources.

4 of those who indicated advice needs to be more enticing); 21% ( $N = 6$ ) indicating current advice and guidance need to be more actionable, especially in relation to flexibility (50%,  $N = 3$  of those who indicated advice needs to be more actionable); and 21% ( $N = 6$ ) indicating that current advice and guidance are already good. Most of the remaining experts (21%,  $N = 6$ ) did not make a suggestion.

End users also followed a similar pattern to experts, with 28% ( $N = 61$ ) indicating current advice and guidance need to be more enticing, and again more user centred (58%,  $N = 35$  of those who indicated advice needs to be more enticing); 23% ( $N = 50$ ) indicating current advice and guidance need to be more actionable, and again especially in relation to flexibility (56%,  $N = 28$  of those who indicated advice needs to be more actionable). However, only 7% ( $N = 15$ ) of end users indicated that current advice and guidance are already good. Some 28% ( $N = 61$ ) of end users did not make a suggestion.

The following quotes each illustrate how advice and guidance can be made more enticing (user centred, first seven quotes below) or more actionable (flexible, last four quotes below).

*It needs better support through training of first- line and middle managers (expert 2)*

*well as I don't know where to find it I'd say it needs better advertising! (end user 21)*

*HSE has done an outstanding job in recent months in making itself more accessible. Excellent pragmatic approach. EA + other agencies should follow suit. Mandatory OH provision to all businesses (as in France) (end user 28)*

*Make us more accessible to the workforce. Enabling more companies to have the occ health cover back. Prevention is better than cure. More education to employers that they need to have preventive measures in place. Yes it costs , but so does people on the sick and not at work! (end user 63)*

*Delivered in an understandable way pertinent to the workers' education and IQ (not just language as in English/Polish/German, but in words and phrases which the workers use in their daily life) (end user 123)*

*Managing the responsibilities of work/health i.e. employment contracts do need to be fulfilled and thus individuals need to self manage health more robustly. Guidance on self management and when to expect sufficient recovery or seek further assistance would be helpful. People often worry that work will make matters worse when in fact it may only be specific activities and the need for adjustments in the domestic setting (end user 149)*

*Yes, I'd like more recognition that people (especially employees) already know what the problem is and (sometimes with input from experts) often know what the answers are (end user 170)*

*Targeted to specific staff groups on topics relevant to the specific workforce profile and hazards inherent to the workplace (end user 177)*

*Re-set the approach that the NHS use, so that these issues are identified at the outset and people are not dragged into extensive medical assessment before addressing the workplace and other non-medical causes (expert 11)*

*'Official' guidance must not merely say that unnecessary bureaucracy is undesirable. It needs to say quite explicitly that it is BAD practice. At present there is a widespread*

*perception that a highly bureaucratic paperwork back covering approach is a wise precaution - 'just in case'. There is little of sufficient weight in current regulator messages to support those making sensible informed judgements at the expense of those sheltering behind useless bureaucracy. The sensible risk management principle is voiced clearly at a broader, higher level (e.g. Judith Hackitt). It is less explicitly evinced at a more detailed guidance level (end user 87)*

*Perhaps an interactive section on the HSE website could be useful for specific guidance (end user 172)*

*Procedures need to ensure that the procedures allow a certain amount of flexibility for people with stress/ mental health problems. If you are not well then strict procedural deadlines are a problem (end user 212)*

Some of those experts that indicated that current advice and guidance are already good did indicate that improvements could be made in other areas through the provision of more resource to improve up-take of good advice and guidance:

*Its not about improving the guidance its about getting people to use the superabundance of what's there already (expert 17)*

*Difficult. Good advice is out there but so is the bad advice. Further efforts to make the good advice more accessible and high profile will help (expert 7)*

In relation to the characteristics of good advice, the dominant view expressed by experts was that of making advice and guidance more enticing (61%,  $N = 17$ ), with many of those that expressed this opinion (71%,  $N = 12$ ) indicating advice and guidance should be straightforward. End users too indicated that good advice and guidance are enticing (52%,  $N = 113$ ), with most of those that expressed this opinion also indicating that good advice and guidance are straightforward (53%,  $N = 60$ ).

*Clear, flexible guidance that employers can implement without the need to commission the services of a consultant (expert 1)*

*Clear, succinct and accurate information - case studies can be particularly useful. A variety of formats may be useful too. For example, going beyond paper-based guidance and providing workshops or consultations may help too (expert 10)*

*Good background information Simple language Relate it to the individuals circumstances Good practice examples they can relate to Not too long or dense (expert 17)*

*it should be brief, concise easily understood a widely available. Web based is the way forward so that it can be update easily and quickly (expert 25)*

*slogans such as 5 a day and catch it, kill it, bin it (end user 5)*

*Easy for all to understand. Easy to locate. Based on science not "HR/legal" speak (end user 6)*

*Simple steps, simple language (i.e. conceptually straightforward) and likely to be cheap! (end user 10)*

*Concise advice which not only explains what the problems are, but also offers what the main causes are together with possible solutions (end user 91)*

*Plain English for clear messages and practical advice e.g. managing the common cold or simple respiratory allergies with basic symptomatic relief to ease symptoms and reset expectations for continuing work rather than staying off at the earliest onset of symptoms. Being clear about what to look out for as significant signs of more serious conditions - red flags - helps set a safe framework for any waiting and seeing (end user 104)*

*Practical advice that can be implemented i.e. not all theoretical or 'model' based; tools for practical application; handouts/forms etc (end user 129)*

*Make sure you are presenting/giving information based on the lowest common denominator. no fancy word or dialog. Feedback from health surveillance should identify this (end user 154)*

*Short and to the point. With illustrations and photographs that can get the message across to anyone. Short videos that can be used for in-house training (end user 183)*

Some of the quotes above embellish the notion that advice and guidance should be given in simple and straightforward language, by incorporating notions of which media would be most enticing (web-based media, expert 25, flag based system, end user 104, videos, end user 183), providing concrete cases (expert 17) and providing workshops and training (expert 10). The provision of advice and guidance that can be actioned without referring to a consultant (expert 1) is interesting in juxtaposition with the dominance of consultants as sources of advice and guidance for end users (see previous section).

The next most frequent feature of good advice and guidance mentioned by experts was that advice and guidance should be focused (21%,  $N = 6$  experts), with a particular focus on training (50%,  $N = 3$  of those that indicated advice and guidance should be focused), as illustrated in the following quote which also highlights some cultural issues which might be amenable to change through training:

*I believe there are 2 critical problems. Firstly individuals need really good people skills. This requires long-term training, and a management group who want to learn. Secondly, our cultural default is to avoid conflict. (i.e. a black flag). This means that conflict does not get resolved properly. Both of these are huge problems, with no quick solutions (expert 5)*

For end users, the next most frequently mentioned characteristic of good advice and guidance related to advice and guidance that are actionable (18%,  $N = 40$ ), with a particular emphasis on specific/concrete information (50%,  $N = 20$  of those that indicated advice and guidance should be actionable):

*People want specific advice, relevant to their actual needs, understanding and situation, not generic, universal information. They also want practical, definite, clear and readable information. They do not want conditional information (e.g. info on likelihoods), academic discussion of considerations or contradictory suggestions. The more abstract, generalised or high level it is, they less useful they find it. They prefer it to be reliable with authority behind it, but do not respond well to patronising or self-important statements. They also prefer it "just in time", rather than in some inappropriate context (end user 67)*

*Specific advice on specific problems. Newsletters and websites that actually tell us about real life cases and prosecutions are a great way to find out how not to do things.*

*As long as the content of advice is specific to its related topic then it can only be good advice or guidance (end user 191)*

In relation to poor advice and guidance, many experts and end users believed that poor advice and guidance are characterised by implementation difficulties (71%,  $N = 19$  of experts and 47%,  $N = 93$  of end users). For both experts and end users, this was mainly because of advice and guidance that are too complex to implement (40%,  $N = 8$  of experts who mentioned implementation difficulties, 24%,  $N = 22$  of end users who mentioned implementation difficulties) or because advice and guidance are abstract or vague (30%,  $N = 6$  of experts who mentioned implementation difficulties, 29%,  $N = 27$  of end users who mentioned implementation difficulties). In addition, some 21% ( $N = 20$ ) of end users who mentioned implementation difficulties indicated poor advice and guidance are poorly focused. These views are illustrated in the following quotes:

*Jargon, overly long, unclear, vague or general (expert 8)*

*Too long Too complicated Lots of language that people don't understand (expert 17)*

*Too detailed, technical advice which is not available to managers and employees (expert 14)*

*Advice that is complicated and too long. Managers don't have time to read long documents. The sort of advice that HSE put out for small business is often helpful in larger organisations (end user 49)*

*Information that is highbrow and that nobody really understands (end user 83)*

*Advice that is too complex and does not give ideas that can be used in a tool kit format. Also, I work for an employer who falls between SME and large company and we are in the position of not being able to afford a dedicated OH nurse or similar and are not able to access the help (like FFWS) that is designed for SMEs. Most advice seems to miss companies like ours (end user 130)*

*technical, too much legalese -not relevant to daily work life (end user 189)*

*Does not say what actions can be put in place to prevent / manage common health problems. Does not relate to the workplace and is theoretical rather than practical (expert 28)*

*Simple broad-brush advice (expert 5)*

*Superficial guidance or lack of guidance - otherwise find it hard to envisage poor guidance (end user 22)*

*Guidance giving 'ideal' situations or the desired state of affairs with no 'route-map' on how to get there in our resource starved real-world. Also guidance giving 'soft' easy to control examples - often the 'correct' course of action is obvious (end user 32)*

*Too much generalisation - not specific enough about a particular job and how someone may need to be accommodated (end user 53)*

*Theoretical advice that cannot be applied to a workplace (end user 195)*

*Generic advice/guidance is sometimes too wide (end user 24)*

*Just a simple list of costs/criminal penalty implications for not taking action (end user 69)*

The next most frequently held view expressed by end users was that poor advice and guidance are unenticing (19%,  $N = 37$ ). This finding echoes earlier findings relating to improving advice and guidance through making them more enticing. Of those end users who indicated that poor advice and guidance are unenticing, 46% ( $N = 17$ ) endorsed this view stating that poor advice and guidance are not credible:

*Hear say Public forums where people discuss what their experience was as if it is medical evidence. Sites from organisations that may have a bias. Often GP advice if it is very proscriptive without them knowing what a job entails or what adjustments can be made (end user 47)*

*Unqualified advice from those with ulterior motives (end user 109)*

*When sites or newsletters etc are completed by people with a limited knowledge of the subjects they are talking about, the advice or guidance is far too general and no use to anyone (end user 191)*

In relation to the questions concerning how to improve advice and guidance, there were some differences between academic/researchers and other experts. No academic/researcher indicated that current advice and guidance are good. Of those who stated current advice and guidance should be more actionable, 67% ( $N = 4$ ) were academics/researchers. Of those who stated current advice and guidance should be more enticing, 63% were academics/researchers ( $N = 5$ ). Of those who indicated that good advice and guidance are focused, 67% were academics/researchers ( $N = 4$ ). Of those who indicated that poor advice and guidance are unfocused, 67% were also academics/researchers ( $N = 4$ ). This compares with just 41% of the expert sample as a whole comprising of academics/researchers. These differences may reflect academics/researchers focus on developing knowledge to improve practice. However, this interpretation is not borne out by quotes from academics/researchers. Only one academic/researcher (expert 20) mentioned a need to develop the research base, whilst two (experts 1 and 5) indicated that the current level of evidence may already be sufficient:

*A comprehensive approach would be useful and would be more easily applicable to SMEs. One such approach is the WHO Healthy Workplaces framework but more work is necessary as concerns tool development (especially for us at the SME context) (expert 20)*

*There is a need to focus employers and employees on the excellent materials that are currently available (namely on the HSE website) rather than develop yet more literature (expert 1)*

*I think there is enough advice/guidance out there but not enough training (expert 5)*

There was a difference between smaller ( $\leq 500$ ) and larger organisations in the characteristics of good advice and guidance. Participants from smaller organisations were less likely than those in larger organisations to indicate that current advice and guidance should improved by making them more actionable (18%,  $N = 17$  and 26%,  $N = 32$  respectively) or that good advice and guidance are characterised by being actionable (14%,  $N = 13$  and 21%,  $N = 26$  percent respectively).<sup>20</sup> This difference may reflect either: a) that SMEs are generally more flexible and so are able to make changes more easily on the basis of current advice; and/or b) those with

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<sup>20</sup> Other differences in the more frequently mentioned categories did not differ by more than three percentage points between smaller and larger organisations.

responsibility for OHS in larger organisations need evidence from HSE or other bodies that specific and concrete actions are necessary in order to convince other stakeholders to engage in change processes. Indeed, one end user from a large organisation specifically asked for advice and guidance to show employers what is expected of them, and two end users from larger organisations specifically indicated the need to engage multiple stakeholders in justifying asking for more actionable advice and guidance:

*A series of HSE produced Guidance Notes so that employers can see the expectations of the enforcing authority (end user 46)*

*I would like to see the occupational health section made more open to employees without having to go through management referrals, some people do not like to discuss problems with managers but would do so with health professionals, easier access to them (end user 79)*

*More joined up thinking. OH very proactive and sound advice. HR very reluctant to take risks (end user 205)*

Comparisons between sectors with higher physical demands and sectors with higher emotional regulation demands did reveal some differences too. When asked about the characteristics of good advice and guidance, participants from sectors with higher physical demands endorsed the category ‘enticing’ more often than participants from sectors with higher emotion regulation demands (55%,  $N = 72$  versus 43%,  $N = 33$  respectively). Similarly, participants from sectors with higher physical demands indicated that poor advice and guidance are unenticing more frequently than those from sectors with higher emotional regulation demands (22%,  $N = 29$  versus 14%,  $N = 11$  respectively). Participants from higher emotion regulation demands sectors were more likely to indicate that good advice and guidance are actionable than those from sectors with higher physical demands (25%,  $N = 19$  versus 18%,  $N = 23$  respectively).<sup>21</sup> There was no clear reason for these differences, in that sector specific issues were not mentioned by participants for endorsing the view that they did. However, one reason for participants from physically demanding sectors asking for more enticing advice and guidance may be related to the supposed physical nature of many of the hazards, from which preventive action can be illustrated using visual media:

*Short and to the point. With illustrations and photographs that can get the message across to anyone. Short videos that can be used for in-house training (end user 148)*

*Simple straight forward advice. Pictorial representations Samples of consequences Bullet points with reference to further reading if interested/required (end user 114)*

*Willingness to listen to the patient by all (GPs, HR / Management and OH, as the patient knows his or her body best. Use more pictures as we all know a picture speaks a thousand words, in the form of leaflets and large posters. Free DVD on the said topic (where anyone can present to the workforce at an appropriate times) (end user 122)*

## ADDITIONAL COMMENTS<sup>22</sup>

<sup>21</sup> Other differences between sectors did not exceed two percentage points, excepting that participants from high emotional regulation demands sectors were less likely to give suggestions concerning the characteristics of poor advice than those from sectors with higher physical demands (25% versus 18% respectively).

<sup>22</sup> In addition, the presence or absence for each secondary code for each question for each participant was coded as 0 or 1 and entered into SPSS. Hierarchical cluster analysis using Ward’s method and the squared Euclidean distance

There were some other issues that became evident upon further reading of the answers to the questions concerning CHPs and the extent to which they are a problem and difficult to manage. In many instances, they represent minority views, but they do indicate areas that need to be addressed, at least in how issues concerning CHPs are communicated. The first two areas that emerged from some of the answers concerned the extent to which CHPs are a problem of contemporary UK society versus not being a problem at all. On the one hand, a few participants blamed CHPs on current working practices and the economic climate as follows:

*The contemporary world of work throws a host of challenges at workers, many of which are new or emerging (e.g., higher retirement age, electronic communications). These challenges, combined with ongoing efficiency drives to improve competitiveness and job insecurity associated with the increased use of short-term contracts, may result in perpetual feelings of unease. (expert 1)*

*Our 'target driven' society - when a target is reached the boundary is re-drawn to a higher target. (end user 50)*

*1) Increased demands on workers from their employers and domestic life, coupled with uncertainties about job insecurity, loss of home; 2) Lack of time to visit GP, especially in the building industry where many workers are away from their registered GP (whether because the worker is from abroad or temporarily relocated within the UK); 3) Lack of knowledge about symptoms and how to access available treatments; 4) Lack of family/colleague support to discuss symptoms/worries. (end user 123)*

*As an OH practitioner I see a lot of employees with the above symptoms often they are work related and often linked to lifestyle issues which link back to work. i.e. long hours, pressure of work reduces the time for taking care of themselves hence lifestyle problems such as obesity, high BP, lack of exercise increases stress symptoms. vicious circle! This results in poor performance, presenteeism, and absence. All of this impacts on work and therefore the economy (end user 164)*

One end user did provide some concrete suggestions for addressing these cultural issues:

*Cultural change is required, change in management styles and employee acceptance. Subtle advertising in the media, sowing the seeds. Promoting companies that seem to have the balance right - look at the Google workforce ads. Education of our young people whilst they are at school, helping them to create bonds to group work. Encouraging social interactions outside of work - businesses providing support for those activities or grouping together to provide them (end user 199)*

In contrast, some participants opined that CHPs are not really a problem at all and may have become 'pathologised' and their management too reliant to healthcare professionals:

*People associate any level of being unwell as a reason for not attending work or performing to expected levels. There is a less robust approach to managing health responsibility with a perceived need for medical interventions rather than self-management. This I feel arises from lack of confidence underpinned by lack of*

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*between cases was performed on these data to determine whether there were a small number of archetypal responses underlying the data. An examination of the agglomeration schedule indicated no particularly large 'jumps' during the clustering process, indicating there was no strong evidence for a small number of archetypal responses underpinning the data. There was weak evidence of a break in the agglomeration schedule consistent with six clusters underpinning the data. However, there was no evidence that the six clusters so derived were related either to perceived significance of CHPs as a problem, the kind of CHP perceived to be the most difficult to manage or any of the demographic variables. Given the weak evidence for clusters in the data from the hierarchical cluster analysis and lack of independent correlates to support the validity of the 'best' six cluster solution, it was decided that there is not a small number of archetypal responses underpinning the data.*



*knowledge, which leads to a higher level of concern about health matters. (end user 149)*

*It is my belief through 20 years experience that most illnesses or reasons for non-attendance in work are not true. Employees will make up excuses for non attendance so I do not think we will ever achieve an actual honest figure. Too many doctors have been guilty of giving workers sick notes for no reason. I do accept that injuries and illnesses occur in the workplace, but not to the reported extent for illnesses (end user 191)*

*You can't question stress. If a doctor diagnoses stress there is nothing any employer can do. You cannot question stress as an illness. (end user 191)*

The second two areas are also inter-linked. One relates to the relevance of individual differences, beliefs and cognitions to the development and maintenance of CHPs, especially stress and mental health. These notions linked to individual circumstances surfaced in many responses in relation to the complexity of CHPs. This then leads onto views that the current approach to prevention may not be optimal.

*Not much between them [the three different forms of CHPs examined here], because the individual's beliefs are normally the key determinants. (expert 19)*

*Steps taken to assess and reduce stress may alter worker beliefs expectations in a way that increases rather than reduces illness (expert 18)*

*no stress case is straight forward. There is always a combination of both personal and work stressors. Every case is virtually unique in the circumstances that are causing stress. There is little that can be done from an employer's perspective if a member of staff has personal/out of work issues that cause stress, even though they may impact heavily on the job they do. (end user 92)*

*Stress and other mental health problems are largely dependent upon individual perception and are therefore difficult to quantify - not everyone takes time off sick when they get stressed. Physical problems often occur because of working posture (end user 113)*

*At least a proportion of physical complaints can be dealt with by 'normalisation' and use of independent evidence based best practice advice. Common mental health problems also have a standard format for self management and workplace support (based on custom and practice). Stress problems are a function of the individuals' perception of their circumstances, which may (to a third party) appear reasonable but difficult to change within the workplace OR may, in large part, be a function of personality traits, which are also difficult to overcome by simple workplace interventions. These comments are confined to employees in whom these issues have led to long term absence. (end user 196)*

*Stress is difficult as what causes one person to feel under pressure is not relevant to another. Not all stressors are work related therefore cannot be dealt with at work - one of the reasons the HSE stress tool is difficult to apply! Where a cause is obvious it can be dealt with reasonably quickly, but sometimes employees will not tell you there is an issue until it has escalated into 4 or 5 issues and then manifests itself through ill health symptoms or changes in behaviour and by then the initial cause is no longer the main issue for them. (end user 176)*

This last quote links issues concerned with individuals rather than work to problems with the current approach to prevention. The notion that personal factors are important in preventing and

managing CHPs has been discussed above. However, whilst very much in the minority, some participants did express some very negative views concerning HSE's approach. For example:

*I'm not sure how much evidence there is that prevention is realistic. Back pain, for example, is very common, but the vast majority is not triggered by specific work factors. For 75% of the people I see, home factors (e.g. relationships, money, bereavement) are very important. These are normal life events, and cannot be prevented (expert 16)*

*Because HSE drives a safety culture of massive red tape with little pragmatism about it. Consequently the smaller companies pay lip service to the rules and do not embrace them. An example of this I know somebody who works in a sausage factory as a recent recruit. The COSHH risk assessments for the ingredients have dust masks as a control method, signs in the area are erected to show this. However there were no dust masks available. On enquiry about getting a mask this person was told by the area leader, if you don't like it there is the door (end user 42)*

*Why do you think prevention is possible?*

and

*Why is it the responsibility of employers to manage all CHPs? (end user 219)*

In the case of one expert (9), concern over the current approach to prevention and management ran through many sections of the questionnaire:

*Step one would be completely scrap all the current guidance on non-specific injury at work. They present the impression that work is toxic, that work is the problem. They encourage a begrudging compliance mentality from duty holders, they detract from using judgement and encourage box ticking. A list of hazards approach for non-specific outcomes is an abuse of the HASAWA and in practice encourages an abuse of the civil law. A list of hazards approach could be balanced out by a checklist of all the non-specific "good" things in the workplace, even those which don't follow a linear relationship with the hazard. Stressors and anti stressors could then be judged as a whole and the overall condition of the workplace assessed. Even if this sounds quite woolly, it would be more accurate than the current approach. If overall the judgement is that workplace is bad, then either reduce the hazards or increase the good things as appropriate. Tell employees what you are doing. The vast majority of these common health problems are not caused or made worse by work but are made worse in their effects (but not their degree) by perceptions of work. If the question is really about managing problems (and it should be) then perceptions are the primary target. Interventions based on compliance have been repeatedly proven to work at the perception level but don't reduce the incidence of actual harm. The only certain way to prevent common health problems at work is not to employ people with common health problems. In short, primary prevention is the wrong question entirely. Sorry HSE, you simply have the wrong model.*

and

*... the idea that common health diagnoses can be prevented by removing non-specific hazards at work is the basic mistake that has been made. using standard risk assessments is a mistake. adopting employment handbook policies which assume a causal model is a mistake. e.g. sending people home until they stop complaining. being guided principally by case law is a mistake. But recall that the individual is not the only stakeholder and that others may be driven by the law or, for marketing purposes, to adopt the above positions. The answer depends very much on which stakeholder you are talking about.*

On the other hand, two participants did not think HSE's approach goes far enough, and there should be greater and more high profile enforcement:

*Prosecute those who do not educate and who allow/encourage risks to be taken - for example by reduced manning levels*

*Prosecute poor performers so that punishments become a counter to shareholder greed and*

*...punitive damages to those who infringe safe working practices (end user 107)*

*a higher enforcement approach that is targeted regularly at employers -particularly larger ones that have the capacity to achieve compliance but choose not to and get away with it repeatedly. Link this with high profile publicity (end user 189)*

Finally, a small number of stakeholders suggested approaches not covered explicitly in many current approaches. These include integration of approaches with other organisational systems and more extensive consultation between stakeholders:

*Effective management of occupational health and safety - integrated with other aspects of management of the workplace, including HR management - based on an awareness and understanding of the hazards and risks present and how to eliminate, reduce and manage them focussing on individuals rather than the organisation as a whole (expert 16)*

*Stress - a buy in from HR professionals would help as a significant number appear to not recognise that stress exists. Mental health -again, there is a poor buy in from HR professionals even though this would be linked to duties under the DDA (end user 189)*

*Approaches agreed through negotiation between employers and workers so that there is consensus around the priorities and how to tackle them. Everyone should be involved, with different means of raising awareness/educating people to deal with different learning styles and acceptance of initiatives. This requires information sharing (including OH stats etc so that Management can't say they know something without sharing the source with H&S reps) and honesty (expert 2)*

*Engage the workforce on how they feel, what they are/aren't happy with, and create a culture that employees can speak up about anything they are unhappy with, with the belief that it will genuinely considered, and not just ignored. Be flexible, where possible, to accommodate peoples exercising habits. Publicise issues, i.e. Mental Health/Stress, and bring them (and related symptoms) to peoples attention - don't just shy away and avoid the issue until somebody approaches you with one (end user 14)*

This consultative two-way approach extends to communications concerning guidance too:

*one way communications - such as bulletins ok to keep you informed but unlikely to convince anyone to change (end user 143)*

*Information that seems boring or preaching is not well received by employees (end user 210)*

## SUMMARY

This section summarises the major findings from the analysis of the stakeholder survey, interweaving findings from different sections where appropriate to provide a coherent overview of related findings. Note, given the relatively low response rates and small numbers of experts, the results cannot be interpreted without due caution and implications extracted only if triangulated from other sources (e.g., literature review).

### CHPs AS A PROBLEM

There were differences between end users and experts on the extent to which CHPs were judged to be a problem. End users considered CHPs to be moderate problem whereas experts considered CHPs to be a significant problem. Differences between experts and end users may be explained by experts' familiarity with or focus on CHPs. Both experts and end users considered CHPs to be a problem because of their impact on people and organisations. However, experts were more likely to focus on absence as a reason for CHPs being a problem, and end users more likely to focus on the occurrence of CHPs in addition to CHPs' impact. Participants from the smallest companies considered CHPs to be even less of a problem. It is not clear why participants from the smallest organisations considered CHPs to be less of a problem: it may be because in the very smallest organisations, CHPs are less likely to occur because of smaller workforces or because workers with CHPs can be accommodated more easily as the smallest organisations are likely to be the most flexible. Participants from sectors with higher physical demands considered CHPs to be less of a problem than participants from sectors with lower physical demands. This may be because MSDs might be more straightforward to deal with: Most participants considered stress and mental health as the most difficult CHPs to deal with, and cited the complexity of CHPs as the reason why CHPs are difficult to manage.

### MANAGING AND PREVENTING CHPs

Experts generally thought that CHPs are best prevented through job/organisational redesign (including manager training) and person-focused interventions may be integrated with job/organisational redesign. End users were more likely to think that CHPs are best prevented through person-focused interventions, personal training and especially manager support for individuals, than other forms of intervention. Some end users noted the importance of management training in relation to provision of support for individuals. Participants from smaller organisations and from physical demanding sectors were more likely to favour person-focused approaches than other approaches. However, sizeable minorities of end users also mentioned job/organisational redesign and information provision as effective means of prevention.

Experts tended to think that job/organisational redesign, especially work adjustment, is the best means of managing CHPs where they occur, followed by person-focused interventions. End users tended to favour person-focused interventions, especially referral to medical practitioners and HR/manager support for specific individuals.

Many participants indicated the need to take into account individual differences, beliefs, coping abilities in interventions. Moreover, some end users were aware of the interconnectedness of interventions for managing CHPs and wanted integrated interventions that went across multiple levels and included consultation between multiple stakeholders in the development of interventions.

### ADVICE AND GUIDANCE

Experts and end users tended to see the main sources of advice and guidance as HSE and bespoke professional services, such as consultancies and occupational health services. End users were more likely to seek bespoke professional services for advice and guidance.

There were some minority views that might need to be addressed in advice and guidance to ensure credibility across a range of stakeholders. First, advice and guidance may need to acknowledge that some people view CHPs as a cultural/societal problem that may not easily be tractable. In contrast, advice and guidance may also need to acknowledge the view held by some that CHPs are not really a problem at all or at least not a problem that organisations should have to deal with. Advice and guidance may need to recognise CHPs complexity and recognise the need to focus prevention and management at multiple levels (personal, manager, job, organisation) through integrated and consultative interventions. Advice and guidance may also need to portray the beneficial aspects of work.

In general, experts and end users in the sample felt that good advice and guidance should be:

- Actionable, including information that is concrete and focused on specific problems, with clear advice on actions yet flexible enough to allow tailoring of actions to specific circumstances – specificity of actions may be particularly useful for those in larger organisations;
- Enticing, including a focus on user requirements and expressed in straightforward, evidence-based language by credible sources that are perceived to be neutral, and using visual media where appropriate;
- Easily accessible and pointing end users to good advice rather than poor advice;
- Supported, especially through the use of flexible media and with follow-ups such as training.

## REFERENCE

King, N. (2004). Using templates in the thematic analysis of text. In Cassell, C., & Symon, G. (Eds.), *Essential Guide to Qualitative Methods in Organizational Research*. London: Sage.



## **Managing Common Health Problems in the Workplace: A Survey of Emerging and Best Practice**

The purpose of this brief survey is to gather views on managing common health problems in the workplace and to identify the types of support and guidance needed. This is part of a Health and Safety Executive (HSE) funded project on developing guidance and a toolkit to minimise the occurrence and manage common health problems at work. We have contacted you because you are an acknowledged expert in research or policy in this field or because you are active in managing health at work.

Common health problems are the sort of complaints that affect many of us at some time. They tend to be recurrent and it is not unusual for various symptoms to occur together. They include:

- \* physical complaints such as muscle and joint pain;
- \* mental health problems such as anxiety and depression;
- \* stress, including related problems such as abdominal or chest symptoms.

They occur frequently in the working population, and are linked to sickness absence, care seeking, health-related benefit claims and reduced productivity.

Your co-operation in completing this survey would be greatly appreciated and your responses will be treated in the *strictest confidence*. The survey consists of **10** main questions, **eight** of which require brief open-ended responses, plus five questions concerning basic demographic information for record keeping purposes.

Please respond by **>date 2 weeks hence<**.

If you feel that a colleague is in a better position to complete this than yourself please forward this survey on to them.

Many thanks for your co-operation in advance.

Louise Carter

Health and Safety Laboratory.

If you require any further information, please contact us on: 01298218378 or email [louise.carter@hsl.gov.uk](mailto:louise.carter@hsl.gov.uk).

Common health problems are the sort of complaints that affect many of us at some time. They tend to be recurrent and it is not unusual for various symptoms to occur together.

- \* physical complaints such as muscle and joint pain
- \* mental health problems such as anxiety and depression
- \* stress, including related problems such as abdominal or chest symptoms.

---

**1. Overall, to what extent do you think common health problems are a problem in the UK working population? (please circle the answer that best represents your view)**

Not a problem at all	A very minor problem	A moderate problem	A significant problem	A major problem
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**2. Please explain briefly your reasons for your answer to question 1.**

*Common health problems are the sort of complaints that affect many of us at some time. They tend to be recurrent and it is not unusual for various symptoms to occur together.*

---

**3. Which of the following three major classes of common health problems do you think is the most difficult to manage in the workplace? (please indicate the problem you think is most difficult to manage)**

- \* physical complaints such as muscle and joint pain*
- \* mental health problems such as anxiety and depression*
- \* stress, including related problems such as abdominal or chest symptoms*

**4. Please explain briefly your reasons for your answer to question 3.**



*Common health problems are the sort of complaints that affect many of us at some time. They tend to be recurrent and it is not unusual for various symptoms to occur together.*

- \* physical complaints such as muscle and joint pain*
- \* mental health problems such as anxiety and depression*
- \* stress, including related problems such as abdominal or chest symptoms*

---

**5. What do you think is the best approach(es) to preventing common health problems in the workplace?** (if you think specific common health problems require different approaches, please note this)

---

**6. What do you think is the best approach(es) to managing people with common health problems in the workplace?** (if you think specific common health problems require different approaches, please note this)

*Common health problems are the sort of complaints that affect many of us at some time. They tend to be recurrent and it is not unusual for various symptoms to occur together.*

- \* physical complaints such as muscle and joint pain*
- \* mental health problems such as anxiety and depression*
- \* stress, including related problems such as abdominal or chest symptoms.*

---

**7. Where can you get advice/guidance on preventing or managing the consequences of common health problems in the workplace?** (if you get advice for specific common health problems, please note this)

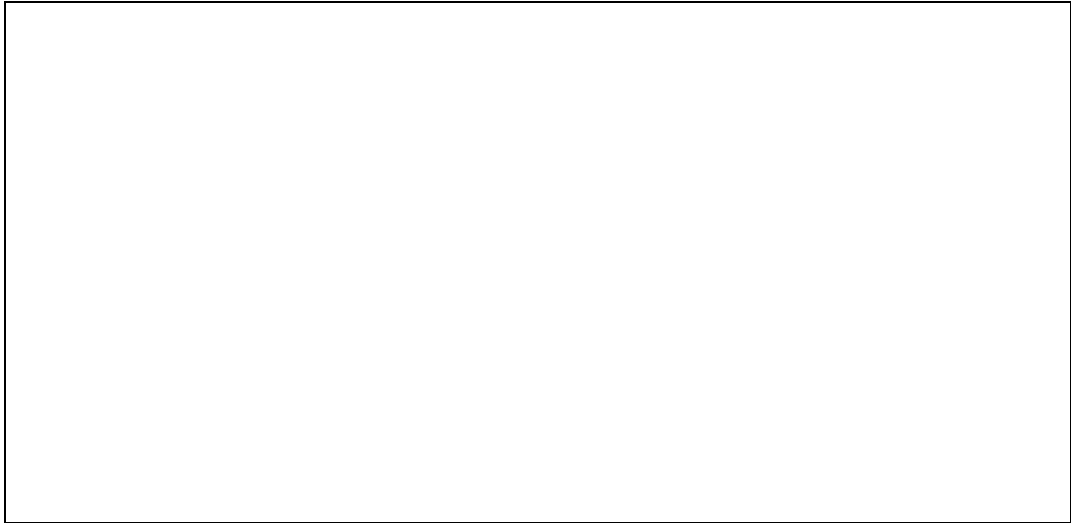
**8. How would you like to see this advice/guidance improved, if at all?**

*Common health problems are the sort of complaints that affect many of us at some time. They tend to be recurrent and it is not unusual for various symptoms to occur together.*

- \* physical complaints such as muscle and joint pain*
- \* mental health problems such as anxiety and depression*
- *stress, including related problems such as abdominal or chest symptoms.*

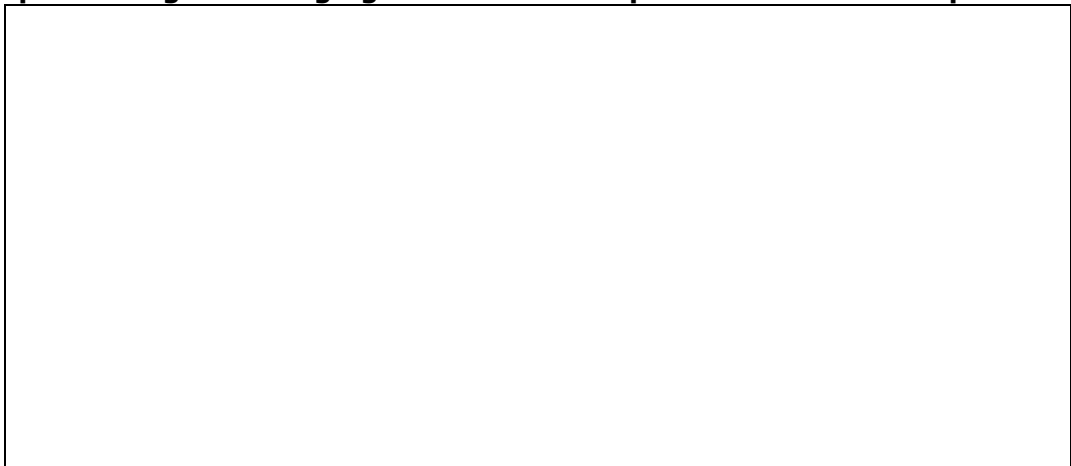
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**9. What do you think characterises *useful* advice/guidance on preventing or managing common health problems in the workplace?**



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**10. What do you think characterises *poor* advice/guidance on preventing or managing common health problems in the workplace?**



**We now need to ask a few brief background questions about you. You cannot be identified from this information.**

---

**A. Please state your age** ..... yrs

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**B. Please indicate your gender** Female Male

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**C. Please indicate the approximate number of people who work in the organisation of your primary employment**

0-5 people	6-50 people	51-250 people
251-500 people	501-1000 people	Over 1000 people

---

**D. Please indicate the sector of the organisation of your primary employment**

Agriculture/Fishing	Energy or water
Manufacturing	Construction
Retail/wholesale	Catering/hotels/restaurants
Transport	Communications
Banking, finance or insurance	Other private sector services
Public administration/Local Government	Health/social work

---

**E. Please indicate your main focus of activity in respect of common health problems**

General or functional manager management	Human resources
Delivering occupational health services in the organisation you work for	Medical practitioner
Independent occupational health consultancy	Research
Developing or implementing Government policy	Developing advice for a professional body
Employee representative (e.g. Trade Union)	Legal advisor
Insurer	

---

**F. Are there any other comments you wish to make about common health problems in the workplace or this questionnaire?**

***THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE***

## INITIAL TEMPLATE

Q2: Why CHPs a problem	Impact/severity	Stigma/disclosure	1
		Impact of work/absence (severity)	2
		Impact on person (severity)	3
	Complexity	Complex/difficult	4
		Difficult to tackle/manage at work (prevention and manage consequence)	5
		Not obviously present/difficult to diagnose/intangible	6
		Work not necessarily the problem	7
	Occurrence/prevalence	Enduring/recurring	8
		Concurrence	9
		Frequent	10
	Misc	Misc	11

Q4: Why MSDs, mental health, stress specifically difficult to manage	<u>Impact/severity</u>	Stigma/disclosure	1
		Impact of work/absence (severity)	2
		Impact on person (severity)	3
	Complexity	Complex/difficult	4
		Difficult to tackle/manage at work (prevention and manage consequence)	5
		Not obviously present/difficult to diagnose/intangible	6
		Work not necessarily the problem	7
	Occurrence/prevalence	Enduring/recurring	8
		Concurrence	9
		Frequent	10
	Misc	Misc	11

Q5: Best approaches to preventing CHPs	Job/organisation focused	Risk management/assessment process	1
		Change work environment (organisation, team, process, job)	2
		Change culture/climate/leadership	3
	Person focused	EAPs/workplace counselling (early stages)	4
		Referral to medical practitioner/occupational health service	5
		Change person – training	6
		Select right people	7
		Ensure person-job fit	8
		Health screening for CHPs	9
		Management/HR support	10
		Informal support	11
	Information focused	Health promotion	12
		Symptom reporting systems	13
		Information provision/education/risk communication	14
	Misc		15



Q6: Best approaches to managing CHPs	Job/organisation focused (person-job fit)	Work re-organisation for person (psychosocial)	1
		Task re-assignment	2
		Work adjustment (ergonomic)	3
		Change culture/climate/leadership	4
	Person focused	Training	5
		Deselection	6
		Referral to medical practitioner/occupational health service	7
		EAPs/workplace counselling, CBTs	8
		Management/HR support	9
		Informal support	10
	Information focused	Health promotion	11
		Symptom reporting systems	12
		Information provision/education	13
		Misc	14

Q7: Sources of advice/guidance	Government – health service	NICE	1
		DoH	2
		NHS	3
	Government – not health service	HSE	4
		DWP	5
	Industry organisation	CIPD	6
		IOSH	7
		Trade associations/unions etc	8
	Bespoke professional advice	Consultancies	9
		GP/primary care	10
		Colleagues/informal networks	11
	Publicly accessible scientific/practitioner opinion	Internet	12
		Scientific books/articles	13
		Popular management/medical press	14
		Conferences	15
		Misc	16

Q8: How to improve guidance	Enticing	User-centred/audience targeted/relevant	1
		Credible source	2
		Straightforward to understand	3
		Plausible	4
		Up-to-date	5
	Actionable	Specific/concrete	6
		Achievable	7
		Measurable	8
		Prescriptive	9
		Flexible/adaptable	10
		Effective	11
		Misc	12

Q9: What is good guidance	Enticing	User-centred/audience targeted/relevant	1
		Credible source	2
		Straightforward to understand	3
		Plausible	4
		Up-to-date	5
	Actionable	Specific/concrete	6
		Achievable	7
		Measurable	8
		Prescriptive	9
		Flexible/adaptable	10
		Effective	11
		Misc	12

Q10: What is poor guidance	Unenticing	Not credible source	1
		Doesn't make sense	2
		Dated	3
		Irrelevant	4
	Difficult to implement	Abstract/vague	5
		Poorly focused/defined	6
		Non-achievable	7
		Rigid	8
		Too complex	9
		Too time/resource consuming	10
		Ineffective	11
		Misc	12

**REVISED TEMPLATE**

Q2: Why CHPs a problem	Impact/severity	Stigma/disclosure	1
		Impact of work/absence (severity)	2
		Impact on person (severity)	3
	Complexity	Complex/difficult	4
		Difficult to tackle/manage at work (prevention and manage consequence)	5
		Not obviously present/difficult to diagnose/intangible	6
		Work not necessarily the problem	7
	Occurrence/prevalence	Enduring/recurring	8
		Concurrence	9
		Frequent	10
		Experience/personal knowledge/knowledge of statistics	11
	Factors beyond the health problem	Change in society/work	12
		Lack of OHS support	13
	Not as big a problem as made out	Not as big a problem as made out	14
	Problem with question	Problem with question	15
	Misc	Misc	16

Q4: Why MSDs, mental health, stress specifically difficult to manage	Impact/severity	Stigma/disclosure	1
		Impact of work/absence (severity)	2
		Impact on person (severity)	3
	Complexity	Complex/difficult	4
		Difficult to tackle/manage at work (prevention and manage consequence)	5
		Not obviously present/difficult to diagnose/intangible	6
		Work not necessarily the problem	7
	Occurrence/prevalence	Enduring/recurring	8
		Concurrence	9
		Frequent	10
		Experience/personal knowledge/knowledge of statistics	11
	Factors beyond the health problem	Change in society/work	12
		Lack of OHS support	13
	Not as big a problem as made out	Not as big a problem as made out	14
	Problem with question	Problem with question	15
	Misc	Misc	16

Q5: Best approaches to preventing CHPs	Job/organisation focused	Risk management/assessment process	1
		Change work environment (organisation, team, process, job)	2
		Change culture/climate/leadership	3
	Person focused	EAPs/workplace counselling (early stages)	4
		Referral to medical practitioner/occupational health service	5
		Change person – training	6
		Select right people	7
		Ensure person-job fit	8
		Health screening for CHPs	9
		Management/HR support	10
		Informal support	11
	Information focused	Health promotion	12
		Symptom reporting systems	13
		Information provision/education/risk communication	14
	Misc		15



Q6: Best approaches to managing CHPs	Job/organisation focused (person-job fit)	Work re-organisation for person (psychosocial)	1
		Task re-assignment	2
		Work adjustment (ergonomic)	3
		Change culture/climate/leadership	4
			5
	Person focused	Training	6
		Deselection	7
		Referral to medical practitioner/occupational health service	8
		EAPs/workplace counselling, CBTs	9
		Management/HR support	10
		Informal support	11
		Stakeholder involvement	12
		Consultation/communication	13
	Information focused	Health promotion	14
		Symptom reporting systems	15
		Information provision/education	16
		Assessment	17
	Early intervention	Early intervention	18
	No answer	No answer	19
		No relevant answer	20
		No specific answer	21
	Misc		22

Q7: Sources of advice/guidance	Government – health service	NICE	1
		DoH	2
		NHS	3
	Government – not health service	HSE	4
		DWP	5
	Industry organisation	CIPD	6
		IOSH	7
		Trade associations/unions etc	8
	Bespoke professional advice	Consultancies	9
		GP/primary care	10
		Colleagues/informal networks	11
	Publicly accessible scientific/practitioner opinion	Internet	12
		Scientific books/articles	13
		Popular management/medical press	14
		Conferences	15
		Misc	16

Q8: How to improve guidance	Enticing	User-centred/audience targeted/relevant	1
		Credible source	2
		Straightforward to understand	3
		Plausible	4
		Up-to-date	5
		Case studies/examples	7
	Actionable	Specific/concrete	6
		Achievable	8
		Measurable	9
		Prescriptive	10
		Flexible/adaptable	11
		Effective	12
	Focus of content	Focus on CHPs/stigma not performance or process	13
		Training	14
		De-medicalisation	15
		Implementation	16
	Guidance is good	Guidance is good	17
	Availability	More availability	18
		More resource	19
	No relevant answer	No suggestion	20
		No relevant answer	21
	Misc		22



## 11. APPENDIX 3

### 11.1.WORKSHOPS – EXPERT GROUPS

#### INTRODUCTION

In addition to the stakeholder survey (Appendix 2), we convened two expert workshops. The purpose of the workshops was to get early feedback on the direction of the project, with regard to the interpretation of the literature, ideas for the shape of the toolkit and factors to consider in developing the toolkit.

Two day long workshops were convened, one with experts from outside of HSE followed by one with HSE experts.

Prior to the workshops, participants were sent a summary of the literature review outlining the overall approach and definitions of major concepts of relevance to the project, plus a briefing document explaining the purpose of the workshop and asking participants to consider a range of questions before the workshop. These questions were:

- *Are there any interventions that might help to prevent onset of CHPs and/or associated symptoms, that are not already included in standard approaches?*
- *What can be done to make jobs more comfortable?*
- *How can struggling workers be identified?*
- *How can we avoid over-identifying less significant problems?*
- *What can be done to improve coping with work-relevant symptoms?*
- *How can resilience be built to deal with unavoidable aspects of work that are unpleasant or uncomfortable?*
- *What type of plan is required in the workplace, and who needs to be involved?*
- *What role is there for problem-solving approaches?*
- *Are there any specific workplace interventions that are reasonably practicable, feasible and effective?*
- *What can be done to facilitate accommodating workplaces?*

The workshops then proceeded as a series of presentations of major findings from the literature, with questions taken as the workshops proceeded, and open-ended debates on key issues in toolkit development related to an indication framework, identifying relevant solutions and implementing solutions.

Participants for the non-HSE workshop were identified in consultation with HSE. The project team initially drew up a list of possible participants for the workshops that covered areas relevant to muscular-skeletal problems, stress and mental health, and included academics, organisational consultants, medical practitioners and expert end users (e.g. senior HR or occupational health managers from large organisations). HSE suggested modifications to this initial list. Invitations were issued, and was attended by six experts and four members of the project team. Two staff from HSE were observers. Participants for the HSE workshop were identified by HSE, and consisted of HSE staff

with special interests in aspects of CHPs. Three members of the research team were present at the HSE workshop.

Overall, findings from the workshops indicated these experts had a favourable opinion of the project team's emerging interpretation of the literature and the conceptual underpinnings of the toolkit, as outlined in the literature review (Appendix 1). The following issues were raised as issues of importance for the toolkit to address or incorporate:

1. Differences between individuals. Different people experience work and interpret symptoms in different ways: Therefore, the toolkit needs to address individual differences in the prevention and accommodation of CHPs. Regular line management meetings and development appraisal processes were discussed as a means of achieving this.
2. The importance of the work-relevance of the toolkit. The toolkit cannot be a medical intervention, although it might help prevent the onset or moderate the experience of symptoms. The focus must be on the work-relevance of preventing and managing CHPs.
3. The word 'comfortable' should not appear in the toolkit, as it might imply work that is too easy and lowered motivation. An alternative term is needed.
4. The toolkit needs to take into account line managers' competencies if they are to be important in assessment and intervention, and also have a means of dealing with line managers if they are problematic (e.g., bullying behaviour is attributed as a cause of CHPs).
5. The toolkit should not encourage presenteeism.
6. It would be useful if senior management commitment to preventing and managing CHPs could be included in the toolkit, as senior management commitment seems to be an important element of implementing interventions.
7. It is important to take into account normative beliefs in the population concerning CHPs and their relation to work.
8. Management of expectations is needed to create realistic perceptions over the amount of effort required and pace of change.
9. It may be necessary to account for background reporting trends (e.g. generated by increased media attention) and reporting cycles stemming from economic, shift patterns, seasonal effects, symptom frequency and duration.

10. Efforts are needed to discourage unnecessary reporting of CHP complaints generated by raised awareness of CHPS.

Most of these points had been indicated elsewhere in the literature review or stakeholder survey, and these points merely reinforced our interpretation of the literature. However, the last point concerning normative beliefs, although present in the literature (e.g., beliefs concerning CHPs may influence recovery processes), had not been addressed in terms of how to overcome such normative beliefs if they were an obstacle to preventing or managing CHPs. Therefore, we conducted an additional search of the literature, looking for major, recent works on risk communication. The findings from this review are presented next.

## **EVIDENCE FINDINGS**

### **RISK COMMUNICATION**

Although the science base is not strong, reviews on risk communication indicate the following characteristics might be included in a checklist to ensure up-take of the toolkit:

- Use a multimedia approach;
- Think about using vodcasts to provide in-person presentations, possibly as an interview with a Q&A to provide clarifications;
- Ensure managers know that the risk is relevant to them, that they probably have personal or vicarious experience of the risk and they can do something about the risk;
- Use credible sources to deliver information – the HSE may be seen as one credible source;
- Tailor communication for the audience;
- Build the content of messages with the strongest scientific evidence available;
- Incorporate text with visuals (pictures, diagrams) with qualitative and quantitative data for print materials;
- Disseminate information in the media through multiple sources;
- Develop communication strategies with the awareness that people make choices based on personal experience;
- Ensure communication strategies are multi-modal and incorporate an opportunity for the public to have their questions and concerns addressed;
- Do not use automated phone call-in systems as a proxy for human interaction;
- Ensure any statistical estimates are correct and cannot be contested;
- Use numeric comparisons with similar phenomena to convey relative risk – especially of the kind X times more likely, but include baselines too;
- Use the same numeric denominator (e.g., compare 5 out of 100 with 15 out of 100);
- Round numbers and avoid decimals;
- Use bar charts to show relative risk;
- Use graphs to emphasise the number of people affected;
- Provide clear and comprehensible explanations of the graphs;

- Communicate probability and ease of implementation of steps to reduce incidence and manage of CHPs and self-efficacy at the local level;
- Use successful SME and larger organisation managers to convey opinions to persuade people to use the toolkit, and then further into the toolkit to use detailed narratives to illustrate how to use the tool.

The data extracted from references in this section are presented in table 4.

**Appendix 3 Table 4.** Evidence statements from follow-up to experts' workshop

HEADLINE	EVIDENCE STATEMENT (GRADING)
<p>It is possible to develop a checklist of factors to guide development of effective risk communication</p>	<p>Use a multimedia approach;            Think about using vodcasts to provide in-person presentations, possibly as an interview with a Q&amp;A to provide clarifications;            Ensure managers know that the risk is relevant to them, that they probably have personal or vicarious experience of the risk and they can do something about the risk;            Use credible sources to deliver information – the HSE may be seen as one credible source            Tailor communication for the audience;            Build the content of messages with the strongest scientific evidence available;            Incorporate text with visuals (pictures, diagrams) with qualitative and quantitative data for print materials;            Disseminate information in the media through multiple sources;            Develop communication strategies with the awareness that people make choices based on personal experience;            Ensure communication strategies are multi-modal and incorporate an opportunity for the public to have their questions and concerns addressed;            Do not use automated phone call-in systems as a proxy for human interaction;            Ensure any statistical estimates are correct and cannot be contested;            Use numeric comparisons with similar phenomena to convey relative risk – especially of the kind X times more likely, but include baselines too            Use the same numeric denominator (e.g., compare 5 out of 100 with 15 out of 100).            Round numbers and avoid decimals;            Use bar charts to show relative risk;            Use graphs to emphasise the number of people affected;            Provide clear and comprehensible explanations of the graphs            Communicate probability and ease of implementation of steps to</p>



HEADLINE	EVIDENCE STATEMENT (GRADING)
	reduce incidence and manage of CHPs and self-efficacy at the local level; (Fitzpatrick-Lewis et al., 2010; Lipkus, 2007; Senay & Kaphingst, 2009) *
Narratives concerning experiences with CHPs may be persuasive, but evidence is unclear	First person narratives tend to be more persuasive, but definitive conclusions cannot be drawn (Winterbottom et al., 2008) *** Therefore, it might be possible to use successful SME and larger organisation managers to convey opinions to persuade people to use the toolkit, and then further into the toolkit to use detailed narratives to illustrate how to use the tool

## REFERENCES

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## 12. APPENDIX 4

### 12.1. UNDERPINNING FRAMEWORK ('EXPERT BACKEND')

#### INTRODUCTION

This appendix document provides the detailed and in-depth justification and 'proof-of-concept' for the toolbox, which maps the scientific literature onto elements for a potential toolbox. At this phase of the project, the toolbox was at an initial conceptual stage, and much work needed to be done in streamlining the tool over remainder of the project to make it a working prototype (see Appendix 6). As this appendix represents the output of the second phase of the Common Health Problems project and as it builds on Phase 1 of the project, it is not intended to stand-alone and should be read following familiarisation with Phase 1 material.

As this appendix provides 'proof of concept', the intention is to demonstrate that it is feasible to build a simple toolbox with an easily applied indication framework that is firmly rooted in and justified by the available scientific evidence. This document is, therefore, a detailed working through of the steps in designing this first stage of 'proof of concept'. This appendix is therefore intended to show the detailed logic underpinning toolbox development from scientific knowledge (see Appendix 1) through the final prototype toolbox (Appendix 6).

#### FRAMEWORK-RELEVANT DEFINITIONS

Definitions pertinent to this framework description are as follows:

**Active interventions:** Interventions that require the target audience to take action.

**Compliance:** Adherence to practices required by formal Common Health Problems (CHP)-related guidance.

**Cultural maturity progression:** Transition between different degrees of readiness. For the purpose of framework, interventions relate to two stages of progression are indicated. The stages are represented by Workbook A and Workbook B. Workbook A enables progression from non-compliance to compliance, Workbook B enables progression from compliance to exceeding compliance.

**Good Work:** Always desirable, de facto minimum standard of 'good' and safe. Enabled by factors operating at a mainly at societal level. Good work does not always produce 'Good Jobs', this also requires:

- *Comfortable jobs:* are subjective. Comfortableness varies between individuals and across time. Comfortable jobs mitigate unavoidable unpleasant/uncomfortable aspects of jobs (e.g. coping, resilience). Intervention is mainly at group level, but may involve individual level interventions. Outcome of interest is reduced complaints of problems (symptoms).
- *Accommodating workplaces:* facilitate coping with temporary symptoms, allow stay at work, maintenance of work habits, job routine, etc. A key element is worker-line

manager relationships. Intervention is predominantly at the individual level. Outcomes of interest are productivity and reduced work loss.

**Health and wellbeing cultural maturity:** Important organisational cultural characteristic that determines an organisation's degree of readiness to manage well-being at work.

**Intervention:** Actions intended to bring about changes in (a) knowledge, attitudes or behaviour at an individual level, (b) the work environment at the group level (c) and/or systems and culture at the organisational level.

**Module:** Self-contained segment of the toolbox. Depending on the organisation's status with respect to work-relevant CHP management, modules can be used on a stand-alone basis or in conjunction with other modules for more comprehensive work-relevant CHP management.

**Passive interventions:** Interventions that affect knowledge/raise the awareness of their target audience without necessarily requiring them to take action.

**Workbook:** Toolbox specific guidance that includes simple instructions on how to identify work-relevant CHP problems, and on the basis of the diagnostic information provided by the tools, information on appropriate interventions and how to implement appropriate interventions. Different workbooks are relevant to different modules.

## UNDERPINNING PRINCIPLES FROM PHASE 1

The evidence synthesis from Phase 1 of this research led to a conceptual model for guiding development of a toolbox for managing common health problems (CHP). This model portrays effective CHP management as requiring: a) *comfortable jobs* capable of reducing the incidence and escalation of work-relevant CHPs; and b) an *accommodating workplace* in which those struggling with work-relevant CHPs can function effectively.<sup>23</sup> Phase 1 also informed the principles upon which the toolbox and its underpinning should be based. These principles are captured below. *Following each statement, a code is provided in brackets indicating the Phase 1-evidence statements that inform that principle* (see Appendices 1 and 2). The toolbox:

- *Supplements current approaches:* Is intended to *supplement* current primary prevention (e.g. the Management Standards (MS), health promotion, and the HSG60 for upper limb disorders) and health care approaches and address a 'zone of lost opportunity' between primary prevention and health care. A key difference from the MS is that the MS approach aims for universal prevention in the workplace. The toolbox is intended to enable targeted or individualised prevention/accommodation. Individuals and groups of

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<sup>23</sup> Note at this stage of the project, the terms 'comfortable jobs' and 'accommodating workplaces' were working terms that mapped onto existing terminology concerned with the physical work environment (which is concerned with removing physically uncomfortable aspects of the work environment). At this stage, we retained these terms. However, because most of the focus of the toolbox is on the psychosocial environment, in prototype toolbox (Appendix 5), we replaced the term 'comfortable jobs' with 'Good Jobs'. This was because feedback indicated the term 'comfortable jobs' could convey a sense of work that is pleasant but de-motivating. It is not the intention of the toolbox to convey such a message. The term 'Good Jobs' may more easily convey a sense of work that is pleasant, motivating and engaging.

individuals can be targeted through comfortable jobs. Individuals who are struggling can be targeted through providing accommodating workplaces.

- *Should prevent escalation of work-relevant CHPs.* It should be able to operate 'just in time' to reduce the incidence or work-relevant CHPs from developing or getting worse (Evidence Statement G-1 0; G-2 \*; G-10 \*\*\*; MS-9 \*\*). Therefore, it should be capable of being on-going, rather than the MS which seems to be used as a one-off. There might be scope to integrate the system into normal performance management, development and appraisal systems, perhaps as part of a 'balanced scorecard' for performance.
- *Should be responsive to individual concerns.* It should be based on the principle enshrined in the MS and HSG60 that 'systems should be in place to respond to individualised concerns'.
- *Should address 'cultural maturity':* It should take into account the organisation's capability or readiness to provide comfortable jobs and accommodating workplaces by identifying actions that can progress the organisation's cultural maturity to one that seriously regards health and well-being issues. As a facet of good work, a more mature health and well-being culture provides an organisational backdrop that can facilitate creation of comfortable jobs and accommodating workplaces. Identification may therefore need to consider a wider range of factors, such as fit between any organisational plans and existing HRM and operations systems (ST-15 O).
- *Utilise worker involvement in problems solving.* In common with the MS and participative ergonomics approaches, the toolbox should be underpinned by a problem solving process that involves workers in planning, action and review.
- *Balance under and over-reporting.* It should strike a balance between avoiding incautious CHP reporting and avoiding inhibition of CHP reporting that warrants health care (expert workshops).
- *Uses identification rather than assessment.* It should seek to *identify* rather than 'assess' work-relevant CHPs to avoid an overly metric approach insufficiently sensitive to individual and contextual aspects of CHPs (G-4 \*).
- *Identifies barriers and enablers:* It should identify problems and enablers to action plans (G-12 \*\*; end users and experts survey).
- *Identifies the full range of consequences associated with work-relevant CHPs.* It should include identification of symptoms (somatic, psychological and social), coping skills deficits, potential for local and/or temporary job redesign (MH-12 \*; G-13 \*\*; G-17 \*\*; MH-10 \*\*\*; MH-11 \*; ST-8 \*\*; G-16 \*\*\*; end users and experts survey).
- *Should be multilevel* (ST – 12 \*\*\*; ST – 14 \*\*\*; ST - 15 O; G-2 \*; G-4 \*; MS-10 \*; MH-3 \*\*; MH-10 \*\*\*; end users and experts survey), and based on the biopsychosocial approach. At one level, work-relevant CHP identification needs to be conducted by line managers. However, there needs to be some way of collating the data at the level of the Occupational Health Service/Human Resource Department level, so that systemic organisational issues can be detected and dealt with.

- *Could encourage supply chain inclusion.* The idea here is that if organisations can pass on good practice to other organisations in the supply chain, they might expect to benefit from improvements in work organisation (expert workshops).
- *Should be useable.* It should be simple to use (G-12 \*\*; end users and experts survey, workshop), especially as many elements might need to be integrated into on-going performance management. A flags based or alternative intuitive system seems appropriate as it is easily understood by line managers and does not require extensive data collection and collation (G-3 \*).
- *Should generate actions.* It should point to action (end users and experts survey) or at least identifiable problems to solve: the action should be worker, work group or line manager initiated (G-3 \*). Again a flags based or alternative intuitive system would seem appropriate as this lends itself to developing plans. Plans might be developed for individuals and/or workgroups.
- *Should be modifiable by HSE.* For identifying problems, this means that associated questions must be sufficiently flexible to cover a range of adverse job conditions and/or be easily modifiable to integrate pointers to emerging risk factors. It also means the indication framework and the toolbox can be easily modified, so that as new intervention technologies come on-line, these new technologies can be integrated easily into those parts of the indication framework that point to action and replace obsolete intervention technologies.
- *Is intended as guidance only.* These processes described will be for guidance only. It will help managers decide on the best course of action, they do not prescribe the best course of action and the extent to these processes are useful will depend on the skills and motivations of those that use the tools.

The toolbox *will not*, however:

- Tell people how to do their jobs and thereby jeopardise engagement with the toolbox. Rather it will empower line managers (principally) to manage people with work-relevant CHPs.
- Accommodate work-relevant CHPs. Rather it accommodates people with work-relevant CHPs.
- Require unending accommodations. Accommodations are time limited.
- Target primary prevention/universal primary interventions. This is already covered by conventional health and safety guidance for musculoskeletal disorders (MSDs), health promotion and the MS. However, facets of a comfortable job may also have primary preventative attributes.

## **APPROACH**

We took the decision to develop the framework through a process of discussion and consensus. We worked as a team through the following steps.

- Determining a basic structure for *capturing* what the toolbox should contain (content) and how it should be implemented. This was agreed through consensus during team meetings.
- Selecting the variables by which a comfortable job and accommodating workplace can be described, based on Phase 1 findings. The project team then grouped these into themes according to similarity in variable meaning. As a reliability measure, themes were then checked against Phase 1. To optimise eventual usability, themes were further condensed into three core themes. These themes provided the criteria that solutions for creating comfortable jobs or accommodating workplaces would need to fill.
- Generating preliminary questions for identifying work-relevant CHP problems and using this to generate a ‘repository’ of interventions through which either comfortable jobs or accommodating workplaces could be generated. Interventions were differentiated into organisational (company-wide), group (team) and individual levels to ensure systematic consideration of all aspects of the biopsychosocial model. From this essential or overarching interventions were selected for inclusion in the actual framework content description. Interventions were selected if they subsumed a range of more specific interventions.
- Agreeing the ‘steps’ by which the toolbox (at least for the purpose of this initial proof-of-concept) would need to be used. Doing so provided a steer for the remaining framework development.
- Fleshing out in more detail the potential content of each step and its implementation. This included producing questions for guiding identification of work-relevant CHP issues.
- Condensing ‘steps’ into self-contained modules differentiated according to preparation, comfortable jobs and accommodating workplaces.

Working through these steps allowed us to produce the material for developing the framework that is presented in the remainder of this appendix. Output is differentiated so that:

- The criteria are presented for describing comfortable jobs and accommodating workplaces.
- The basic structure used for organising framework content then follows. As such this represents the most basic layer of the framework.
- The process for identifying work-relevant CHP issues is then presented as an indication framework and culminates in a schematic. This represents the third output.
- More detail on the content and implementation/procedural considerations required for each module of the toolbox is presented as a module specification, and corresponds to the final level of complexity.

- Technical detail is provided later in this appendix.

At this stage, the aim was been to develop the feasibility of the approach outlined here and to demonstrate such an approach can be justified by and anchored within available scientific evidence. It was not our intention at this stage to determine the exact content of the toolbox. This back end framework defines an initial outline of potential content of the toolbox. We were inclusive at this stage, considering it better to highlight potential steps and processes consistent with comfortable and accommodating workplaces. Therefore, the example indication framework and associated tool box content shown in this appendix contained more elements and complexity than included in the final toolbox (Appendix 6).

### **BUILDING BLOCKS FOR PROOF OF CONCEPT**

The project team generated a list of principles that could contribute to the ‘proof of concept’ stage for the toolbox through discussion and iteration. These principles were grouped into themes that formed the acronym SCRAIFFI:

Supportive – of workers (MS-8 \*\*).

Consistent with other policies – do solutions mean other organisational processes can function as intended or even by improved (ST - 15 O).

Responsive – to the needs of workers.

Acceptable – to the worker, the manager, co-workers and other relevant stakeholders (basic tenet of change management).

Inclusive – have workers been consulted on matters that affect them (principle in HSE Management Standards; MS-8 \*\*).

Flexible – are generic solutions capable of being adapted for specific circumstances (end user survey), can procedures and work be changed rapidly to accommodate workers should things get worse or be rolled back if things get better.

Fair – to all stakeholders (ST-6 \*\*\*).

Investment – Is this the solution that gives the best return on investment – could line managers or workers come up with something just as effective that is easier and/or less costly to implement?

The variables that constitute comfortable jobs have considerable overlap with those outlined in primary prevention (i.e., MS). A key difference concerns inclusion of resilience related factors. Its inclusion should mean that a comfortable job equips people with skills for dealing with unavoidable sources of discomfort in their job. Variables for accommodating workplaces also mapped onto the same acronym. Accordingly any solutions for creating comfortable jobs and accommodating workplaces must conform to SCRAIFFI themes.

Clearly, SCRAIFFI is too complex an acronym to be used in the indication framework. Therefore, the SCRAIFFI themes can be summarised as three overarching criteria summarised by the acronym RAW:



**Responsive**: Is the proposed solution *responsive* to the needs of workers and *flexible* enough to be adapted for specific purposes and contexts.

**Acceptable**: Is the proposed solution *acceptable* to the worker, the manager, co-workers and other relevant stakeholders, *inclusive* in that relevant stakeholders have been consulted and *fair* to all stakeholders, including the organisation.

**Worth investing in**: Is the proposed solution *consistent* with other organisational policies and practices and is it the solution that gives the best return on *investment*, in that there are no other solutions that are just as effective but easier and/or less costly to implement and that the intervention is *supportive* of workers.

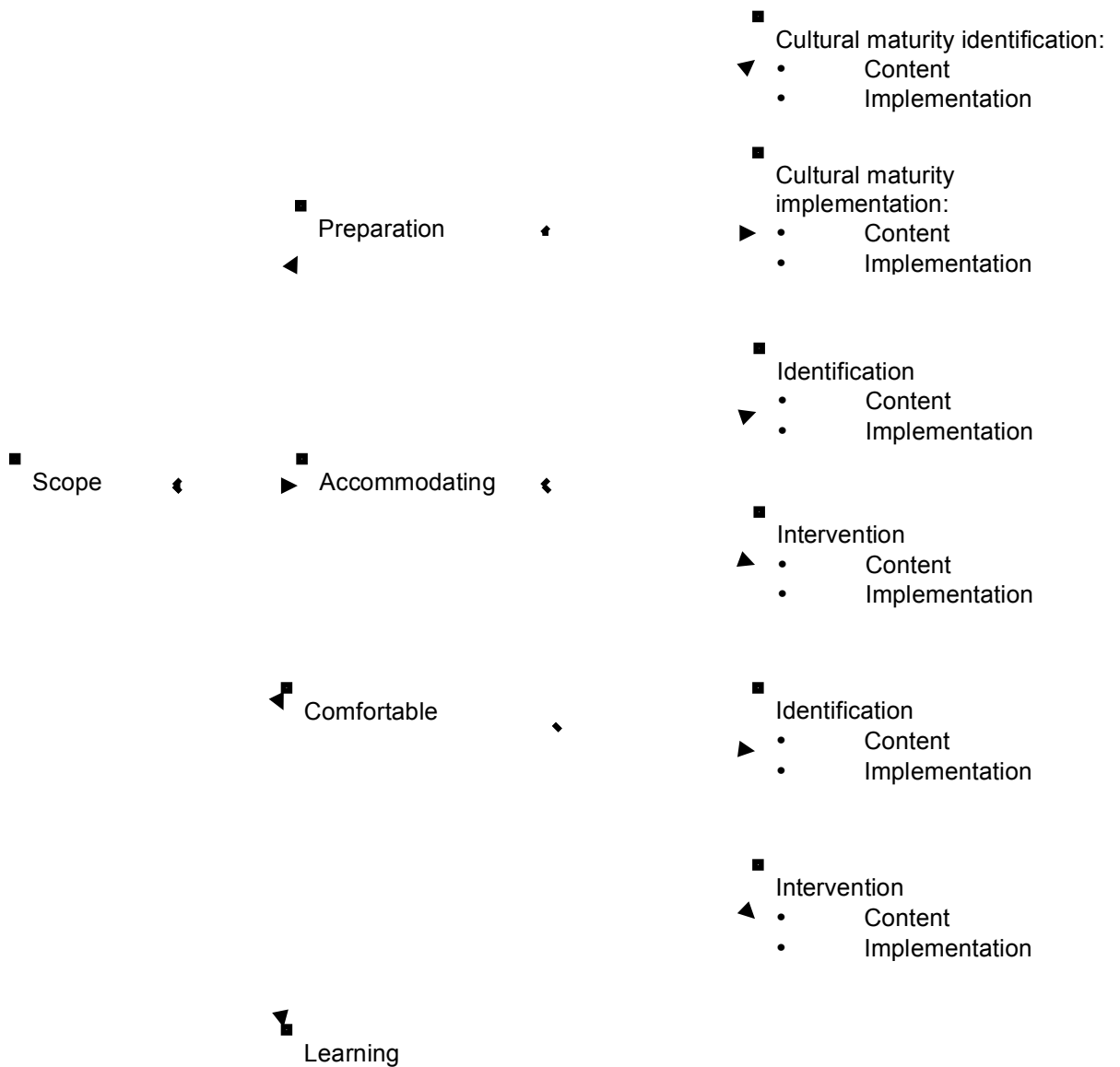
## **BASIC STRUCTURE**

Appendix 4 Figure 1 provides the basic structure for the framework denoting toolbox scope. The toolbox would encompass four main areas: preparatory material for addressing health and well-being cultural maturity; comfortable jobs; and accommodating workplaces. It was also recognised that it would be desirable to build organisational learning into the process of using the toolbox. Each area is then split into identification of work-relevant CHP issues relevant to that area and intervention sub-categories, which in turn are each profiled according to content and implementation considerations. As this toolbox is intended to supplement existing approaches, primary preventative approaches (for example, MS, health promotion, the manual handling regulations and HSG60 for upper limb disorders in the workplace) and conventional approaches to health care and rehabilitation are outside the scope of this toolbox.

Figure 1 indicates that an indication tool needs to address four issues:

1. Identification of problems and solutions for ‘comfortable’ jobs;
2. Identification of implementation issues for ‘comfortable’ jobs;
3. Identification of problems and solutions for ‘accommodating’ workplaces;
4. Identification of implementation issues for ‘accommodating’ workplaces;

Adding further complexity to the mix is the need to take into account the cultural maturity of organisations to identify problems and take appropriate remedial actions (Figure 1). The indication framework also needs to be simple, capable of being applied consistently and returning consistent answers, and capable of producing credible diagnosis of problems and credible solutions.



**Appendix 4 Figure 1.** Initial toolbox scope

This might indicate that any indication framework (later sections of this appendix give examples) needs to take into account different levels of cultural maturity. If we work to three levels of cultural maturity (non-compliance, minimum compliance, exceeding compliance), it

might be concluded that there needs to be an indication framework for each of the three levels, as shown in the matrix below (Appendix 4 Table 1).

**Appendix 4 Table 1: Cultural Maturity Matrix**

Cultural maturity level	Identification of problems and solutions for 'comfortable' job	Identification of implementation issues for 'comfortable' job	Identification of problems and solutions for 'accommodating' workplaces	Identification of implementation issues for 'accommodating' workplaces
Non-compliance <i>'I can't do anything about work-relevant CHPs'</i>	Indication i	Indication ii	Indication iii	Indication iv
Basic compliance <i>'I do it because I have to'</i>	Indication v	Indication vi	Indication vii	Indication viii
Exceeding compliance <i>'I do it because it's important'</i>	Indication ix	Indication x	Indication xi	Indication xii

Clearly, having 12 sets of questions is not feasible, nor desirable. However, it is possible to have a unified set of questions, yet with different interventions indicated for each level of cultural maturity – with more sophisticated interventions occurring at higher levels, or additional, remedial actions specified at lower levels of cultural maturity. Both comfortable and accommodating could be integrated into one package, like a workbook, for each level of cultural maturity, as in the matrix below (Appendix 4 Table 2).

**Appendix 4 Table 2: Allocation of workbook according to cultural maturity level**

Cultural maturity level	Identification of problems and solutions for 'comfortable' work	Identification of implementation issues for 'comfortable' work	Identification of problems and solutions for 'accommodating' work	Identification of implementation issues for 'accommodating' work
Non-compliance 'I can't do anything about work-relevant CHPs'	Indication i  Tailored Workbook A for <i>lower</i> levels of cultural maturity	Indication ii  Tailored Workbook A for <i>lower</i> levels of cultural maturity	Indication iii  Tailored Workbook A for <i>lower</i> levels of cultural maturity	Indication iv  Tailored Workbook A for <i>lower</i> levels of cultural maturity
Basic compliance 'I do it because I have to'	Indication i  Tailored Workbook A for <i>lower</i> levels of cultural maturity	Indication ii  Tailored Workbook A for <i>lower</i> levels of cultural maturity	Indication iii  Tailored Workbook A for <i>lower</i> levels of cultural maturity	Indication iv  Tailored Workbook A for <i>lower</i> levels of cultural maturity
Exceeding compliance 'I do it because it's important'	Indication i  Tailored Workbook B for <i>higher</i> levels of cultural maturity	Indication ii  Tailored Workbook B for <i>higher</i> levels of cultural maturity	Indication iii  Tailored Workbook B for <i>higher</i> levels of cultural maturity	Indication iv  Tailored Workbook B for <i>higher</i> levels of cultural maturity

Note the matrix indicates two different workbooks, one for the lower levels of cultural maturity through to that which could be said to be meeting minimal compliance (Workbook A) and one for the highest level that could be said to exceed minimum compliance levels (Workbook B). This is both to prevent over complication and also to acknowledge that although higher fidelity in identifying cultural maturity might be desirable, capturing organisational capabilities to regulate work-relevant CHPs need not require high levels of fidelity.

It was proposed that the workbooks include simple instructions on how to complete the indication tools, and on the basis of the diagnostic information provided by the tools, information on appropriate interventions and how to implement appropriate interventions. The same workbooks could be distributed to both senior and line managers even though some steps outlined below are to be carried out by line managers and other steps by more senior managers.

The reasoning here is that more senior managers can consult the workbook to understand how the processes applied at the line and line managers can understand how the information they provide is used elsewhere in the organisation. The workbooks could include small case studies, perhaps supplemented with web-based podcasts, illustrating how the toolbox can be used and how some of the anticipated problems can be overcome.

This in turn would leave another workbook for senior managers on improving cultural maturity. It would also be desirable to give guidance to organisations on how to learn from the experiences of line managers and their teams to build improvements throughout the organisation.

To simplify things further, it was proposed to split the workbooks into four modules (see Figure 3). These modules are:

Module 1: Preparation (culminating in senior management commitment)

Module 2: Comfortable jobs (line management), with indication steps i) and ii).

Module 3: Accommodating workplace (line management), with indication steps iii) and iv).

Module 4: Learning organisation (more senior, OHS, HRM or middle management).

This would leave three workbooks:

Workbook Zero: Cultural maturity workbook encompassing module 1: Preparation (culminating in senior management commitment).

Workbook A: For the lowest levels of cultural maturity, encompassing modules 2 (comfortable jobs, indication steps i and ii), 3 (accommodating workplace, indication steps iii and iv) and 4 (learning organisation).

Workbook B: For the highest levels of cultural maturity, encompassing modules 2 (comfortable jobs, indication steps i and ii), 3 (accommodating workplace, indication steps iii and iv) and 4 (learning organisation).

Combining the modules together with the desire to tailor the sophistication and range of interventions to the levels of cultural maturity leads to a set of inter-related components in the toolbox as outlined in Appendix 4 Figure 2.

Essentially, the toolbox is based on the idea that senior managers complete Module 1 (preparation), which is accompanied by its own Workbook (Zero). It is designed to help senior managers plan for and allocate sufficient resources to the management of work-relevant CHPs. The Workbook for Module 1 would also include an assessment of cultural maturity, and guidance on how to improve cultural maturity for organisations at the lower levels. Identification of cultural maturity would lead senior managers to choose the appropriate workbooks for the organisation's level of cultural maturity.

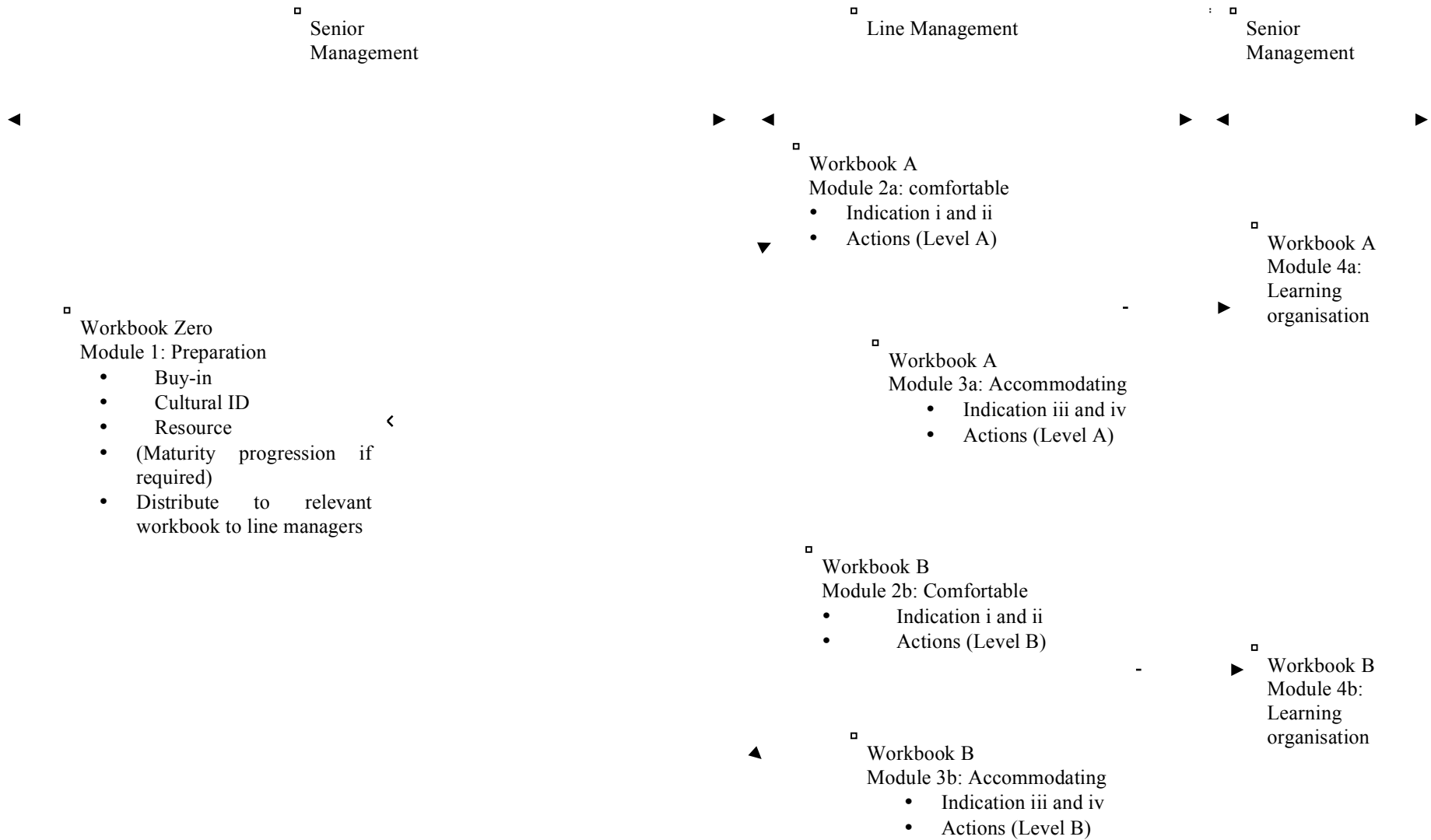
This process is illustrated in Appendix 4 Figure 2. Using Workbook Zero, senior managers first prepare for managing work-relevant CHPs and identify the level of cultural maturity (Module

1). Module 1 in Workbook Zero will involve getting buy-in, identifying cultural maturity levels, scoping resources required for managing work-relevant CHPs, progressing cultural maturity levels for those organisations performing below or at minimum levels of compliance, and distributing relevant workbooks to line managers,

Workbook A is distributed to line managers in lower cultural maturity organisations, Workbook B to line managers in high cultural maturity organisations. Workbooks A and B will have a different array of solutions tailored to each cultural maturity levels. Line managers then work through Module 1 (comfortable jobs) at regular intervals. This will involve using indication frameworks to diagnose areas where jobs can be made more comfortable (indication i) and, where appropriate, to identify how to implement solutions (indication ii). Where there are signs that workers may not be able to cope with the work-relevant aspects of CHPs, line managers should use Module 2. Module 2's indication frameworks will help to identify where workplaces can be made more accommodating (indication iii) and, where appropriate, to identify how to implement solutions (indication iv). The outputs from Modules 2 and 3 can be collated at higher levels of the organisation to facilitate wider organisational changes and organisational learning if appropriate (Module 4)

In the next section, a series of tables illustrate the potential content of the modules, along with some important principles that have guided the development of the indication framework. More detail and examples of how an indication framework might be operationalised are provided in later sections of this Appendix. To reiterate an earlier point, at this stage in the development of the tool we attempted to be inclusive, and the content of the appendices only illustrative of what might appear in the final toolbox. As the toolbox developed further, we expected the process underpinning the various modules to become more streamlined and elements of modules or even whole modules to become redundant. This 'proof of concept' illustrated in this appendix is to demonstrate it is feasible to have an evidence-based indication and intervention toolbox based on simple questions, with answers cross-referenced against action in a work book, and that can work across multiple organisational levels.

**Appendix 4 Figure 2. Workbooks and modules.**



## **MODULE SPECIFICATION & JUSTIFICATION**

Appendix 4 Table 3 over the page describes in more detail the potential content of each module. Content is distinguished according to whether it represents a ‘passive’ intervention that raises awareness, or ‘active’ intervention requiring end-users to carry out actions. Active interventions are distinguished according to whether they enable compliance or exceed compliance for work-relevant CHP related guidance. The level at which the intervention is carried out (organisational, work group or individual) is also indicated. Ways in which workers or managers are involved in each of the modules are highlighted in a separate column. For comfortable jobs and accommodating workplaces, interventions were selected for inclusion at this stage in the toolbox development on the basis of their potential to fulfil RAW criteria and the extent to which they subsumed other interventions. Appendix 4 Table 3 will represent a resource for selecting actual content during development of the toolbox ‘front-end’ during the subsequent phase.



**Appendix 4 Table 3: Module Specification.**

Module*		'Passive Interventions' • Knowledge/awareness raising	Worker involvement ('problem solving')		Active Interventions: A = Minimum compliance for CHPs (one-off actions) (Workbook A) B = Exceeding Compliance for CHPs (ongoing requirements) (Workbook B)						
Module 1: Preparation	Step 1. Getting 'buy-in. (See Table 3.1)	<ul style="list-style-type: none"> <li>• Myth busting messages</li> <li>• Moral, legal (inc HSWA &amp; Management Regulations requirements), business case with emphasis on commitment</li> <li>• 'In it together'/dual responsibility message</li> <li>• Signposting to related tools (DSE /MAC tool, management standards)</li> <li>• Tool purpose</li> </ul>	Organisation	✓	<table border="1"> <tr> <td>A</td> <td>Persuasion techniques based on 'do we have a problem?' (e.g. collating relevant data) targeting senior management</td> </tr> <tr> <td>B</td> <td>Persuasion techniques based on 'can we do better' (e.g. collating relevant data) targeting senior management</td> </tr> <tr> <td colspan="2">Key output: Senior Management Buy-In</td> </tr> </table>	A	Persuasion techniques based on 'do we have a problem?' (e.g. collating relevant data) targeting senior management	B	Persuasion techniques based on 'can we do better' (e.g. collating relevant data) targeting senior management	Key output: Senior Management Buy-In	
	A		Persuasion techniques based on 'do we have a problem?' (e.g. collating relevant data) targeting senior management								
	B		Persuasion techniques based on 'can we do better' (e.g. collating relevant data) targeting senior management								
Key output: Senior Management Buy-In											
Step 2. Health and well-being cultural maturity identification	<ul style="list-style-type: none"> <li>• Information provision on 'good work'</li> <li>• Instruction on evaluating cultural maturity level by consensus.</li> <li>• Analyse/interpret existing organisational data</li> <li>• Does equivalence apply?</li> </ul>	Senior Management		@ Senior Level	Key output: Selection of appropriate cultural maturity workbook for distribution to senior management and line management.						
		HRM									
		OHS									
		Unions									
Step 3. Resource	• Indicate who might be	Organisation	✓		Key outputs: Structures (Problem solving)						

Module*		‘Passive Interventions’ • Knowledge/awareness raising		Worker involvement (‘problem solving’)	Active Interventions: A = Minimum compliance for CHPs (one-off actions) (Workbook A) B = Exceeding Compliance for CHPs (ongoing requirements) (Workbook B)
	requirements	involved, when, how often and for how long as checklist	Group	✓	circles/communities of practices), resource commitment for communication
	Step 4. Corporate cultural maturity improvement	Instructions on how to define and prioritise actions through consensus.	Senior Management	✓	@ Senior Level A <ul style="list-style-type: none"> <li>Follow conventional risk assessment guidance (management standards, ergonomics guidance, traditional occupational health procedures</li> <li>Review &amp; improve leadership practices</li> <li>Establish communication and worker involvement practices</li> <li>Review policies and practices relating to fairness (e.g. equal opportunity, negotiation, recruitment, promotion, reporting, referrals, absence management)</li> <li>Set up communication structures to obtain staff feedback on well-being.</li> <li>Reviewing management systems integration for well-being/work-relevant CHPs</li> <li>Review line management training &amp; support</li> <li>Reviewing &amp; improving information provision on work-relevant CHPs</li> </ul>

Module*		‘Passive Interventions’		Worker involvement (‘problem solving’)	Active Interventions: A = Minimum compliance for CHPs (one-off actions) (Workbook A) B = Exceeding Compliance for CHPs (ongoing requirements) (Workbook B)
			HRM	✓	B <ul style="list-style-type: none"> <li>Reviewing &amp; improving range of well-being related to flexibility and accommodations (flexible work arrangements, scope of job redesign, redeployment etc)</li> <li>Supply chain inclusion on work-relevant CHPs/well-being</li> <li>Examine &amp; define work-relevant CHP values - e.g. generating vision/aspirational statements and promote</li> <li>Values ‘gap’ analysis (ideal against reality for work-relevant CHPs)</li> <li>Conduct investment assessments</li> <li>Review the sustainability of management support</li> </ul>
			OHS	✓	
	Step 5. Distribute workbooks to line managers	<ul style="list-style-type: none"> <li>Instruction to ‘engage’ line manager</li> <li>Advice on alternative routes where line-management relationship is poor.</li> </ul>	Senior Management	✓	Key output: Instruction receipt and uptake of workbooks for comfortable and accommodating

Module*		‘Passive Interventions’		Worker involvement (‘problem solving’)	Active Interventions: A = Minimum compliance for CHPs (one-off actions) (Workbook A) B = Exceeding Compliance for CHPs (ongoing requirements) (Workbook B)	
Module 2: Comfortable	Step 6. Identification of comfortable by line managers according to RAW (positive framing).	<ul style="list-style-type: none"> <li>‘How to’ instructions for identification for line manager</li> </ul>	Group	✓	✓ (based on workers’ needs)  Guided questioning between line-manager and individual workers according to: <ol style="list-style-type: none"> <li>demands/challenge</li> <li>general resources,</li> <li>support,</li> <li>coping/resilience resources,</li> <li>line management support,</li> <li>goal resources,</li> <li>job crafting</li> </ol>	Key output: Identification of problems undermining comfortable jobs.
			Individual	✓		

Module*	‘Passive Interventions’	Worker involvement (‘problem solving’)	Active Interventions: A = Minimum compliance for CHPs (one-off actions) (Workbook A) B = Exceeding Compliance for CHPs (ongoing requirements) (Workbook B)	
	Step 7. Action: Make jobs more comfortable	<ul style="list-style-type: none"> <li>• Instructions for identifying actions through worker involvement</li> <li>• Description of comfortable jobs</li> </ul>	<ul style="list-style-type: none"> <li>✓ Elicit suggestions from workers by identifying:               <ul style="list-style-type: none"> <li>• Enablers</li> <li>• Obstacles to;</li> <li>• Actions for overcoming obstacles</li> <li>• Key success factors.</li> <li>• Fulfillment of the RAW criteria.</li> <li>• Time table for implementation</li> </ul> </li> </ul>	<p>A</p> <p>Group:</p> <ul style="list-style-type: none"> <li>• Job design – job enrichment, job enlargement, developed decision making,</li> <li>• Work load reallocation/reorganisations meetings</li> <li>• Ergonomic work design</li> <li>• Establishing support groups (e.g. learning/safety/problem-solving circles)</li> <li>• Communications and briefing</li> <li>• Individual/Group:</li> <li>• Job coping skills training/emotional regulation</li> </ul>

Module*	‘Passive Interventions’ • Knowledge/awareness raising	Worker involvement (‘problem solving’)	Active Interventions: A = Minimum compliance for CHPs (one-off actions) (Workbook A) B = Exceeding Compliance for CHPs (ongoing requirements) (Workbook B)						
			<table border="1"> <tr> <td data-bbox="1429 387 1518 807">B</td> <td data-bbox="1518 387 2054 807"> <ul style="list-style-type: none"> <li>• Group:</li> <li>• Semi-autonomous work teams</li> <li>• CPD/retraining support</li> <li>• Coaching/mentoring</li> <li>• Social networking</li> <li>• Team functioning</li> <li>• Individual/Group:</li> <li>• Training on cognitive reappraisal/mental capital</li> <li>• Training on negotiation/assertiveness skills to craft work</li> </ul> </td> </tr> <tr> <td colspan="2" data-bbox="1429 807 2054 847">Review &amp; monitor actions for comfortable</td> </tr> <tr> <td colspan="2" data-bbox="1429 847 2054 938">Key Outputs: Action plans formulated, monitored and corrective actions taken where necessary.</td> </tr> </table>	B	<ul style="list-style-type: none"> <li>• Group:</li> <li>• Semi-autonomous work teams</li> <li>• CPD/retraining support</li> <li>• Coaching/mentoring</li> <li>• Social networking</li> <li>• Team functioning</li> <li>• Individual/Group:</li> <li>• Training on cognitive reappraisal/mental capital</li> <li>• Training on negotiation/assertiveness skills to craft work</li> </ul>	Review & monitor actions for comfortable		Key Outputs: Action plans formulated, monitored and corrective actions taken where necessary.	
B	<ul style="list-style-type: none"> <li>• Group:</li> <li>• Semi-autonomous work teams</li> <li>• CPD/retraining support</li> <li>• Coaching/mentoring</li> <li>• Social networking</li> <li>• Team functioning</li> <li>• Individual/Group:</li> <li>• Training on cognitive reappraisal/mental capital</li> <li>• Training on negotiation/assertiveness skills to craft work</li> </ul>								
Review & monitor actions for comfortable									
Key Outputs: Action plans formulated, monitored and corrective actions taken where necessary.									

Module*		'Passive Interventions'			Worker involvement ('problem solving')	Active Interventions: A = Minimum compliance for CHPs (one-off actions) (Workbook A) B = Exceeding Compliance for CHPs (ongoing requirements) (Workbook B)	
Module 3: Accommodating	Step 8. Identify by line managers if anyone is struggling (despite comfortable jobs) according to the RAW criteria (identification for accommodating workplaces)	<ul style="list-style-type: none"> <li>Line manager instructions</li> </ul>	Individual	✓	✓(based on workers' needs)  Guided questioning between line-manager and individual workers distinguished according to: <ul style="list-style-type: none"> <li>Work-relevant symptoms</li> <li>Temporary changes</li> <li>Symptom coping job crafting</li> </ul>	<ul style="list-style-type: none"> <li>Interpersonal skills training for sensitive issues for line managers</li> </ul>	Key Outputs: Key output: Identification of areas where changes are necessary to make work more accommodating.
	Step 9. Make, monitor and adapt accommodations	<ul style="list-style-type: none"> <li>Information provision on adjustments/accommodation options</li> <li>Information provision on CBT related skills (e.g. cognitive challenging)</li> <li>Instructions on HR support required to manager</li> </ul>			✓ Elicit suggestions from workers and others (HR, etc) by identifying: <ul style="list-style-type: none"> <li>Enablers</li> <li>Obstacles to;</li> <li>Actions for overcoming</li> </ul>	A	

Module*		'Passive Interventions'	Worker involvement ('problem solving')	Active Interventions: A = Minimum compliance for CHPs (one-off actions) (Workbook A) B = Exceeding Compliance for CHPs (ongoing requirements) (Workbook B)
		<ul style="list-style-type: none"> <li>Knowledge/awareness raising</li> </ul>	obstacles <ul style="list-style-type: none"> <li>key success factors.</li> <li>fulfilment of the RAW criteria.</li> <li>Appropriate time table</li> </ul>	B <ul style="list-style-type: none"> <li>Assertiveness/coping skills to craft work</li> <li>Condition/symptoms coping/resilience skills training HR support for line manager</li> <li>Managing peer perceptions of accommodations</li> <li>Individual</li> </ul>
				Review & monitor actions
				Key Output: Corrective actions taken for improving accommodation
Module 4: Learning Organisation	Step 10. Dept heads, OHS or HRM monitor for trends and share lessons learnt with key players	Line managers complete indication frameworks and send to Dept Heads	Dept. heads, OHS or HR	Dept heads, OHS and HR managers meeting to share lessons learnt and document.



The sub-tables to Appendix 4 Table 3 are shown over the page. These tables provide the rationale for the content portrayed in the module specification table. Under 'implementation', the sub-tables also summarise how each module can be carried out. Supporting evidence statements and findings from Phase 1 are indicated in brackets. Further implementation detail is provided in remaining sections of this Appendix.

**Appendix 4 Table 3.1:** Module 1 preparation: Getting buy in.

<b>Purpose</b>	Motivate target-audience to use toolbox by targeting messages at different end-user groups.	
Content		
<b>Intervention Name</b>	<b>Type</b>	<b>Rationale</b>
Myth busting messages	Passive (information)	Correct misconceptions about prevalence, causes and responsiveness to intervention to generate recognition that toolbox is worth using [MS-1***; MS-2***; MS3***; MS7**; MS-8; MH-1***; MH-2**; MH-4**; MH-6***; G-6***;G-20**].
Moral, legal and business case	Passive	Create a selection of meaningful incentives for using the toolbox relevant to different end-user groups. For examples, the business case may have the greatest influence on senior management, the moral case may have more leverage at the individual level. [MS-12**; MH-10***].
‘In it together’/dual responsibility.	Passive	Foster an organisation-wide team approach. Convey success as most likely if responsibility and ownership of work-relevant CHP problems is shared between employer and employee [G-19***; experts workshop]
Signpost links with related tools/related legal requirements.	Passive	Conveys toolbox as a supplement to related approaches, as opposed to substitution. Navigation aid for related legal health and safety requirements [expert’s workshop].
Tool purpose	Passive	Raise awareness of toolbox’s added value to other approaches. [MS-8**;’ MS-12*]
Persuasion techniques	Active	Instructions for key players initially viewing toolbox who many need to persuade other influential key players (e.g. senior management) on the toolbox’s merits by collating relevant evidence. This may be to recognise there is a problem/and or room for improvement. Advice could encompass collecting relevant data as a way of creating an internal ‘business’ case [experts workshop].
Implementation		
<b>Who</b>	All key players who access tool (employees, union representative, HRM manager, OH manager, senior management, middle management). Targeted messages to be provided where appropriate.	
<b>When</b>	First level of toolbox information to be accessed.	
<b>How</b>	As main body, or as links from the first page of a website-based tool (for example).	
<b>Output</b>	Buy-in from senior management having following persuasion by other key players	

**Appendix 4 Table 3.2:** Module 1 preparation: Identification of health and well-being/work-relevant CHP cultural maturity (with bypass option).

<b>Purpose</b>	Identify an organisation’s level of health and well-being /work-relevant CHP cultural maturity, or cultural readiness to provide comfortable jobs/manage work-relevant CHPs. From this the organisational level actions necessary for progressing maturity can be identified. <i>Cultural maturity identification and associated actions can be bypassed if equivalent measures are already in place.</i> [MS-8***; MS-12**; MH-12*workshop summary; stakeholder survey].	
Content		
<b>Intervention Name</b>	<b>Type</b>	<b>Rationale</b>
Instructions on implementation and intervention	Passive	Standardise use.
Implementation		
<b>Who</b>	Targets the organisational level as an aspect of good work. Identification should be undertaken by senior managers, including the most senior managers responsible for HRM and OHS as a group. Inclusion of trades union of other employee representatives may also be desirable.	
<b>When</b>	At the beginning of the process, and once every one to two years thereafter. Periodic assessment will be required as cultural maturity is expected to change, albeit slowly. The interval may depend on the pace of change in organisations.	
<b>How</b>	False consensus may be prevented by individuals completing the maturity assessment first by themselves (approximately five minutes). Answers can then be discussed as a group until a consensus emerges on the cultural maturity of the organisation, as indexed by the maturity assessment. Discussion and resolution of discrepancies is important, since these provide both consistency in the assessment of jobs and credibility with various stakeholders. Each management team will have their own preferred ways of discussing the findings of this exercise that ensures inclusiveness and respect of all individuals’ views, appropriate chairing of the discussion and feelings for when consensus has been reached. Obviously, the length of time to reach agreement depends on the levels of prior disagreement, but this is not intended to be a lengthy exercise unless there are significant issues that require management attention.	
<b>Output</b>	Indication of the level of cultural maturity for dealing with OHS and well-being issues in the organisation. This will then guide choice of intervention for progression to the next level.	

**Appendix 4 Table 3.3:** Module 1 preparation: Highlight resource requirements.

<b>Purpose</b>	Enable preparation [expert’s workshop].	
Content		
<b>Intervention Name</b>	<b>Type</b>	<b>Rationale</b>
Indicate who might be involved, when, how often and for how long as checklist	Passive	Create realistic expectations of time and other resource requirements from outset. Encourage contingency planning (expert’s workshop).
Implementation		
<b>Who</b>	Senior managers, including the most senior managers responsible for HRM and OHS, possibly include trades union or other employee representatives.	
<b>When</b>	Usually at the same time as cultural maturity assessment.	
<b>How</b>	Discussion. It is proposed to give a simple checklist, corresponding to the steps outlined in reducing the incidence and escalation of work-relevant CHPs and managing work-relevant CHPs, concerning who is involved (e.g., line managers, OHS managers), who might usefully also be involved (e.g., trades union safety representatives), what their time commitment may be, for how long they may need to be involved, and what support they may need. The purpose is to provide some initial understanding of the effort required and to provide prior notification to relevant stakeholders of the process, so they are prepared when subsequent steps are enacted throughout the organisation.	
<b>Output</b>	An indication of resource requirements to be communicated to department heads and line managers.	

**Appendix 4 Table 3.4: Module 1 preparation: Take corporate action to improve health and well-being/work-relevant CHP maturity.**

<b>Purpose</b>	Enable cultural maturity progression that provides an organisational ‘back-drop’ for attainment of comfortable jobs. Accommodating workplace is excluded on the premise that (a) an organisational culture that enables comfortable jobs are capable of providing job-relevant accommodation, (b) to reduce complexity, and (c) because accommodations predominantly apply to the individual level. Interventions can be selected according to organisation’s current level of maturity so that they can progress to the next level. [MH-9***; MH-10***;MH-12*; MH13*; ST-3*; ST-12***; G-16***] experts workshop; stakeholder survey].	
Content		
<b>Intervention Name</b>	<b>Type</b>	<b>Rationale</b>
Instructions for prioritisation	Passive	Standardise use
Review & improve work-relevant CHP related policies	Active (A)	To ensure policies and practices satisfy RAW criteria. These may relate to flexible working, worker involvement, negotiation, dual responsibility, temporary accommodations, job security, job design, workload reallocation, CPD support, supply chain inclusion, performance appraisals, inductions etc
Review & improve information provision for work-relevant CHPs	Active (A)	Raise generic work-relevant CHP/health awareness and of how to create comfortable jobs and accommodating workplace.
Reviewing management systems integration for work-relevant CHPs	Active (A)	Ensure consistency between human resource, work-relevant CHP, occupational health and operational management, e.g., performance appraisal inclusion of work-relevant CHP considerations; inclusion of work-relevant CHPs / work retention issues in work-relevant CHPs. [MS-12*]
Supply chain inclusion	Active (B)	Facilitation ‘spread’ of good work-relevant CHP practice
Examine & define work-relevant CHP values/values ‘gap’ analysis (ideal against reality for work-relevant CHPs)	Active (B)	Key catalyst of cultural change. Precursor to/ facet of changing leadership practices. [ST-3*; ST-4**]
Reviewing & improving worker involvement practices for work-relevant CHPs/ well-being	Active (B)	Fulfils RAW criteria. Key aspect of cultural and behaviour change with respect to work-relevant CHPs.
Implementation		
<b>Who</b>	Senior Management, HRM, OHS, Unions	
<b>When</b>	Following maturity identification. At the beginning of the process, and once every one to two years thereafter	
<b>How</b>	Identify potential actions through consensus. Choice guided by actions indicated in tool, but not directed. Actions may need to be implemented at an organisation wide level or cascaded through the line management structure.	
<b>Output</b>	Action to improve cultural maturity	

**Appendix 4 Table 3.5:** Module 1 preparation: Distribute workbooks to line managers.

<b>Purpose</b>	Engage and prepare line managers [MS-12*; G-9***; G-17**].	
<b>Content</b>		
Instructions to engage line manager	Passive	Persuade line manager on advantages of using the toolbox
Advice on alternative routes where line-manager/employee relationship prohibits	Passive	Ensure a poor relationship with the line manager does not inhibit toolbox use (workshop summary)
Line management briefing	Passive	Prepare line manager. Instructions would need to convey that: <ul style="list-style-type: none"> <li>i) Identification is meant to be integrated into normal group meetings, formal and informal one-to-one meetings with workers if needed, and as part of the developmental appraisal processes with individuals;</li> <li>ii) the identification framework is a problem-solving aid that in addition to helping manage work-relevant CHPs, may also be useful in helping to reduce absence and improve performance;</li> <li>iii) the expectation is that line managers and workers can manage work-relevant CHPs best themselves, but OHS and HRM are available for support if needed;</li> <li>iv) any changes implemented as at a local level need to be heedful of other organisational processes.</li> </ul>
Interpersonal skills training for line managers	Active	Ensure line managers are equipped with appropriate skills for creating comfortable jobs. E.g. through an example training presentation.
<b>Implementation</b>		
<b>Who</b>	The most senior HRM or OHS identifies the correct workbook, the most senior manager distributes the workbook via internal mail or email to department heads, who in turn distribute it to line managers.	
<b>When</b>	Annually.	
<b>How</b>	Workbooks distributed via internal mail or via email.	
<b>Output</b>	Receipt and take up of assessment process by department heads and line managers.	

**Appendix 4 Table 3.6:** Module 2 comfortable jobs: Identification of comfortable job by line manager (or alternatives where line management relationship prohibits).

<b>Purpose</b>	Guided questioning to ensure the work is comfortable/engaging from the perspective of the team members or an individual team member. Positively framed questioning required to convey comfortable jobs as aspiration goals. Key differences from the Management Standards relate to the inclusion of coping/resilience for unavoidable sources of discomfort/problems and use of a different method of assessment. As the suggested method in this tool is not psychometric or survey based but group and individual face-to-face questioning, the term “identification” is preferable to assessment. [G-12**]	
Content		
<b>Intervention Name</b>	<b>Type</b>	<b>Rationale</b>
‘How to instructions’ to line managers for identifying a comfortable job	Passive	Standardise practice in identification. Ensure discrepancies in views between line manager and employees are appropriately resolved. Instructions.
Advice on treatment of other data for line managers	Passive	Indicate where other data may be appropriate in determining whether jobs are sufficiently comfortable.
Guided questioning	Active/worker involvement	Determine whether jobs are comfortable according to demands/challenges, general resources, support, coping/resilience resources, line management support, goal resources, job-crafting
Implementation		
<b>Who</b>	Line manager and team members	
<b>When</b>	Annually and when significant problems arise	
<b>How</b>	Guided questioning using Identification Tool as presented in workbook during team meetings or meeting with individual team member if work-relevant CHP-related problems arise, and during one-to-one performance/development appraisals Completion of the indication framework between the line manager and workers in two main fora. The first is through a formal group meeting. The second is through one to one meetings as part of formal performance/development reviews. The former allows identification and changes to be made at a group level, the latter individual changes, which may be especially important for some individuals who are less vocal or otherwise marginalised in a group. In both group meeting and one-to-one meetings, unless there are significant problems or disagreements (which in itself may indicate a problem), it is not anticipated that completion of the indication framework takes more than ten minutes (group meeting) or five minutes (individual meeting).	
<b>Output</b>	Identification of any problems to be dealt with and how work may be changed to be comfortable or identification of no problems and that work is generally comfortable. Completed forms to be sent to HRM/OHS.	

**Appendix 4 Table 3.7:** Module 2 comfortable jobs: Action to make jobs more comfortable.

<b>Purpose</b>	Address work-relevant CHP issues identified in previous step in order to create comfortable jobs by focussing on action required, identifying facilitators to action and overcoming obstacles To fulfil attributes of a comfortable job, actions need to be responsive, acceptable and worth investing in (RAW). Potential interventions are distinguished according to health and well-being cultural maturity to enable tailoring to cultural maturity level. [MH-12*; G12-***]	
Content		
<b>Intervention Name</b>	<b>Type</b>	<b>Rationale</b>
Instructions for implementation questions	Passive	Standardise practice. Encourage uptake by reducing end user burden in deducing how to identify and take action.
Description of comfortable jobs (using RAW criteria)	Passive	Raise awareness of goal/end state required.
Implementation questions	Worker Involvement	Overcome barriers, and build on enablers for action
Job Design	Active (group, A)	Fulfil RAW criteria. Potentially one-off activity. [ST-3*;G-13**]
Workload reallocation	Active (group, A)	Fulfil RAW criteria. Potentially one-off activity. [ST-3*; G-13**]
Risk assessment of physical environment	Active (group, A)	Tackle ‘physical’ features of job to fulfil RAW criteria. Potentially one-off activity.
Support groups	Active (group, A)	Fulfil RAW criteria through social networking. Setting up potentially a one-off activity. [G-13**]
Job/coping skills training	Active (group/individual A)	Fulfil RAW criteria. Emphasis on job demands/challenges. Training potentially a one-off undertaking. [ST-3*; G-13**], although better if training is topped up regularly [ST- 14 ***]
Communication/briefing	Active (group/individual A)	Fulfil RAW criteria. Include assertiveness, constructive feedback, communication process [MS-8**; G-13**]
Semi-autonomous work teams.	Active (group, B)	Fulfil RAW criteria. Ongoing activity. [ST-3*; G-13**]
CPD/retraining support	Active (group, B)	Fulfil RAW criteria through maintaining skills. Ongoing activity. [G-13**]
Coaching/mentoring	Active (group, B)	Fulfil RAW criteria through maintaining skills. Ongoing activity.
Networking	Active (group, B)	Fulfil RAW criteria. Ongoing activity [G-13**]
Team functioning	Active (group, B)	Fulfil RAW criteria. Includes team-interdependence building, team effectiveness meetings. Ongoing activity (could be merged with semi-autonomous work teams) [G-13**]



Training on cognitive reappraisal/mental capital	Active (group/individual, B)	Fulfil RAW criteria. Target resilience. Ongoing activity [MH-11*; G-9****, ST-14 ***]
Training on negotiation/assertiveness skills to craft work	Active (group/individual, B)	Fulfil RAW criteria. Emphasis on worker empowerment. Ongoing activity. [MH-13*; G-13**]
<b>Implementation</b>		
<b>Who</b>	Line managers and team members or individual member as appropriate	
<b>When</b>	This phase is only introduced if there are problems with providing comfortable jobs. If there are no problems identified at previous step, this phase is not initiated.	
<b>How</b>	<p>Discuss and agree most appropriate intervention/action (example list is given in workbook) associated with the work-relevant CHPs related issues identified in previous step.</p> <p>Implementation questions need to be conducted in group meetings for comfortable jobs at a group level and in regular one-to-one meetings for a specific comfortable job at an individual level (e.g. performance/development reviews). To ensure credibility and consistency, as with the other tools, answers must be discussed and any disagreements resolved. If discrepancies cannot be resolved or there are significant problems in the relationships between a worker or workers and the line manager then organisational grievance/bullying and line manager performance management systems should be used to resolve the issues.</p>	
<b>Output</b>	Action plans formulated, monitored and corrective actions taken where necessary. Completed forms to be sent to HRM/OHS.	

**Appendix 4 Table 3.8:** Module 3 accommodating workplace: Identify struggling individuals.

<b>Purpose</b>	<p>Guided questioning between the line manager and individual workers for individuals who might still be struggling despite creation of comfortable jobs [MS-3***; MS11**; MH-8*; G-12***]. This is with a view to identifying temporary accommodations if necessary. Key differences from comfortable concern coping with symptoms (as opposed to demands), individual emphasis and temporary nature of accommodations. Questions would therefore address:</p> <p>8. Symptoms and how the line manager can help to deal with them: This subsumes establishing the presence of symptoms that affect work, whether the line managers knows how to seek support from OHS in order to deal with problem and general line manager support and responsiveness to the problem;</p> <p>9. The extent to which the features of comfortable jobs could be reasonably and temporarily changed to accommodate work-relevant CHPs in a manner desired by the worker, which includes changing levels of job resources, demands and physical conditions;</p> <p>10. Coping potentials including beliefs concerning recovery and workability, and the skills, job resources and support to solve problems caused by symptoms, regulate symptoms and recovery from particularly painful episodes;</p> <p>11. Job crafting – covering the extent to which individual workers can temporarily shape and/or negotiate the content of their own work to achieve accommodating workplace and the extent to which co-workers and the line manager can support the worker in so doing.</p>	
Content		
<b>Intervention Name</b>	<b>Type</b>	<b>Rationale</b>
Line manager instructions	Passive	Standardise practice [MS-3***; MS-4**, MS-10*]
Line manager interpersonal skills training.	Active	Ensure line managers are equipped with appropriate skills for noticing symptoms (e.g. noticing changes in usual working patterns) and managing sensitive issues. [MS-9**; G-6***]
Guided questioning	Active/worker involvement	Identify potential accommodations required according to noticeable work-relevant symptoms, viable temporary changes; and symptom coping.
<b>Who</b>	Line manager and worker.	
<b>When</b>	When a problem is identified.	

<b>How</b>	<p>Guided questioning in one-to-one meeting. Issues with work-relevant CHPs may emerge during formal one-to-one meetings (e.g., performance/development appraisals), or they may become apparent in questioning regarding drops in performance, expressed complaints at work, changes in mood and/or recurrent short absences. Where line managers notice such things or workers or their colleagues bring potential work-relevant CHP problems to their attention, then line managers should arrange a brief meeting with the worker to complete both the indication framework and, if all goes well, the framework to identify and implement solutions. The indication framework for accommodating workplace needs to be completed at this meeting, which will also be a set of guided questions directed at the worker. Any disagreements with the line manager on how accommodating workplace is or could be made need to be resolved. Unless there are significant disagreements or issues to resolve, it is anticipated the indication framework should take less than 60 minutes.</p> <p>As well as asking about and discussing the questions, the indication framework needs to provide a simple means of recording problems (if any), in order to send the completed assessment to those responsible for HRM or OHS.</p>
<b>Output</b>	<p>Identification of any problems to be dealt with and what about work needs to be changed to make it more temporarily accommodating. Completed forms to be sent to HRM/OHS.</p>

**Appendix 4 Table 3.9:** Module 3 accommodating workplace: Make appropriate accommodations.

<b>Purpose</b>	Determine what of the accommodations identified in the previous step are appropriate and implement. Actions would need to be responsive, acceptable and worth investing in (RAW) to fulfil attributes for an accommodating workplace. Key differences from comfortable interventions are that they are transient, have emphasis on the individual and upon coping with symptoms as opposed to exclusively demands. [MS-8**;G12-***]	
Content		
<b>Intervention Name</b>	<b>Type</b>	<b>Rationale</b>
Information provision on accommodation	Passive	Raise line manager’s awareness of options [MS-11** (stepped approach)]
Information provision of CBT related skills	Passive	Fulfil RAW criteria. Raise line manager’s awareness of the type of active listening, cognitive challenges that can be used to promote symptom coping skills. Potentially on-going if training needs follow-ups [ST- 14 ***]
HR support for line manager	Passive	Fulfil RAW criteria. Raise HR function awareness on the type of support they may need to provide staff.
Line management training in health awareness & leadership	Active (group, A)	Fulfil RAW criteria. Enhance line manager’s responsiveness to symptoms/changes in work practices and ability to take action (duplication with interpersonal skills in previous). One-off activity. [MS-12*; G-9***; G-17**].
Managing peer perceptions of accommodations	Active (group, B)	Fulfil RAW criteria. Avoid ‘unfair’ perceptions in colleagues. Foster team support. Ongoing activity.
Assertiveness/coping skills to craft work	Active (individual, B)	Fulfil RAW criteria Empower struggling individuals. [MH-13*; G-13**]
Condition/symptoms coping/resilience skills training	Active (individual, B)	Fulfil RAW criteria Instil adaptive self-regulation of symptoms. [G-19***]
Implementation		
<b>Who</b>	Line managers and groups of worker or individual workers as appropriate.	
<b>When</b>	When problems are identified, so that work is either not comfortable or accommodating.	
<b>How</b>	Guided questioning provided by indication tool in workbook in group or one-to-one meetings as appropriate.	
<b>Output</b>	Action plans formulated, monitored and corrective actions taken where necessary. Completed forms to be sent to HRM/OHS.	

**Appendix 4 Table 3.10:** Module 4 organisational learning: Monitor trends and share lessons learnt.

<b>Purpose</b>	Monitor health and more specifically work-relevant CHP issues at corporate level	
Content		
<b>Intervention Name</b>	<b>Type</b>	<b>Rationale</b>
Line managers complete indication frameworks and send to Dept Heads	Active	Identify trends on work-relevant CHPs related issues at department/organisational level by conducting an analysis of management information (all relevant statistics available) and summary report from line managers following appraisals with their individual team member to monitor occupational health at corporate level. [MS-12**]
Implementation		
<b>Who</b>	OHS, HR, Senior Management	
<b>When</b>	Annually or bi-annually	
<b>How</b>	Working through a set of guided questions	
<b>Output</b>	Identification of progress and identification of issues at departmental/organisation level informing the level of cultural maturity of the organisation	



## **IMPLEMENTATION SPECIFICATION**

This section of Appendix 4 describes in detail how it was envisaged the ‘proof of concept’ stage would be implemented if no further improvements were to be made. It provides the detail that is summarised in Table 3 and its sub-tables.

### **MODULE 1: PREPARATION**

#### **STEP 1: GETTING BUY IN AT A SENIOR LEVEL**

This is a generic step that is led by the most senior manager responsible for OHS and/or prompts from trade unions or other employee representatives. It is guided by generic information provided by HSE through its web-site and builds a moral, legal and business case for preventing work-relevant CHPs and preventing the escalation of problems with work-relevant CHPs where the consequences are work-relevant through effective management.

#### **Summary:**

*Who:* Senior managers, including the most senior managers responsible for HRM and OHS, possibly include trades union or other employee representatives.

*When:* Once and at the beginning of the process.

*How:* Presentations and persuasion from interested stakeholders using HSE information and guidance.

*Output:* Senior management buy-in.

## MODULE 1: PREPARATION

### STEP 2: HRM/OHS TO IDENTIFY CULTURAL MATURITY FOR MANAGING HEALTH AND WELL-BEING

This is a generic step, and one that should be completed relatively quickly. It is proposed that senior managers, including the most senior managers responsible for HRM and OHS should discuss the cultural maturity assessment tool as a group. It may be desirable to include trade unions or other employee representatives. There is a caveat here – organisations may already have done something to assess their levels of cultural maturity for managing health and well-being or occupational health and safety in general. If so, this stage might be completed relatively quickly or even be redundant.

Cultural maturity does need to be reassessed periodically, as it is expected to change, albeit slowly. An appropriate interval for re-assessing cultural maturity might be every one or two years, depending on the pace of change in organisations. The process of implementing processes for comfortable jobs and accommodating workplaces should lead to improvements in cultural maturity, so reassessing cultural maturity regularly is one way of monitoring the success of reducing the incidence of, preventing the escalation of, and managing work-relevant CHPs. External shocks or other internal changes may lead to a regression of cultural maturity. As maturity changes, so the relevant workbooks distributed to line managers should change.

To prevent false consensus emerging, it is suggested individuals complete the maturity assessment first by themselves (approximately five minutes). Answers can then be discussed as a group until a consensus emerges on the cultural maturity of the organisation, as indexed by the maturity assessment. The discussion and resolution of discrepancies is important, since these provide both consistency in the assessment of jobs and credibility with various stakeholders.

Each management team will have their own preferred ways of discussing the findings of this exercise that ensures inclusiveness and respect of all individuals' views, appropriate chairing of the discussion and feelings for when consensus has been reached. Obviously, the length of time to reach agreement depends on the levels of prior disagreement, but this is not intended to be a lengthy exercise unless there are significant issues that require management attention.

#### **Summary:**

*Who:* Senior managers, including the most senior managers responsible for HRM and OHS, possibly include trades union and other employee representatives.

*When:* Near the beginning of the process, and once every one to two years thereafter.

*How:* Maturity assessment is completed by individuals separately, and then discussed until a consensus on the maturity is reached.

*Output:* An indication of the level of cultural maturity for dealing with OHS issues in the organisation.



### STEP 3: POTENTIAL RESOURCE REQUIREMENTS ARE SCOPED AND CONTINGENCIES PLANNED FOR

Again, this is a generic step, and one that should be completed relatively quickly. It is proposed that senior managers, including the most senior managers responsible for HRM and OHS should discuss potential resource requirements for managing, reducing the incidence of and preventing the escalation of work-relevant CHPs. Again, it may be desirable to include trade unions and other employee representatives in the discussion. The discussion can take place at the same time as discussing cultural maturity, and can be revisited with the same frequency as assessment of cultural maturity.

It is proposed to give a simple checklist, corresponding to the steps outlined in reducing the incidence of, preventing the escalation of, and managing work-relevant CHPs, concerning who is involved (e.g., line managers, OHS managers), who might usefully also be involved (e.g., trades union safety representatives), what their time commitment may be, for how long they may need to be involved, and what support they may need. The purpose is to provide some initial understanding of the effort required and to provide prior notification to relevant stakeholders of the process, so they are prepared when subsequent steps are enacted throughout the organisation.

Each management team will have their own preferred ways of discussing the findings of this exercise that ensures inclusiveness and respect of all individuals' views, appropriate chairing of the discussion and feelings for when consensus has been reached. Obviously, the length of time to reach agreement depends on the levels of disagreement, but this is not intended to be a lengthy exercise unless there are significant issues that require management attention.

#### **Summary:**

*Who:* Senior managers, including the most senior managers responsible for HRM and OHS, possibly include trade unions and other employee representatives.

*When:* Usually at the same time as cultural maturity assessment.

*How:* Discussion.

*Output:* An indication of resource requirements to be communicated to department heads and line managers, a commitment from the organisation to supply those resources and structures to support line managers in reducing the incidence of, preventing the escalation of, and managing work-relevant CHPs.

## MODULE 1: PREPARATION

### STEP 4: TAKE ACTION TO IMPROVE CORPORATE CULTURAL MATURITY

This step is only to be completed for those with the lower levels of cultural maturity. The workbook will have separate sections for this. One section on improving cultural maturity will include guidance for actions that will move cultural maturity from one typified by non-compliance to one typified by meeting basic standards of compliance. A second section will be tailored towards guidance for actions to move cultural maturity from one typified by basic compliance to one typified by exceeding minimum standards. Obviously, for those organisations at the highest levels of cultural maturity, no action is needed to improve cultural maturity.

Again, it is envisaged that this stage will be completed through discussion in the senior management team and consultation with relevant stakeholders. The example actions provided in the workbook could be used as a basis for discussion and as a means for generating other actions.

Any actions to improve cultural maturity must of course meet the RAW criteria:

**Responsive:** Are the proposed actions *responsive* to the needs of workers and *flexible* enough to be adapted for specific purposes and contexts.

**Acceptable:** Are the proposed actions *acceptable* to the worker, the manager, co-workers and other relevant stakeholders, *inclusive* in that relevant stakeholders have been consulted and *fair* to all stakeholders, including the organisation.

**Worth investing in:** Are the proposed actions *consistent* with other organisational policies and practices and is it the solution that gives the best return on *investment*, in that there are no other solutions that are just as effective but easier and/or less costly to implement and that the intervention is *supportive* of workers.

#### **Summary:**

*Who:* Senior managers, including the most senior managers responsible for HRM and OHS, possibly include trade unions and other employee representatives.

*When:* Usually at the same time as cultural maturity assessment or shortly afterwards.

*How:* Discussion.

*Output:* An indication of actions for improving cultural maturity, action plans formulated, resources allocated and reviews timetabled. The key outcome would be a move to the next stage of cultural maturity.

## MODULE 1: PREPARATION

### STEP 5: APPROPRIATE WORKBOOKS DISTRIBUTED TO LINE MANAGERS.

The cultural maturity framework gives indications of how to develop cultural maturity. This is covered in the documentation for that tool. However, in respect of reducing the incidence of, preventing the escalation of, and managing work-relevant CHPs, it gives an indication of which of the two workbooks should be distributed to line managers. It is proposed that the most senior HRM or OHS manager identify the correct workbooks for comfortable jobs and accommodating workplaces, yet the most senior manager distributes the workbooks to department heads either via internal mail or by email, who in turn distribute it to line managers. This lends considerable weight to the credibility of using the tool. Distribution of workbooks should be accompanied by instructions that:

- a) assessment is meant to be integrated into normal group meetings, formal and informal one-to-one meetings with workers if needed, and as part of the developmental appraisal processes with individuals;
- b) the indication frameworks are problem-solving aid that in addition to helping reducing the incidence of, preventing the escalation of work-relevant CHPs on the one hand, and manage work-relevant CHPs on the other, may also be useful in helping to reduce absence and improve performance;
- c) the expectation is that line managers and workers can reducing the incidence of, preventing the escalation of, and manage work-relevant CHPs best themselves, but OHS and HRM are available for support if needed;
- d) any changes implemented as at a local level need to be heedful of other organisational processes.

The last criterion is embedded in RAW framework, yet it may be worth signalling this early in the process.

Since developmental appraisals typically take place annually, it is expected senior managers will remind department heads and line managers annually to complete the assessment of comfortable jobs at a minimum of once a year, yet assessment for accommodating workplaces need to be completed when a problem is noticed or anticipated.

#### **Summary:**

*Who:* The most senior HRM or OHS identifies the correct workbook, the most senior manager distributes the workbook via internal mail or email to department heads, who in turn distribute it to line managers.

*When:* Annually.

*How:* Workbooks distributed via internal mail or via email.

*Output:* Receipt and take up of assessment process by department heads and line managers.

## MODULE 2: COMFORTABLE JOBS.

### STEP 6: IDENTIFYING COMFORTABLE WORK.

It is anticipated that this steps can be accomplished by guided questioning between the line manager and individual workers and groups of workers on a regular basis during one-to-one performance reviews, team meetings and more informal meetings. The indication tools (for examples see later in the document) could be used to record answers to the questions, and use the answers as a basis for action.

In both group and individual cases and for assessing comfortable work, it is important that the indication framework is used to identify problems (if any) and discrepancies in views be resolved through discussion. The discussion and resolution of discrepancies is important, since these provide both consistency in the assessment of jobs and credibility with various stakeholders. If discrepancies cannot be resolved or there are significant problems in the relationships between a worker or workers and the line manager, and we anticipate these to be relatively rare, then organisational grievance/bullying and line manager performance management systems should be used to resolve the issues.

This stage requires discussion and completion of the indication framework between the line manager and workers in two main fora. The first is through a formal group meeting. The second is through one to one meetings as part of formal performance/development reviews. The former allows identification and changes to be made at a group level, the latter individual changes, which may be especially important for some individuals who are less vocal or otherwise marginalised in a group. In both group meetings and one-to-one meetings, unless there are significant problems or disagreements (which in itself may indicate a problem), it is not anticipated that completion of the indication framework will take more than ten minutes (group meeting) or five minutes (individual meeting).

As well as asking about and discussing the questions, the indication framework needs to provide a simple means of recording problems (if any) in order to send the completed assessment to those responsible for HRM or OHS.

The indication framework for comfortable work needs to work on the basis of flags or a similar intuitive system (G-3 \*) that identifies and guides the development of action plans based on:

The extent to which the line manager is considerate and supportive (MS-8 \*\*; notes to ST-3; ST - 15 O);

The extent to which broad categories of the features of comfortable jobs are present (MH-12 \*; G-13 \*\*; G-17 \*\*; notes to ST-3)

Enhanced job resources - job control; skill development and use; variety in tasks; role and clarity concerning the future; opportunities for social contact; support from line manager and co-workers; career and other development opportunities;

Reasonable job demands and hygienic conditions - reasonable level of demands; physical security and safety; good physical conditions (heat, temperature, light, noise); adequate equipment for the work; job security and fair pay; minimal role

conflict; work life balance; worker expectation should be that they do not expect their work to be harmful;

The extent to which broad categories of the features of comfortable jobs are desired by workers, whether present or not (ST – 13 \*; G-14 \*);

Fairness in how workers are treated (ST-6 \*\*\*);

The extent to which workers can pursue their own goals, aspirations and values provided there are consonant with work unit and organisational goals (MH-13 \*; ST-4 \*\*; ST – 13 \*; G-14 \*; G-17 \*\*);

Coping potentials and personal resilience, e.g., problem-solving, breaks from demanding work, and skills and job resources and support to realise those potentials (MH-10 \*\*\*; MH-11 \*; ST-8 \*\*; G-16 \*\*\*);

The extent to which individual workers and work groups can shape the content of their own work to achieve comfortable jobs, their goals and cope with demands (MH-10 \*\*\*).

The extent to which line managers have to provide additional support to workers to the content of their own work in order to achieve comfortable jobs, their goals and cope with demands (MH-10 \*\*\*).

Clearly, this is too extensive a list to be able to include in a quick assessment consisting of just a few questions.

Therefore, it is proposed to break the questions down into six main areas:

1. Demands, level and desirability: Reasonable quantitative and qualitative job demands, neither too high nor too low and hygienic, safe conditions;
2. Resources in general, level and desirability: Including autonomy, variety, skill use, job control; skill development and use; variety in tasks; role and clarity concerning the future; opportunities for social contact; support co-workers; career and other development opportunities; fairness in treatment;
3. Line manager support, level and desirability;
4. Resources for coping with demands – skills, job resources and support necessary to solve problems in a timely manner and take breaks from demanding work when needed;
5. Resources for goals – the extent to which workers can pursue their own goals, aspirations and values, provided they are reasonable and consonant with work unit or organisational goals;
6. Job crafting – the extent to which workers and work groups can shape the content of their own work to achieve comfortable jobs, their goals and cope with demands, and the extent to which the line manager supports them in so doing.

Where problems are identified, the appropriate workbook should be consulted and a range of appropriate interventions, as indicated in the workbook considered. Once the preferred

intervention(s) is (are) chosen and agreed upon by line managers and workers, then the line managers and workers should proceed to step 7. If there are no problems identified, then the process for line managers and workers stops at this step.

It is expected for lower levels of cultural maturity, the emphasis in developing comfortable work should be on the first three areas (demands, resources in general, line manager support). For more culturally mature organisations, where active management of health and safety is more of a norm, then opportunities to self-regulate might be emphasised to a greater extent (i.e., resources for coping, resources for goals, job crafting).

**Summary:**

*Who:* Line manager and workers.

*When:* Annually.

*How:* Guided questioning provided by indication tool in workbook in workgroup meetings and one-to-one performance/development appraisals.

*Outputs:* Identification of any problems and how work may be changed to be comfortable or identification of no problems and that work is generally comfortable. Completed forms to be sent to HRM/OHS.

## MODULE 2: COMFORTABLE WORK.

### STEP 7: APPROPRIATE ACTIONS ARE IMPLEMENTED BY WORKERS AND LINE MANAGERS.

This stage needs to be focused on action, identifying facilitators to action and overcoming obstacles (G-12 \*\*; end users and experts survey). A simple, intuitive system based on guided questioning is recommended. Also, it is important at this stage to determine whether identified actions are:

**Responsive**: Is the proposed solution *responsive* to the needs of workers and *flexible* enough to be adapted for specific purposes and contexts.

**Acceptable**: Is the proposed solution *acceptable* to the worker, the manager, co-workers and other relevant stakeholders, *inclusive* in that relevant stakeholders have been consulted and *fair* to all stakeholders, including the organisation.

**Worth investing in**: Is the proposed solution *consistent* with other organisational policies and practices and is it the solution that gives the best return on *investment*, in that there are no other solutions that are just as effective but easier and/or less costly to implement and that the intervention is *supportive* of workers.

Like the identification questions for problems that leads to potential solutions, the questions for implementation need to be conducted in group meetings for comfortable work at a group level and in regular one-to-one meetings for comfortable at an individual level (e.g. performance/development reviews for). To ensure credibility and consistency, as with the other tools, answers must be discussed and any disagreements resolved. If discrepancies cannot be resolved or there are significant problems in the relationships between a worker or workers and the line manager, and we anticipate these to be relatively rare, then organisational grievance/bullying and line manager performance management systems should be used to resolve the issues. However, unless there are significant disagreements or issues to resolve, it is anticipated the indication framework should take less than 60 minutes to complete. Note that this phase is only introduced if there are problems with providing comfortable work. If there are no problems identified at step 3, this phase is not initiated.

In ordinary circumstances, it is anticipated the implementation questions should follow immediately after the identification of problems and solutions. However, this may not always be appropriate if there are significant disagreements or it is decided for other reasons to defer decision to a subsequent meeting. We feel the decision on when to complete the implementation questions is best left to the discretion of line managers and workers.

It is proposed to break the questions down into six main areas concerning:

1. Identification of appropriate enablers of the intervention;
2. Identification of obstacles to the intervention;
3. Identification of actions to overcome obstacles;
4. Identification of key success factors for the intervention.
5. Checking that any proposed solutions fulfil the RAW criteria.
6. Identifying a timetable to review implementation and process for resolving any difficulties with implementation.

On the basis of the questions, an action plan should be formulated and recorded. This action plan should be recorded and sent to those responsible for HRM or OHS. This means that a simple framework is needed in order to record the action plan. It is also envisaged that the workbook will provide guidance on enablers, obstacles and strategies to overcome obstacles. Line managers and workers should monitor and review the success of the intervention and take further actions where necessary to ensure the plan is implemented.

**Summary:**

*Who:* Line managers and groups of worker or individual workers as appropriate.

*When:* When problems are identified, so that work is either not comfortable or accommodating.

*How:* Guided questioning provided by indication tool in workbook in group or one-to-one meetings as appropriate.

*Output:* Action plans formulated, monitored and corrective actions taken where necessary. Completed forms to be sent to HRM/OHS.



### MODULE 3: ACCOMMODATING WORKPLACE:

#### STEP 8: IDENTIFYING ACCOMMODATING WORK.

It is anticipated that this step can be accomplished by guided questioning between the line manager and individual worker. The indication tools (for examples see later in the document) could be used to record answers to the questions, and use the answers as a basis for action.

It is important that the indication framework is used to identify problems (if any) and that discrepancies in views be resolved through discussion. The discussion and resolution of discrepancies is important, since these provide both consistency in the assessment of jobs and credibility with various stakeholders. If discrepancies cannot be resolved or there are significant problems in the relationships between a worker or workers and the line manager, and we anticipate these to be relatively rare, then organisational grievance/bullying and line manager performance management systems should be used to resolve the issues.

Issues with work-relevant CHPs may emerge during formal one-to-one meetings (e.g., performance/development appraisals), or they may become apparent in questioning regarding drops in performance, expressed complaints at work, changes in mood and/or recurrent short absences. Where line managers notice such things or workers or their colleagues bring potential work-relevant CHP problems to their attention, then line managers should arrange a brief meeting with the worker to complete both the indication framework and, if all goes well, the framework to identify and implement solutions. The indication framework for accommodating work needs to be completed at this meeting, which will also be a set of guided questions directed at the worker. Any disagreements with the line manager on how accommodating work is or could be made need to be resolved. Unless there are significant disagreements or issues to resolve, it is anticipated the indication framework should take less than 10 minutes to complete.

As well as asking about and discussing the questions, the indication framework needs to provide a simple means of recording problems (if any), in order to send the completed assessment to those responsible for HRM or OHS.

The indication framework for accommodating work needs to work on the basis of flags or a similar intuitive system (G-3 \*) for identifying and developing action plans based on:

The presence of symptoms, somatic, psychological, behavioural and social that affect work – including absence patterns

Does line manager know how to seek support from OHS in order to deal with problem?

The extent to which the line manager is considerate, supportive and responsive to work-relevant CHPs (MS-8 \*\*; MH-8 \*; ST - 15 O);

Extent to which broad categories of the features of comfortable jobs could be temporarily changed to accommodate work-relevant CHPs (MH-6 \*\*\*; MH-8 \*; MH-12 \*; G-13 \*\*; G-17 \*\*; G-18 \*\*\*) -

Enhanced job resources - job control – especially over schedules or tasks; skill development and use; variety in tasks; role and clarity concerning the future; support from line manager and co-workers; career and other development opportunities;

Reasonable job demands and hygienic conditions - reasonable level of demands; physical security and safety; job security and fair pay; minimal role conflict;

Extent to which broad categories of the features of accommodating job is desired by the worker, whether present or not (ST – 13 \*; G-14 \*);

Fairness in how workers are treated – ensuring temporary changes do not adversely affect others (ST-6 \*\*\*);

Coping potentials, resilience and beliefs can remain in work and recover, e.g., regulating symptoms and recovery from particularly painful episodes, and skills and job resources and support to realise those potentials (MH-6 \*\*\*; MH-8 \*; MH-10 \*\*\*; MH-11 \*; G-16 \*\*\*; G-19 \*\*\*; G-20 \*; MS-7 \*\*; MS-8 \*\*);

The extent to which individual workers can shape and/or negotiate the content of their own work to achieve accommodating jobs, their goals and cope with demands (MH-10 \*\*\*).

The extent to which line managers have to provide additional support to workers to the content of their own work to achieve accommodating workplaces, their goals and cope with demands (MH-10 \*\*\*).

Clearly, this is too extensive a list to be able to include in a quick assessment consisting of just a few questions.

Therefore, it is proposed to break the questions down into four main areas:

1. Symptoms and how the line manager can help to deal with them: This subsumes establishing the presence of symptoms that affect work, whether the line managers knows how to seek support from OHS in order to deal with problem and general line manager support and responsiveness to the problem
2. The extent to which the features of comfortable jobs could be reasonably and temporarily changed to accommodate work-relevant CHPs in a manner desired by the worker, which includes changing levels of job resources, demands and physical conditions;
3. Coping potentials including beliefs concerning recovery and workability, and the skills, job resources and support to solve problems caused by symptoms, regulate symptoms and recovery from particularly painful episodes;
4. Job crafting – covering the extent to which individual workers can temporarily shape and/or negotiate the content of their own work to achieve accommodating jobs and the extent to which co-workers and the line manager can support the worker in so doing.

Ensuring that temporary changes do not adversely affect others will be covered in step 9 under the RAW criteria.

Answers to questions should guide the line manager to appropriate interventions through consultation of the appropriate workbook. Once the preferred intervention(s) is (are) chosen and agreed upon by line managers and workers, then the line managers and workers should proceed to

step 9. If there are no problems identified, then the process for line managers and workers stops at this step.

For lower levels of cultural maturity, the emphasis may be on line manager support, manager or OHS initiated changes to work and developing coping potentials (1, 2, 3). For higher levels of cultural maturity, the emphasis might be on job crafting and worker initiated changes to self-regulate (3, 4).

**Summary:**

*Who:* Line manager and worker.

*When:* When a problem is identified.

*How:* Guided questioning provided by indication tool in workbook in one-to-one meeting.

*Output:* Identification of any problems to be dealt with and what about work needs to be changed to make it more temporarily accommodating. Completed forms to be sent to HRM/OHS.

### MODULE 3: ACCOMMODATING WORKPLACE:

#### STEP 9: APPROPRIATE ACTIONS ARE IMPLEMENTED BY WORKERS AND LINE MANAGERS.

This stage needs to be focused on action, identifying facilitators to action and overcoming obstacles (G-12 \*\*; end users and experts survey). A simple, intuitive system based on guided questioning is recommended. Also, it is important at this stage to determine whether identified actions are:

**Responsive:** Is the proposed solution *responsive* to the needs of workers and *flexible* enough to be adapted for specific purposes and contexts.

**Acceptable:** Is the proposed solution *acceptable* to the worker, the manager, co-workers and other relevant stakeholders, *inclusive* in that relevant stakeholders have been consulted and *fair* to all stakeholders, including the organisation.

**Worth investing in:** Is the proposed solution *consistent* with other organisational policies and practices and is it the solution that gives the best return on *investment*, in that there are no other solutions that are just as effective but easier and/or less costly to implement and that the intervention is *supportive* of workers.

Like the identification questions for problems that lead to potential solutions, the questions for implementation need to be conducted in ad hoc one-to-one meetings when a problem is identified for accommodating work. To ensure credibility and consistency, as with the other tools, answers must be discussed and any disagreements resolved. If discrepancies cannot be resolved or there are significant problems in the relationships between a worker or workers and the line manager, and we anticipate these to be relatively rare, then organisational grievance/bullying and line manager performance management systems should be used to resolve the issues. However, unless there are significant disagreements or issues to resolve, it is anticipated the indication framework should take less than 60 minutes to complete. Note that this phase is only introduced if there are problems with providing comfortable or accommodating work. If there are no problems identified at step 3, this phase is not initiated.

In ordinary circumstances, it is anticipated the implementation questions should follow immediately after the identification of problems and solutions. However, this may not always be appropriate if there are significant disagreements or it is decided for other reasons to defer decision to a subsequent meeting. We feel the decision on when to complete the implementation questions is best left to the discretion of line managers and workers.

It is proposed to break the questions down into six main areas concerning:

1. Identification of appropriate enablers of the intervention;
2. Identification of obstacles to the intervention;
3. Identification of actions to overcome obstacles;
4. Identification of key success factors for the intervention.
5. Checking that any proposed solutions fulfil the RAW criteria.
6. Identifying a timetable to review implementation and process for resolving any difficulties with implementation.

On the basis of the questions, an action plan should be formulated and recorded. This action plan should be recorded and sent to those responsible for HRM or OHS. This means that a simple framework is needed in order to record the action plan. It is also envisaged that the workbook provide guidance on enablers, obstacles and strategies to overcome obstacles. Line managers and workers should monitor and review the success of the intervention and take further actions where necessary to ensure the plan is implemented.

**Summary:**

*Who:* Line managers and groups of worker or individual workers as appropriate.

*When:* When problems are identified, so that work is either not comfortable or accommodating.

*How:* Guided questioning provided by indication tool in workbook in group or one-to-one meetings as appropriate.

*Output:* Action plans formulated, monitored and corrective actions taken where necessary. Completed forms to be sent to HRM/OHS.

#### MODULE 4: LEARNING ORGANISATION:

STEP 10: COPIES OF THE COMPLETED INDICATION FRAMEWORKS COULD THEN BE FED TO DEPARTMENT HEADS, OHS OR HRM, DEPARTMENT HEADS, OHS OR HRM IMPLEMENT AND MONITOR ACTION PLANS TO IMPROVE DEPARTMENT'S/ORGANISATION'S ABILITY TO PROVIDE COMFORTABLE AND ACCOMMODATING WORK.

The purpose of this stage is to allow departments and organisations to identify areas in which concerted departmental/organisation action and changes in policy might improve work. The purpose of this stage is not to prescribe action, but merely to suggest areas in which departmental/organisational action might facilitate line managers and workers in their efforts to provide more comfortable work or potential to provide temporarily engaging work.

This stage is based on departmental heads, HRM or OHS departments making assessments of any emerging trends that are apparent in line manager reports submitted from steps 6 through 9. The most straightforward way to do this might be for department heads, senior HRM and/or OHS managers to meet with all line managers in a section to review completed line manager reports submitted from steps 6 through 9.

Again, it is intended that guided questioning form this phase in which department heads, OHS and HR managers work through the questions with line managers, with the answers being determined by the process that is most suitable for the department or organisation. Answers to the questions could be cross-referenced against the appropriate workbooks to determine appropriate courses of action or changes in policy.

Additional information may be required (e.g. on job security – see below). However, it is anticipated organisations should easily be able to form a judgement on such issues. For example, most larger organisations will conduct employee attitude surveys that can inform this process. How such assessments should be made and which information to integrate with line manager reports can be left to the discretion of organisations, as the most appropriate course of action will depend on the size and sophistication of the organisation. For example, larger organisations may decide to employ consultants to code and analyse statistically reports from line managers, and feed this information to department heads as well as considering information at the most senior levels. Senior management teams in smaller organisations may find it sufficient to simply review reports from line managers on a periodic basis. Like assessing cultural maturity and dependent on the rate of change in an organisation, it is proposed that this assessment take place every one to two years.

Of course, if there are no problems identified, there is no need to proceed further into action.

The questions should assess overall levels in the organisation and also seek to determine whether there are specific departments, areas or groups with particularly high levels that need to be attended to. The questions necessarily fall into three areas – one set for identifying comfortable work (step 6), one set for the potential to provide temporarily accommodating work (step 8) and one set for line managers' and workers' capabilities to implement necessary actions (steps 7 and 9). The question sets corresponding to steps 6 and 8 follow the same lines as the questions line managers and workers answer, since they are concerned with actions to provide comfortable and temporarily accommodating work. However, for step 6, there is an additional issue concerning comfortable work that line managers cannot easily influence. This is whether organisations provide as much job security and fair pay as possible (ST-6 \*\*\*; G-13 \*\*).

The set corresponding to steps 7 and 9 is more concerned with capabilities for change. The set corresponding to steps 7 and 9 is therefore concerned with a different set of issues as follows:

organisational responsiveness to occupational health issues;

senior management leadership (notes to ST-3; G-13 \*\*);

organisational values regarding people and health;

communication practices (MS-12 \*);

line management responsiveness to occupational health issues;

fit of occupational health practices with other organisational systems (ST - 15 O).

These areas can be roughly broken down into questions concerning senior managers and the organisation, line managers and fit with other organisational systems.

Two other issues relevant to implementation, procedural justice (ST-6 \*\*\*) and worker involvement (principle in HSE Management Standards; MS-8 \*\*) are embedded in the identification and implementation processes of steps 6 through 9.

#### **Set A. Emergent trends in comfortable work – collating answers to step 6 above.**

Questions aimed at examining overall levels in the department/organisation and whether they are any specific problems in particular departments, areas or groups.

1. Overall levels of work-relevant CHPs, and whether these might be attributable to work or a consequence of the nature of the workforce and labour market (e.g. employment of a large cohort of older workers).
2. Demands, level and desirability: Reasonable quantitative and qualitative job demands, neither too high nor too low and hygienic, safe conditions;
3. Resources in general, level and desirability: Including autonomy, variety, skill use, job control; skill development and use; variety in tasks; role and clarity concerning the future; opportunities for social contact; support co-workers; career and other development opportunities; fairness in treatment;
4. Line manager support, level and desirability;
5. Resources for coping with demands – skills, job resources and support necessary to solve problems in a timely manner and take breaks from demanding work when needed;
6. Resources for goals – the extent to which workers can pursue their own goals, aspirations and values, provided they are reasonable and consonant with work unit or organisational goals;
7. Job crafting – the extent to which workers and work group can shape the content of their own work to achieve comfortable jobs, their goals and cope with demands, and the extent to which the line manager supports them in so doing.
8. Are jobs as secure as they can be and is pay distributed fairly and according to clear criteria?

#### **Set B. Emergent trends in potential to provide accommodating work – collating answers to step 8 above.**

Questions aimed at examining overall levels in the department/organisation and whether they are any specific problems in particular departments, areas or groups.

1. Establishing the presence of symptoms that affect work and cannot be prevented through changes in work practices, whether line manager know how to seek support from OHS in order to deal with problems and general line manager support and responsiveness to problems;
2. The extent to which the features of comfortable jobs could be reasonably and temporarily changed to accommodate work-relevant CHPs in a manner desired by the worker, which includes changing levels of job resources, demands and physical conditions;
3. Coping potentials including beliefs concerning recovery and workability, and the skills, job resources and support to solve problems caused by symptoms, regulate symptoms and recovery from particularly painful episodes;
4. Job crafting – covering the extent to which individual workers can temporarily shape and/or negotiate the content of their own work to achieve accommodating jobs and the extent to which co-workers and the line manager can support the worker in so doing.
5. Whether temporary changes made to accommodate work-relevant CHPs have had adverse effects on others or other areas of the business.

### **Set C. Capabilities for line managers and workers to make improvements.**

Senior management commitment and responsiveness to work-relevant CHPs is important, but this will already have been dealt with in steps 1-4. Similarly, line management commitment and responsiveness will have been dealt with in steps 6-9, and any specific problems in particular departments, areas or groups will have been identified in the collation of reports under Set A and Set B questions in step 10. Therefore, only one additional question is required:

14. Is there evidence that changing work to make it comfortable and temporarily accommodating is having adverse effects on other organisational systems and what can be done about this?

Answers to this question should guide departmental, OHS or HR managers to appropriate interventions or changes in policies through consultation of the appropriate workbook. Once the preferred intervention(s) is (are) chosen and agreed upon with relevant stakeholders, then the process moves to implementation. If there are no specific problems identified that cannot be dealt with more efficiently through line management action, then the process stops as there is no need to implement any changes.

### **Solutions**

For lower levels of cultural maturity, the emphasis may be on interventions or policies that seek to develop line manager support, manager or OHS initiated changes to work and developing coping potentials. For higher levels of cultural maturity, the emphasis might be on job crafting, worker initiated changes to self-regulate and establishing communities of practice amongst line managers to share knowledge.



If problems and solutions are identified, solutions need to be implemented. Therefore, the focus shifts to implementing changes: However, here changes are to be at a departmental/organisational level. The process for this stage is very much dependent on the processes chosen to collate and interpret line manager reports. For example, a large organisation might find it better to implement changes at a departmental level, whereas a smaller organisation might find it better to implement changes across the whole organisation. Like steps 7 and 9, any interventions need to be checked so that are:

**Responsive:** Is the proposed solution *responsive* to the needs of workers and *flexible* enough to be adapted for specific purposes and contexts.

**Acceptable:** Is the proposed solution *acceptable* to the worker, the manager, co-workers and other relevant stakeholders, *inclusive* in that relevant stakeholders have been consulted and *fair* to all stakeholders, including the organisation.

**Worth investing in:** Is the proposed solution *consistent* with other organisational policies and practices and is it the solution that gives the best return on *investment*, in that there are no other solutions that are just as effective but easier and/or less costly to implement and that the intervention is *supportive* of workers.

The process of implementation will again be concerned with working through a set of questions, with the workbook pointing to certain areas for special consideration and solutions if problems are identified. How organisations do this will depend on their preferred processes. However, we would recommend the issues and implementation plans are discussed and modified if appropriate at the most senior and general levels possible (e.g. departmental or senior management rather than OHS or HRM meetings), even if initial plans are developed by OHS or HR managers. However, it is not envisaged that working through the questions will take long and that they can be dealt with in a relatively straightforward manner.

The questions can be parallel to those for step 4, that is the questions will cover six main areas at the department/organisational level:

1. Identification of appropriate enablers of the intervention;
2. Identification of obstacles to the intervention;
3. Identification of actions to overcome obstacles;
4. Identification of key success factors for the intervention.
5. Checking that any proposed solutions fulfil the RAW criteria.
6. Identifying a timetable to review implementation and process for resolving any difficulties with implementation.

**Summary:**

*Who:* Department heads, OHS or HR departments as appropriate.

*When:* Every one to two years as appropriate.

*How:* Working through a set of guided questions.

*Output:* Identification of any problems to be dealt with at departmental or organisational levels and what about the department/organisation needs to be changed to make the work environment more comfortable, have better potentials to be temporarily accommodating and/or develop capabilities of line managers and workers to make improvements. Where appropriate, action plans formulated, monitored and corrective actions taken where necessary.

## **EXAMPLE INDICATION QUESTIONS**

This section of Appendix 4 gives examples only to illustrate how the indication framework may work. These examples then are mainly a rough thought experiment to illustrate the feasibility of the general approach and steps outlined above. Through a process of revision and refinement, we expect the final questions to be different from these examples given here.

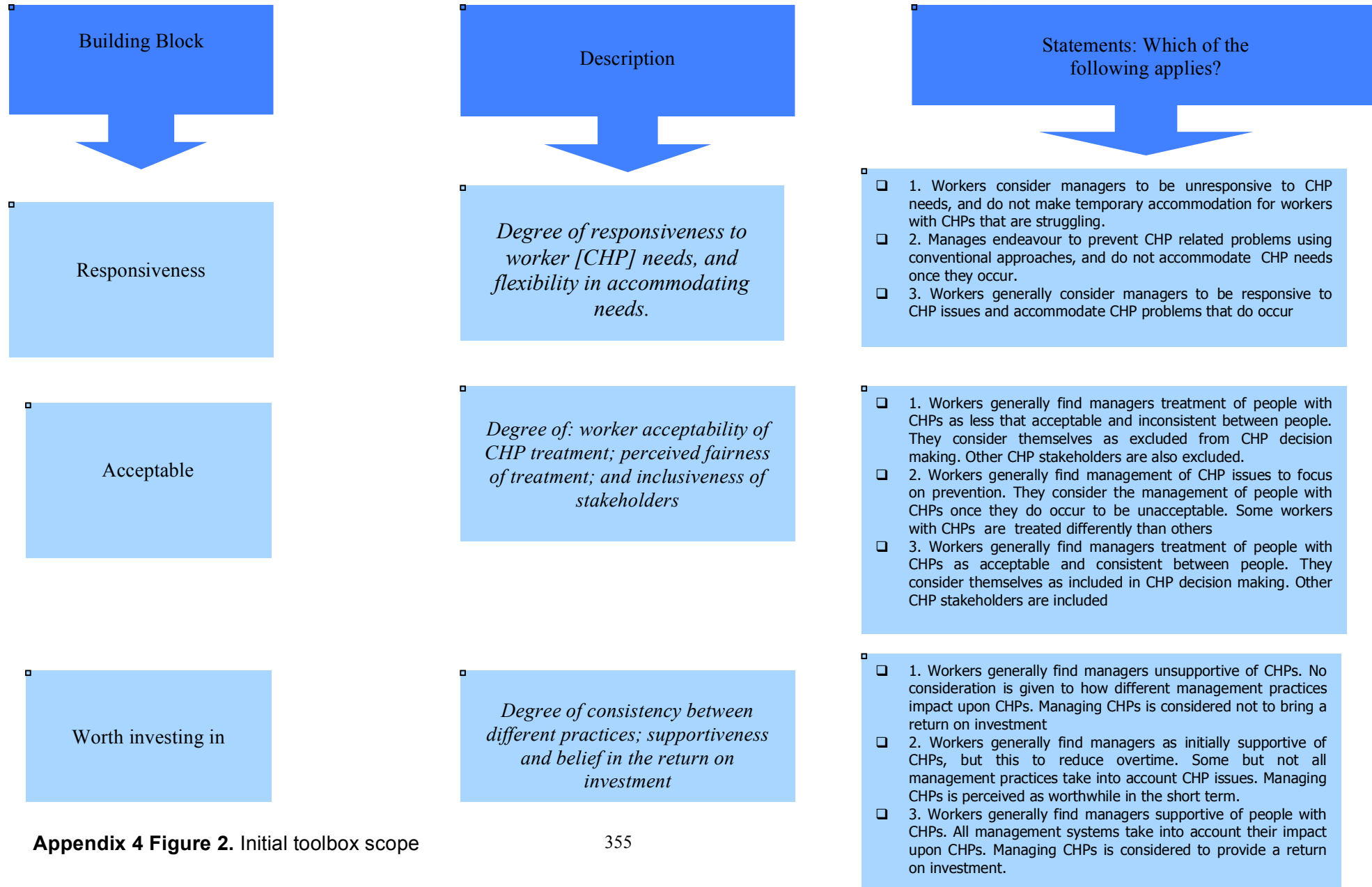
MODULE 1: PREPARATION

STEP 1: GETTING SENIOR MANAGEMENT BUY-IN

**No questions**

MODULE 1: PREPARATION

STEP 2: HRM/OHS TO IDENTIFY CULTURAL MATURITY



Appendix 4 Figure 2. Initial toolbox scope

**Appendix 4: Table 4 Progressing Maturity**

	<b>Maturity Progression Solutions</b>	
	<i>Non-compliance-Basic Compliance</i>	<i>Basic Compliance- Exceeding Compliance</i>
Responsiveness	<p>Follow conventional risk assessment guidance (management standards, ergonomics guidance, traditional occupational health procedures)</p> <p>Set up communication structures to obtain staff feedback on well-being</p> <p>Review &amp; improve leadership practices</p>	<p>Reviewing &amp; improving range of well-being related to flexibility and accommodations (flexible work arrangements, scope of job redesign, redeployment etc)</p> <p>Examine &amp; define work-relevant CHP values - e.g. generating vision/aspirational statements and promote</p> <p>Values ‘gap’ analysis (ideal against reality for work-relevant CHPs)</p>
Acceptability	<p>Establish communication and worker involvement practices</p> <p>Review policies and practices relating to fairness (e.g. equal opportunity, negotiation, recruitment, promotion, reporting, referrals, absence management)</p>	<p>Extend policies to apply to supply chain and other stakeholders</p>
Worth Investing In	<p>Reviewing management systems integration for well-being/work-relevant CHPs</p> <p>Review line management training &amp; support</p>	<p>Conduct investment assessments</p> <p>Review the sustainability of management support</p>



## MODULE 1: PREPARATION

### STEP 3: QUESTIONS TO SCOPE POTENTIAL RESOURCE REQUIREMENTS AND PLANNING FOR CONTINGENCIES

**1. Key stakeholders and time commitment.** The indication framework is simple enough to implement in a small amount of time, and for comfortable work to be integrated into normal group meetings and performance/development appraisals. However, in some organisations, managers may feel it desirable to involve other stakeholders.

- a. As well as the OHS function, line managers and workers, who else needs to be involved in developing comfortable and accommodating work?

*This may include trades union/employee representatives or key members of the supply chain amongst companies with highly interdependent working (such as temporary project based organisations).*

- b. How should these other stakeholders be involved?

*Do they need merely to be informed, should they be involved at a more strategic level, should they be involved at a line level. Might special meetings be needed, or can issues be dealt with during routine and/or informal meetings.*

**2. Other resources.** It is anticipated that the indication framework and any resulting changes should be easy to implement. However, some organisations may feel that additional resources are required at various levels.

- a. Do any of the key stakeholders require additional support?
- b. Which stakeholders require support?
- c. What kind of support do they require?

*For example, additional information, additional equipment (e.g., IT), extra human resources, extra financial resources, problem-solving circles, communities of practice.*

**3. Senior management resources.** Senior management support for initiatives is vital for effectively reducing the incidence of, preventing the escalation of, and managing work-relevant CHPs.

- a. How much time does the Managing Director/most senior manager need to devote to this?

*Is time needed to gain political and other support from other stakeholders, to attend key meetings, to communicate with key stakeholders.*

- b. Who does s/he need to communicate with?

*This may include the board, trades union/employee representatives, key members of the supply chain amongst others. It will certainly include key department/section heads, line managers and line workers.*

- c. How should s/he communicate?

*Email, face-to-face, formal meetings, informal meetings – depending on size of organisations and importance of stakeholders.*

- d. What should be communicated?

*This should include the small amount of time required of line managers and workers to complete the indication framework, that senior management recognise the simple steps in the framework and any changes are part of normal working practices and not ‘extra-curricular’, the benefits for line managers of taking the exercise seriously, the seriousness with which senior management is taking these issues. Other issues might also be appropriate.*



## MODULE 1: PREPARATION

### STEP 4: TAKE CORPORATE ACTION TO IMPROVE CULTURAL MATURITY

Actions to guide discussion of steps in improving cultural maturity.

*A. Moving from non-compliance to basic compliance:*

#### **Actions to improve cultural maturity to the next level are:**

*Following conventional risk assessment and management guidance for ergonomic work design and stress (e.g. HSE Management Standards for Work-Related Stress).*

*Review and improve integration of occupational health and safety policies and practices with each other and with other organisational policies and practices.*

*Review and improve communication structures to obtain staff feedback on well-being and ensure worker involvement in well-being related issues (e.g., setting up health and safety committees, ensure well-being is an agenda item of OHS committee meetings).*

*Review and improve current policies and practices relating to health, well-being and fairness (e.g., equal opportunities – recruitment, selection, development, career advancement, employees' opportunities to negotiate terms and conditions, sickness reporting, absence management policies).*

*Review line manager training and support for managing occupational health and safety.*

Do we need to make any changes in these areas?

If so, what changes should we make?

Are there any other areas we could improve on?

Are these changes:

**responsive** to the needs of workers and the nature of the work?

**acceptable** to workers, managers, co-workers and other people at work who may be affected by the changes?

**worth investing in?** Does it give the best return on investment, all things considered including impact on co-workers and other organisational practices?

*A. Moving from basic compliance to exceeding compliance:*

**Actions to improve cultural maturity to the next level are:**

*Reviewing and improving range of well-being related policies and practices (e.g., flexible work arrangements, scope for job and task redesign – temporary or permanent).*

*Reviewing on-going and sustainability of management support for reducing the incidence of, preventing the escalation of, and managing work-relevant CHPs.*

*Conduct values gap analysis – examine values in relation to well-being and identify gap between current and desired practice.*

*Carry out return on investment assessments for policies and practices.*

*Review extending current good health and safety practice in organisation through disseminating lessons to elsewhere in the supply chain.*

Do we need to make any changes in these areas?

If so, what changes should we make?

Are there any other areas we could improve on?

Are these changes:

**responsive** to the needs of workers and the nature of the work?

**acceptable** to workers, managers, co-workers and other people at work who may be affected by the changes?

**worth investing in?** Does it give the best return on investment, all things considered including impact on co-workers and other organisational practices?

MODULE 2: COMFORTABLE JOBS.

STEP 6: IDENTIFYING COMFORTABLE JOBS.

These questions are designed to be asked by line managers in group meetings and in regular performance/development appraisals. They are presented in an example matrix to guide action.

Question	Record answer here	Next step
<p><b>Q1. What are work demands and conditions like?</b></p> <p>Comfortable is balanced. Job would have work that is challenging and motivating, but not too difficult or too easy. There would be enough work to stop people feeling bored, but the pace of work would not be so fast that people could not work to an adequate or safe standard in normal working hours. The physical environment at work would be good and comfortable.</p> <p>Work that is not comfortable may be either too difficult or too easy for people. There may not be enough to do to sustain people’s motivation and attention, or there may so much to do that it is not possible to finish things to a good and/or safe standard in normal hours or working hours may become excessively long (and possibly interfere with family life). The physical environment may be uncomfortable and there might be obvious and unmanaged threats to safety</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page X</p>

<p><b>Q2. What are opportunities and support to use and develop skills like?</b></p> <p>Comfortable jobs have good support and opportunities to develop skills. People will feel supported by their work colleagues when they have problems, and the team will swap advice on how to tackle difficult work problems. People will feel they are treated fairly. People will be clear on their job responsibilities. People will be able to make decisions relevant to their work and appropriate to their levels of skill. People will have opportunities to practice a variety of skills relevant to the work and develop these skills further. This might be through training, but also through on-the-job learning. People will have some idea of how their work and development will pan out over a foreseeable time frame.</p> <p>Work that is not comfortable will offer few or no opportunities to take decisions relevant to workers' tasks and levels of skills. There will be little support from co-workers and people will feel unfairly treated. There will be little or no opportunity to use and develop a range of skills, and workers will not be clear on their responsibilities or what the future holds.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page X</p>
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<p><b>Q3. What do those I manage think I am like as a line manager?</b></p> <p>For comfortable work, managers need to communicate regularly and well with workers, and offer support when it is wanted and to treat workers fairly. Offering support does not always mean ‘a shoulder to cry on’. It can be a lot more concrete than that – such as offering advice on how to complete tricky work tasks, finding out about skills development opportunities.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page X</p>
<p><b>Q4. Can people cope when problems occur?</b></p> <p>Problems do occur at work – such as difficult customers, equipment breaking or conflicts with other work teams. For comfortable work, workers need to be able to cope with problems when they occur. This can mean having the skills and ability to take decisions to solve problems in a timely manner and have support from others to help solve problems in a timely manner if needed, It can also mean the opportunity to take breaks from particularly demanding problems or work within the working day in order to ‘recharge’ batteries and look at problems anew.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page X</p>

<p><b>Q5. Is work interesting for people?</b></p> <p>Comfortable work is interesting and motivating. Different people have different things that motivate and interest them. For example, some people are interested in helping customers, whereas others like solving technical problems. Comfortable work allows people to pursue these interests, provided they are <i>reasonable</i> and <i>consistent</i> with work unit or organisational goals.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page <b>X</b></p>
<p><b>Q6. Can workers help themselves to make their work comfortable?</b></p> <p>Each person has slightly different interests and desires, abilities to solve problems and each person experiences work differently. One way to take these differences into account is to support work groups and individuals make their own work more comfortable. People will need the skills, support and opportunities to do so, and will also have to negotiate with others, so that any changes to work do not compromise the work of others, the work unit or organisational goals.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page <b>X</b></p>

STEP 7: APPROPRIATE ACTIONS ARE IMPLEMENTED BY WORKERS AND LINE MANAGERS FOR COMFORTABLE JOBS.

These questions are designed to be asked by line managers in group or individual meetings if problems are identified in step 6.

Q1. What action has been identified to make work more comfortable?	(insert answers here)
Q2. What would help this solution to work properly and how can we get this help? <i>This might be support for occupational health, human resources management, more senior managers or co-workers. It might be additional resources, e.g. equipment.</i>	
Q3. What might stop us making this solution work and how do we overcome these obstacles? <i>This might mean developing contingencies to get round some obstacles, or it might mean consulting with relevant stakeholders to ensure smooth implementation.</i>	
Q4. How will we know the action has worked? <i>Identify the key success factors, such as a noticeable change in working practices, improved productivity, development of key skills, improved communications practices.</i>	
Q5. Is this action <b>responsive</b> to the needs of workers and the nature of the work?	If NO refer back to work book for another solution or adapt solution so it is responsive
Q6. Is this action <b>acceptable</b> to the worker, the manager, co-workers and other people at work who may be affected by the changes? Note, other people may need to be consulted.	If NO refer back to work book for another solution or adapt solution so it is acceptable
Q7. Is this action <b>worth investing in</b> ? <i>Does it give the best return on investment, all things considered including impact on co-workers and other organisational practices?</i>	If NO refer back to work book for another solution or adapt solution so it is worth investing in
Q8. What are the key steps in taking this action and when should they occur? When do we have interim reviews to check progress and deal with any difficulties in implementing actions? When do we have a final review of the action?	

MODULE 3: ACCOMMODATING WORK.

STEP 8: IDENTIFYING ACCOMMODATING WORK.

<p><b>Q1. Have you noticed any work-relevant symptoms?</b></p> <p>Common health problems include a number of physical complaints and can affect people's mood and performance at work.</p> <p>Look out for people complaining about aches and pains, difficulty sleeping or grumbling excessively about work conditions. People that become more aggressive, irritable or passive than usual may be experiencing problems. Noticeable and unexplained increases in absence or lateness, as well as a drop in productivity, may also indicate problems.</p>	<p>If in doubt, consult the person in your organisation responsible for occupational health for advice.</p>	<p>If no problems, no action needed</p> <p>If problems – move to Q2</p> <p>If appropriate notify your own line manager that there might be a problem you need to deal with.</p>
<p><b>Q2. Can work be changed temporarily to help manage the work-relevant CHP?</b></p> <p>Accommodating work can involve making temporary changes to work tasks. Changing work tasks might be a temporary change in work so that the worker engages in less physically or mentally taxing work, is given fewer work tasks to complete, is allowed to use additional equipment, or is moved to a different location temporarily. It can also mean that people are given more control over their schedules, so that they can take breaks if the symptoms become too difficult to cope with.</p>		<p>If work can be changed – refer to Workbook page X</p>



<p><b>Q3. Can people cope when common health problems occur or could they help themselves make their work more accommodating?</b></p> <p>Many common health problems are minor and many people prefer to soldier on until the problems go away or become manageable on their own accord. Each person's experience of common health problems will be different and each person's experience of work is different. One way work is to work with people's individuality and desire to cope with common health problems themselves. It is to support individuals to make their work accommodating.</p> <p>People who are able to cope with common health problems tend to believe they will recover in time and can stay in work. They will have the ability to cope with their symptoms and adjust their own behaviour at work accordingly. They will have the control over schedules and tasks to allow them to adjust their work temporarily when problems occur, and they will have the support from their co-workers and you the line manager to do so. If other changes are to be made, they will have the skills and support to negotiate temporary changes to work with you and their co-workers, so that changes do not affect others work or organisational or work unit goals.</p> <p>People who are <b>unable</b> to cope with common health problems tend to believe that the common health problem is a significant and long term disability. Their symptoms will be too strong for them to cope with. They may have no control over their schedules and tasks, so that they cannot adjust their work temporarily when problems occur, and they may not have the support from co-workers to make those adjustments. They will not have the ability to negotiate their own adjustments.</p>		<p>If people do not have the potential to cope – refer to Workbook page <b>X</b></p>
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MODULE 3: ACCOMMODATING WORK.

STEP 9: APPROPRIATE ACTIONS ARE IMPLEMENTED BY WORKERS AND LINE MANAGERS FOR ACCOMMODATING WORK.

*These questions are to be asked by line managers in meetings with the person with work-relevant CHPs.*

Q1. What action has been identified to make work more accommodating?	(insert answers here)
Q2. What would help this solution to work properly and how can we get this help? <i>This might be support for occupational health, medical practitioners, human resources management, more senior managers or co-workers. It might be additional resources, e.g. equipment.</i>	
Q3. What might stop us making this solution work and how do we overcome these obstacles? <i>This might mean developing contingencies to get round some obstacles, or it might mean consulting with relevant stakeholders to ensure smooth implementation.</i>	
Q4. How will we know the action has worked? <i>Identify the key success factors, such as a noticeable change in working practices, improved productivity, development of key skills, improved communications practices.</i>	
Q5. Is this action <b>responsive</b> to the needs of workers and the nature of the work?	If NO refer back to work book for another solution or adapt solution so it is responsive
Q6. Is this action <b>acceptable</b> to the worker, the manager, co-workers and other people at work who may be affected by the changes? Note, other people may need to be consulted.	If NO refer back to work book for another solution or adapt solution so it is acceptable
Q7. Is this action <b>worth investing in</b> ? <i>Does it give the best return on investment, all things considered including impact on co-workers and other organisational practices?</i>	If NO refer back to work book for another solution or adapt solution so it is worth investing in
Q8. What are key steps in taking this action and when should they occur? When do we have interim reviews to check progress and deal with any difficulties in implementing actions. When do we have a final review of the action	

MODULE 4: LEARNING ORGANISATION.

STEP 10: COPIES OF THE COMPLETED INDICATION FRAMEWORKS COULD THEN BE FED TO DEPARTMENT HEADS, OHS OR HR DEPARTMENTS AND DEPARTMENT HEADS, OHS OR HR DEPARTMENTS IMPLEMENT AND MONITOR ACTION PLANS TO IMPROVE DEPARTMENT'S/ORGANISATION'S ABILITY TO PROVIDE COMFORTABLE AND ACCOMMODATING WORK

*Answers to the questions can be cross-referenced against the appropriate workbooks to determine appropriate courses of action or changes in policy.*

**Set A. Emergent trends in comfortable work and capabilities for line managers and workers to make improvements.**

– collating answers to steps 6 and 7 above.

<p><b>Q1. What are levels of work-relevant CHPs in the organisation or in specific departments?</b></p> <p>As well as line manager reports, look for unusually high levels of grievances, increases in absence or lateness, as well as a drop in productivity.</p> <p>Levels of work-relevant CHPs might not be caused by work, and they may simply be due to the nature of the work (e.g. if the organisation employs a lot of older workers who are more likely to develop muscular aches and pains just to the natural ageing process). However, work in some organisations can cause work-relevant CHPs, so you need to be sure this is not the case in your organisation.</p>		<p>If no problems, no action needed</p> <p>If problems – the answers to Q2-Q8 in this set may help you develop effective action to reduce work-relevant CHPs.</p>
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<p><b>Q2. What are work demands and conditions like across the organisation and in specific departments?</b></p> <p>Comfortable job is balanced. Work would have work that is challenging and motivating, but not too difficult or too easy. There would be enough to work to stop people feeling bored, but the pace of work would not be so fast that people could not work to an adequate or safe standard in normal working hours. The physical environment at work would be good and comfortable.</p> <p>Work that is not comfortable may be either too difficult or too easy for people. There may not be enough to do to sustain people's motivation and attention, or there may so much to do that it is not possible to finish things to a good and/or safe standard in normal hours or working hours may become excessively long (and possibly interfere with family life). The physical environment may be uncomfortable and there might be obvious and unmanaged threats to safety</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page X</p>
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<p><b>Q3. What opportunities and support to use and develop skills like across the organisation and in specific departments?</b></p> <p>Comfortable jobs have good support and opportunities to develop skills. People will feel supported by their work colleagues when they have problems, and the team will swap advice on how to tackle difficult work problems. People will feel they are treated fairly. People will be clear on their job responsibilities. People will be able to make decisions relevant to their work and appropriate to their levels of skill. People will have opportunities to practice a variety of skills relevant to the work and develop these skills further. This might be through training, but also through on-the-job learning. People will have some idea of how their work and development will pan out over a foreseeable time frame.</p> <p>Work that is not comfortable will offer few or no opportunities to take decisions relevant to workers' tasks and levels of skills. There will be little support from co-workers and people will feel unfairly treated. There will be little or no opportunity to use and develop a range of skills, and workers will not be clear on their responsibilities or what the future holds.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page X</p>
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<p><b>Q4. What is line manager support like across the organisation and in specific departments?</b></p> <p>For comfortable work, managers need to communicate regularly and well with workers, and offer support when it is wanted and to treat workers fairly. Offering support does not always mean ‘a shoulder to cry on’. It can be a lot more concrete than that – such as offering advice on how to complete tricky work tasks, finding out about skills development opportunities.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page <b>X</b> and especially interventions concerned with line management training</p>
<p><b>Q5. Can people across the organisation or in specific department cope when problems occur?</b></p> <p>Problems do occur at work – such as difficult customers, equipment breaking or conflicts with other work teams. For comfortable work, workers need to be able to cope with problems when they occur. This can mean having the skills and ability to take decisions to solve problems in a timely manner and support from others to help solve problems in a timely manner if needed, It can also mean the opportunity to take breaks from particularly demanding problems or work within the working day in order to ‘recharge’ batteries and look at problems anew.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page <b>X</b></p>

<p><b>Q6. Is work interesting for people across the organisation and in specific departments?</b></p> <p>Comfortable work is interesting and motivating. Different people have different things that motivate and interest them. For example, some people are interested in helping customers, whereas others like solving technical problems. Comfortable work allows people to pursue these interests, provided they are <i>reasonable</i> and <i>consistent</i> with work unit or organisational goals.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page X</p>
<p><b>Q7. Can workers help themselves to make their work comfortable across the organisation and in specific departments?</b></p> <p>Each person has slightly different interests and desires, abilities to solve problems and each person experiences work differently. One way to take these differences into account, is to support work groups and individuals make their own work more comfortable. People will need the skills, support and opportunities to do so, and will also have to negotiate with others, so that any changes to work do not compromise the work of others, the work unit or organisational goals.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page X</p>

<p><b>Q8. What are job security and rewards like across the organisation and in specific departments?</b></p> <p>Comfortable is secure, well rewarded and rewards are distributed fairly. A review of employment practices with regards to contracts, rewards and the allocation of rewards will give you some idea of whether the levels of security, rewards and fairness of rewards allocation are comparable with or better than other organisations in your sector.</p>		<p>If no problems, no action needed</p> <p>If problems – refer to Workbook page X</p>
<p><b>Q9. Is there evidence that changing work to make it comfortable is having adverse effects on other organisational systems and what can be done about this?</b></p> <p>Reducing the incidence, preventing the escalation of and managing work-relevant CHPs to line managers makes interventions more responsive to problems and is more efficient as it involves fewer layers of management. Moreover, steps are in place to ensure solutions do not conflict with other processes.</p> <p>It is important to assess whether solutions implemented in some areas lead to problems in others. For example, implementation of flexible working in one area may mean unpredictable service delivery to another part of the organisation, causing problems. Routine examination of problems in an area with absence or productivity when noticed and with department heads may uncover difficulties.</p>		



## Solutions

<p>Q1. What action has been identified to make work more comfortable across the organisation or in specific departments, or what action has been identified to reduce adverse effects in other parts of the organisation?</p>	<p>(insert answers here)</p>
<p>Q2. What would help this solution to work properly and how can we get this help? <i>This might be support from senior management, human resources management, external consultants, and HSE or trades unions. It might be additional resources, e.g. equipment.</i></p>	
<p>Q3. What might stop us making this solution work and how do we overcome these obstacles? <i>This might mean developing contingencies to get round some obstacles, or it might mean consulting with relevant stakeholders to ensure smooth implementation.</i></p>	
<p>Q4. How will we know the action has worked? <i>Identify the key success factors, such as a noticeable change in working practices, improved productivity, development of key skills, improved communications practices.</i></p>	
<p>Q5. Is this action <b>responsive</b> to the needs of workers and the nature of the work?</p>	<p>If NO refer back to work book for another solution or adapt solution so it is responsive</p>
<p>Q6. Is this action <b>acceptable</b> to workers, managers and others who may be affected by the changes? Note, other people may need to be consulted.</p>	<p>If NO refer back to work book for another solution or adapt solution so it is acceptable</p>
<p>Q7. Is this action <b>worth investing in</b>? <i>Does it give the best return on investment, all things considered including impact on workers and other organisational practices?</i></p>	<p>If NO refer back to work book for another solution or adapt solution so it is worth investing in</p>
<p>Q8. What are the key steps in taking this action and when should they occur? When do we have interim reviews to check progress and deal with any difficulties in implementing actions? When do we have a final review of the action</p>	

**Set B. Emergent trends in potential to provide accommodating work – collating answers to steps 8 and 9 above.**

<p><b>Q1. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</b></p> <p>It may be the case, for example where large numbers of older workers are employed, that the incidence or escalation of work-relevant CHPs cannot be completely prevented through changing work practices. In this case, organisational policies aimed at facilitating accommodation may need to have wider scope than just dealing with isolated cases.</p>		<p>If reducing the incidence or escalation of work-relevant CHPs only partially effective for a lot of the workforce:</p> <p>Ensure there is sufficient support from occupational health to meet the demands of line managers and move to Q2</p>
<p><b>Q2. Can work be changed temporarily to help manage the work-relevant CHP?</b></p> <p>Accommodating work can involve making temporary changes to work tasks. Changing work tasks might be a temporary change in work so that the worker engages in less physically or mentally taxing work, is given fewer work tasks to complete, is allowed to use additional equipment, or is moved to a different location temporarily. It can also mean that people are given more control over their schedules, so that they can take breaks if the symptoms become too difficult to cope with.</p>		<p>If work can be changed – refer to Workbook page X</p>

<p><b>Q3. Can people cope when common health problems occur or could they help themselves make their work more accommodating?</b></p> <p>Many common health problems are minor and many people prefer to soldier on until the problems go away or become manageable of their own accord. Each person's experience of common health problems will be different and each person's experience of work is different. One way to take many people's desire to cope with common health problems themselves and to take people's individuality into account is to support individuals make their own work more accommodating.</p> <p>People who are able to cope with common health problems tend to believe they will recover in time and can stay in work. They will have the ability to cope with their symptoms and adjust their own behaviour at work accordingly. They will have the control over schedules and tasks to allow them to adjust their work temporarily when problems occur, and they will have the support from their co-workers and you the line manager to do so. If other changes are to be made, they will have the skills and support to negotiate temporary changes to work with you and their co-workers, so that changes do not affect others work the organisational or work unit goals.</p> <p>People who are <i>unable</i> to cope with common health problems tend to believe that the common health problem is a significant and long term disability. Their symptoms will be too strong for them to cope with. They may have no control over their schedules and tasks, so that they cannot adjust their work temporarily when problems occur, and they may not have the support from co-workers to make those adjustments. They will not have the ability to negotiate their own adjustments.</p>		<p>If people do not have the potential to cope – refer to Workbook page <b>X</b></p>
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<p><b>Q4. Is there evidence that changing work to make it accommodating is having adverse effects on other organisational systems and what can be done about this?</b></p> <p>Reducing the incidence, preventing the escalation of and managing work-relevant CHPs to line managers makes interventions more responsive to problems and is more efficient as it involves fewer layers of management. Moreover, steps are in place to ensure solutions do not conflict with other processes.</p> <p>However, it is important to assess whether solutions implemented in some areas lead to problems in others. For example, implementation of flexible working for a key decision maker in one area may create bottlenecks that impact on other parts of the organisation, causing problems. Routine examination of problems in an area with absence or productivity when noticed and with department heads may uncover difficulties.</p>		
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## Solutions

<p>Q1. What action has been identified to make work more accommodating, or what action has been identified to reduce adverse effects in other parts of the organisation?</p>	<p>(insert answers here)</p>
<p>Q2. What would help this solution to work properly and how can we get this help? <i>This might be support from senior management, human resources management, external consultants, HSE or trades unions. It might be additional resources, e.g. equipment.</i></p>	
<p>Q3. What might stop us making this solution work and how do we overcome these obstacles? <i>This might mean developing contingencies to get round some obstacles, or it might mean consulting with relevant stakeholders to ensure smooth implementation.</i></p>	
<p>Q4. How do we know the action has worked? <i>Identify the key success factors, such as a noticeable change in working practices, improved productivity, development of key skills, improved communications practices.</i></p>	
<p>Q5. Is this action <b>responsive</b> to the needs of workers and the nature of the work?</p>	<p>If NO refer back to work book for another solution or adapt solution so it is responsive</p>
<p>Q6. Is this action <b>acceptable</b> to workers, managers and others who may be affected by the changes? Note, other people may need to be consulted.</p>	<p>If NO refer back to work book for another solution or adapt solution so it is acceptable</p>
<p>Q7. Is this action <b>worth investing in</b>? <i>Does it give the best return on investment, all things considered including impact on workers and other organisational practices?</i></p>	<p>If NO refer back to work book for another solution or adapt solution so it is worth investing in</p>
<p>Q8. What are key steps in taking this action and when should they occur? When do we have interim reviews to check progress and deal with any difficulties in implementing actions. When do we have a final review of the action?</p>	

## INTERVENTION OPTIONS FOR CREATING A COMFORTABLE JOB

Appendix 4 Table 4 captures the types of interventions that map onto potential answers from identification questions. A given intervention can apply to more than one question. These may be presented as options within the toolbox. Most of the questions below are asked by line managers, but they have organisational/departmental analogues. One question (What are job security and rewards like across the organisation and in specific departments?) is answered only at the organisational level.

**Appendix 4 Table 4.** Intervention options for creating a comfortable job.

LEVEL	INTERVENTION	ADDRESSES WHICH QUESTIONS
ORGANISATIONAL	Career/skills development routes and opportunities	<p>What opportunities and support to use and develop skills like?</p> <p>Is work interesting for people?</p> <p>What are job security and rewards like across the organisation and in specific departments?</p>
	Community of practices for line managers/ workers in problem solving?	<p>What do those I manage think I am like as a line manager?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>Can people cope when problems occur?</p> <p>Can workers help themselves to make their work comfortable?</p>

<b>LEVEL</b>	<b>INTERVENTION</b>	<b>ADDRESSES WHICH QUESTIONS</b>
<b>ORGANISATIONAL</b>	Line management training (e.g. in communication skills, flexible management of resources)	What do those I manage think I am like as a line manager?
	Flexible working/family friendly policies	Can workers help themselves to make their work comfortable?  What are work demands and conditions like?
	Recruitment/induction/creating realistic expectations (psychological contracting)	Is work interesting for people?  What are opportunities and support to use and develop skills like?  What are job security and rewards like across the organisation and in specific departments?
	Worker involvement practices	What are opportunities and support to use and develop skills like?  What do those I manage think I am like as a line manager?  Can people cope when problems occur?  Can workers help themselves to make their work comfortable?
	HR/OR support/resources to line managers	What do those I manage think I am like as a line manager?
<b>LEVEL</b>	<b>INTERVENTION</b>	<b>ADDRESSES WHICH QUESTIONS</b>

<b>GROUP INDIVIDUAL</b>	<b>&amp;</b>	Assertiveness skills training	Can people cope when problems occur?  Can workers help themselves to make their work comfortable?
		Cognitive reappraisal/cognitive reframing/ enhancing mental capital	Can people cope when problems occur?
		Communication skills (inc assertiveness/constructive feedback)	What are opportunities and support to use and develop skills like?  Can people cope when problems occur?  Can workers help themselves to make their work comfortable?
		Coaching	What are work demands and conditions like?  What are opportunities and support to use and develop skills like?  What do those I manage think I am like as a line manager?  Can people cope when problems occur?  Is work interesting for people?  Can workers help themselves to make their work comfortable?



LEVEL	INTERVENTION	ADDRESSES WHICH QUESTIONS
<b>GROUP &amp; INDIVIDUAL</b>	CPD support	<p>What are opportunities and support to use and develop skills like?</p> <p>Can people cope when problems occur?</p> <p>Can workers help themselves to make their work comfortable?</p>
	Individual Involvement	<p>What are opportunities and support to use and develop skills like?</p> <p>Is work interesting for people?</p> <p>Can workers help themselves to make their work comfortable?</p>
	Job redesign	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>Can people cope when problems occur?</p> <p>Is work interesting for people?</p>

<b>LEVEL</b>	<b>INTERVENTION</b>	<b>ADDRESSES WHICH QUESTIONS</b>
<b>GROUP &amp; INDIVIDUAL</b>	Risk assessment (of physical environment)	What are work demands and conditions like?
	Mentoring	<p>What are opportunities and support to use and develop skills like?</p> <p>What do those I manage think I am like as a line manager?</p> <p>Is work interesting for people?</p>
	Negotiation	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>Can people cope when problems occur?</p> <p>Is work interesting for people?</p> <p>Can workers help themselves to make their work comfortable?</p>

LEVEL	INTERVENTION	ADDRESSES WHICH QUESTIONS
<b>GROUP &amp; INDIVIDUAL</b>	Performance feedback	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>What do those I manage think I am like as a line manager?</p>
	Retraining	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>Can people cope when problems occur?</p> <p>Is work interesting for people?</p> <p>Can workers help themselves to make their work comfortable?</p>
	Social networking	<p>What are opportunities and support to use and develop skills like?</p> <p>Can people cope when problems occur?</p> <p>Is work interesting for people?</p> <p>Can workers help themselves to make their work comfortable?</p>

<b>LEVEL</b>	<b>INTERVENTION</b>	<b>ADDRESSES WHICH QUESTIONS</b>
<b>GROUP &amp; INDIVIDUAL</b>	Training	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>Can people cope when problems occur?</p> <p>Is work interesting for people?</p> <p>Can workers help themselves to make their work comfortable?</p>
<b>GROUP &amp; INDIVIDUAL</b>	Team interdependence building (inc. communication training)	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>What do those I manage think I am like as a line manager?</p> <p>Can people cope when problems occur?</p> <p>Can workers help themselves to make their work comfortable?</p>

<b>LEVEL</b>	<b>INTERVENTION</b>	<b>ADDRESSES WHICH QUESTIONS</b>
<b>GROUP &amp; INDIVIDUAL</b>	Team effectiveness meetings	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>What do those I manage think I am like as a line manager?</p> <p>Can people cope when problems occur?</p> <p>Can workers help themselves to make their work comfortable?</p>
<b>GROUP &amp; INDIVIDUAL</b>	Team communication/sharing information	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>What do those I manage think I am like as a line manager?</p> <p>Can people cope when problems occur?</p> <p>Can workers help themselves to make their work comfortable?</p>

LEVEL	INTERVENTION	ADDRESSES WHICH QUESTIONS
<b>GROUP &amp; INDIVIDUAL</b>	Training in transferable skills	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>Can people cope when problems occur?</p> <p>Is work interesting for people?</p> <p>Can workers help themselves to make their work comfortable?</p>
	Work load reallocation meetings	<p>What are work demands and conditions like?</p> <p>Can people cope when problems occur?</p>
	Work reorganisation	<p>What are work demands and conditions like?</p> <p>What are opportunities and support to use and develop skills like?</p> <p>Can people cope when problems occur?</p> <p>Is work interesting for people?</p>

<b>LEVEL</b>	<b>INTERVENTION</b>	<b>ADDRESSES WHICH QUESTIONS</b>
<b>GROUP &amp; INDIVIDUAL</b>	Worker involvement through a group representative	<p>What do those I manage think I am like as a line manager?</p> <p>Can people cope when problems occur?</p> <p>Can workers help themselves to make their work comfortable?</p>
	360 degree feedback to line manager	What do those I manage think I am like as a line manager?

## INTERVENTION OPTIONS FOR CREATING AN ACCOMMODATING WORKPLACE

Appendix 4 Table 5 captures the types of interventions that map onto potential answers from identification questions. A given intervention can apply to more than one question. These may be presented as options within the toolbox. Most of the questions below are asked by line managers, but they have organisational/departmental analogues. Two questions are only asked at the organisational/departmental level (Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation? Is there evidence that changing work to make it accommodating is having adverse effects on other organisational systems and what can be done about this?) These are prefixed by O.

**Appendix 4 Table 5** Intervention options for creating an accommodating workplace.

Action plans	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p> <p>O. Is there evidence that changing work to make it accommodating is having adverse effects on other organisational systems and what can be done about this?</p>
Community collaboration	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p>
Escalation procedures	<p>Have you noticed any work-relevant symptoms?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p> <p>O. Is there evidence that changing work to make it accommodating is having adverse effects on other organisational systems and what can be done about this?</p>



<p>Design and promote relevant dual responsibility policies and procedures</p>	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p>
<p>Fair policies /practices</p>	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>O. Is there evidence that changing work to make it accommodating is having adverse effects on other organisational systems and what can be done about this?</p>
<p>Statement of intent</p>	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p>
<p>Information provision/guidance on healthier work etc</p>	<p>Have you noticed any work-relevant symptoms?</p> <p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p>
<p>Information provision on types of accommodation</p>	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p>
<p>Line management training in health awareness and leadership</p>	<p>Have you noticed any work-relevant symptoms?</p> <p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p>

<p>Line management training on accommodations</p>	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p>
<p>Line management training in CBT/related/interviewing skills/support</p>	<p>Have you noticed any work-relevant symptoms?</p> <p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p>
<p>Line management support</p>	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p>
<p>Performance appraisals for dual responsibility</p>	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p> <p>O. Is there evidence that changing work to make it accommodating is having adverse effects on other organisational systems and what can be done about this?</p>
<p>Regular hot spot meetings</p>	<p>Have you noticed any work-relevant symptoms?</p> <p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p>

360 degree feedback	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p>
Main streaming/strategic alignment of HR/OHS and op management decision with comfortable and accommodating issues.	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>O. Is there evidence that changing work to make it accommodating is having adverse effects on other organisational systems and what can be done about this?</p>
Staff surveys	<p>Have you noticed any work-relevant symptoms?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p>
Senior management walkabouts	<p>Have you noticed any work-relevant symptoms?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p> <p>O. Is there evidence that changing work to make it accommodating is having adverse effects on other organisational systems and what can be done about this?</p>
Senior management training	<p>Have you noticed any work-relevant symptoms?</p>
Senior management peer observation and feedback	<p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p>

Two way communication channels	Can people cope when common health problems occur or could they help themselves make their work more accommodating?
Timely, visible responses	<p>Have you noticed any work-relevant symptoms?</p> <p>Can work be changed temporarily to help manage the work-relevant CHP?</p> <p>Can people cope when common health problems occur or could they help themselves make their work more accommodating?</p> <p>O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?</p>
Values gaps analysis/workshops for leaders (reflects an organisational structure)	O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?
Line manager training in health awareness and leadership	O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?
Line manager negotiation skills	O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?
Line management training in cognitive behavioural therapy/related/interviewing skills/support	O. Are changes in work practices ineffective in reducing work-relevant CHPs in this organisation?
Assertiveness training	Can people cope when common health problems occur or could they help themselves make their work more accommodating?

Communication	Can people cope when common health problems occur or could they help themselves make their work more accommodating?
Coping skills training (self-regulation of health beliefs/workability beliefs)/cognitive behavioural therapy	Can work be changed temporarily to help manage the work-relevant CHP?
Temporary job redesign	Can work be changed temporarily to help manage the work-relevant CHP?
Negotiation skills	Can work be changed temporarily to help manage the work-relevant CHP?  Can people cope when common health problems occur or could they help themselves make their work more accommodating?
Line manager evaluate physical resource availability	Can work be changed temporarily to help manage the work-relevant CHP?
Review/provide contact/access with line manager	Can people cope when common health problems occur or could they help themselves make their work more accommodating?
Training	Can work be changed temporarily to help manage the work-relevant CHP?  Can people cope when common health problems occur or could they help themselves make their work more accommodating?
Retraining	Can work be changed temporarily to help manage the work-relevant CHP?  Can people cope when common health problems occur or could they help themselves make their work more accommodating?

Risk Assessment	Can work be changed temporarily to help manage the work-relevant CHP?
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## 13. APPENDIX 5

### 13.1. USABILITY TESTING OF WORK↔HEALTH TOOLBOX

#### INTRODUCTION

The purpose of this appendix is to describe both the feedback on the first version a web-based common health problems toolbox, which was given the name Work↔Health Toolbox and the methods used to obtain that feedback. The feedback obtained can be used to improve the next version of the Work↔Health Toolbox.

#### METHODS

##### SAMPLE AND PROCEDURE

Participants were potential end-users of the Toolbox, including those in general/line management positions and those responsible for occupational health and safety in workplaces.

Participants were directed to a web-site that hosted the Work↔Health Toolbox, asked to look through the Toolbox as if there were using it for real, and to dip into the Toolbox when they needed to for specific issues. At the same time, participants were also sent a link to a web-based survey to record their opinions on the Toolbox and how the Toolbox could be improved. Participants were given around two weeks to consult the Toolbox and asked to complete the survey in this time. Reminders were sent after two weeks.

Participants were recruited through institutional and personal contacts. We aimed for a sample of 20-25 responses. The procedure used to recruit participants may have narrowed the range of knowledge and attitudes concerning common health problems, and the sample size precludes generalisation from these data. There were 22 responses. Twenty came from responses to web-questionnaires and two participants provided comments via email. This represents a response rate of 41%. However, it became clear during analysis of the data that at least two participants had distributed the Toolbox to others in their organisations and collated the responses. Therefore, views were solicited from over 22 potential end users. Fourteen participants occupied general or line management roles, and six participants specialised in health and safety management (two participants declined to state their role). Five participants reported working in organisations with over 500 employees, 12 in organisations with 11-499 employees and three in organisations with 10 or fewer employees.

Data from participants who provided comments by email were integrated into the results where their comments seemed most appropriate. Three participants were also interviewed, and their responses integrated into results where their responses seemed most appropriate. It was our initial plan to interview only those participants with uniformly negative views on the Toolbox and who had also consented to be interviewed after consulting the Toolbox. However, because no participant had a uniformly negative view of the Toolbox (see below), we chose participants that had consented to be interviewed and because they had the least favourable views of the Toolbox (two) or had given particularly detailed comments concerning specific issues with the Toolbox (one). Interviews were structured around specific points raised by participants in their open-ended feedback on the Toolbox.



## QUESTIONNAIRE

The questionnaire was developed through consultation with members of staff from the Health and Safety Executive (HSE) and the research team. It was agreed the questionnaire should pick up negative aspects of the Toolbox, positive aspects, and suggestions for improving the Toolbox. It was also agreed that the methodology should obtain qualitative information, and so the questionnaire was designed to elicit both open-ended and closed responses. Follow-up telephone interviews were also designed to elicit further qualitative information. It was also agreed to reduce the burden on participants by asking no more than 10 questions. The questions used in the web-based questionnaire are shown later in this appendix.

## ANALYSIS

For the open ended questions on the survey, data were analysed by template analysis (King, 2004). An initial template was generated by KD. This was then checked by JL, who examined quotes attributed to each code for consistency. There were no disagreements. The interpretation of the analysis from the template was checked by the rest of the research team. The template is shown at the end of this appendix.

## RESULTS AND DISCUSSION

For most questions on the web-based questionnaire, the majority of participants provided favourable responses on the Work ↔ Health Toolbox.

On the closed questions, unfavourable responses were confined to two or three participants for each question (i.e. only about 10% of participants). Importantly, no participant on the closed questions provided a uniformly negative assessment of the Toolbox (i.e., responses that fell into either of the two least favourable response categories). This meant there was no requirement to interview any of the participants according to pre-agreed protocols with HSE. Five participants answered just one question unfavourably. Two participants answered two questions unfavourably: Neither provided contact details for further interviews. No participants provided more than two unfavourable answers to the closed questions.

On the closed end questions, nine participants provided favourable responses on all four questions (i.e., responses that fell into either of the two most favourable response categories), three participants provided favourable responses to three questions, four participants provided favourable responses to two questions, two participants provided favourable responses to just one question and only one participant answered each question either unfavourably or was undecided.

Another indication of the mainly positive responses to the Toolbox can be gauged by scoring each of the closed end questions on a one to five scale, where the most favourable response is given a score of one, and then summing the answers to each question. On this scaling, a total score of four would indicate the most favourable response, 12 a neutral response and 20 the least favourable response possible. Sixteen participants scored 11 or less, indicating a generally favourable response. Three participants scored 12, indicating a neutral response. Only one participant had a total score greater than 12 (16). Of the participants with the neutral and negative responses, only two provided contact details for interview. It was therefore decided to contact these participants for interviews. A third interview was conducted with a participant that had provided detailed feedback in the form of emails, had invited a follow-up call, and had expressed detailed reservations around the concept of 'Good Jobs' and the use of business friendly language in the Toolbox.

### RESULTS FROM THE QUESTION "IS THE WORK ↔ HEALTH TOOLBOX LAID OUT IN A WAY THAT IS EASY TO FOLLOW?"

In response to the question 'Is the Work ↔ Health Toolbox laid out in a way that is easy to follow?', the majority of participants responded favourably (10 indicated it was 'probably easy' to follow, four indicated it was 'definitely easy' to follow). Four participants were undecided and only two gave unfavourable responses (one each for 'probably no' and 'definitely no').

On the open ended questions, participants stated they liked the fact that the Toolbox was easy to navigate and that there were links to more information, as illustrated in the following two quotes:

*Formats are logical and user- friendly. Additionally the key headings are informative and allow the reader to navigate to areas of specific interest, where more detailed information is then available. (HTML3)*

*Plenty of information all of which is easy to access. (HTML12)*

However, some participants did indicate that the Toolbox could be improved by streamlining the navigation of the site, reducing the amount of detail and providing more graphics in Toolbox.

*The info behind the headings 'knowledge', 'Good Jobs' etc needs to be read in order to understand what they are about, so on first glance if you are looking for guidance e.g. on how to support a member of staff who is off sick or struggling to stay in work I'm not sure that you would immediately locate it. (HTML6)*

*It needs to be more direct and less complicated - the thrust of the message is excellent but line managers and business people are busy and need to digest things quickly and succinctly or they will be distracted and lose focus. (HTML13)*

*Far too 'wordy'. It doesn't look or feel user friendly. Certainly not a tool I could use if I was the manager of a busy store - would be put off but the perceived time it would take to find what I needed. (HTML16)*

*There is a lot of great information on the website but perhaps there is a little too much for the target audience. It may be that the really useful information is lost or difficult to locate because there is so much of it. The homepage in particular has a lot of theory and content. In our experience line managers have a small knowledge base and may be overwhelmed by the amount of detail. We found the resource library very helpful but found we had to read through a lot of detail to find the links. Given line managers are likely to be seeking practical advice/solutions perhaps the links could be signposted better. (HTML7)*

*The website appears to feel quite text based: More graphical use may draw your attention to the relevant areas and attract user to look at information (HTML1)*

*It is very wordy, a lot of managers simply won't have time to read so much text. How about using an info graphic perhaps to make it more visual? (HTML17)*

*Lots of text and links to click, could do with a diagram or site map, with the main points first leading onto further detail. Perhaps layout the information as checklist. (HTML14)*

In a follow-up interview, one participant (HTML14) stated that the most useful part of the Toolbox was the resource library, and that this should be easily accessible, perhaps even the first port of call and that a spider diagram on the top page may help to orient the reader.

Two participants indicated they did not like the use of blue text. For example, one stated:

*Personally I didn't like the light blue type used for the headings as I found it harder to read so this was slightly off-putting (HTML6)*

One participant questioned the clarity of the distinction between the different major areas of the Toolbox:

*The overview, detail, to do is a sensible breakdown. But I don't know if knowledge, Good Jobs, Supportive Workplace is that clear a distinction (HTML15)*

RESULTS FROM THE QUESTION "IS THE CONTENT OF WORK ↔ HEALTH TOOLBOX UNDERSTANDABLE?"

In response to the question ‘Is the content of Work ↔ Health Toolbox understandable?’, the majority of participants responded favourably (four indicated it was ‘probably easy’ to follow, 10 indicated it was ‘definitely easy’ to follow). One participant was undecided and only two gave unfavourable responses (one each for ‘probably no’ and ‘definitely no’).

In the open ended questions, participants stated they liked the use of plain English in the text. For example:

*Although some of the issues and principles are quite complex, the terminology is angled to ensure that the key messages are easy to identify. (HTML3)*

*It is all very clear and no jargon is used (HTML4)*

*The toolbox is understandable, particularly the action steps, the reasonable recommendations and the checklists are all really clear. (HTML7)*

*The material was easy to understand. I could see how changes could be made in the workplace and how I could respond in different situations. The actions section was very helpful. (HTML19)*

*Plain English and short sentences (HTML20)*

Two participants stated the content of the Toolbox was scientifically accurate and up to date. For example:

*Great ideas that are obvious and logical; it's a refreshingly modern outlook (HTML13)*

However, some participants did struggle with the amount of text and some of language used. However, as some of the quotes illustrate, this may be more of an issue of navigation from high-level information to very detailed information. Some participants indicated that the Toolbox could be improved by using other media to supplement the text and graphics.

*Yes. Some of the language could be simplified perhaps, but overall very easy to understand. (HTML2)*

*More of an essay than a Toolbox (from interview with HTML10)*

*Takes a lot of time to read through, not clear what the aims are when first started to navigate the pages, or who it is aimed at. There is a lot of theory, and academic language to be a tool for 'all levels of management'. Would a manager spend time trying to read through? The language is colloquial which makes a welcome change from anodyne directgov type language. But it's very wordy, perhaps overly so. Bear in mind these are SMEs who may not have much time - they need a bit of why, some what and what should they be doing - templates e.g. of return to work interviews etc. (HTML14)*

In a follow-up interview, one participant (HTML14) indicated that although the information was useful from his professional point of view as a health and safety manager, it would be difficult for a line manager to navigate through the links and the amount of information that was relevant to policy but not changes made at a line level. HTML14 suggested that it would be useful if the Toolbox made a clear separation of the policy aspects of the Toolbox from the line management aspects, perhaps through providing different buttons for senior, HRM/OHS and line managers to direct them more quickly to the information and/or tools needed for their circumstances. In another interview, one participant (HTML10) agreed with this assessment and also indicated that a separate button for small and medium sized

businesses (SMEs) would be useful in order to direct SME managers to the most appropriate resources for SMEs, given SMEs may not have access to a specialised HRM or health and safety function.

Some participants indicated that the Toolbox could be improved by using other media to supplement the text and graphics. For example:

*The toolbox is understandable, particularly the action steps, the reasonable recommendations and the checklists are all really clear. Perhaps this information could be reinforced through more interactive presentation. The case studies are great to bring the advice to life and we were wondering if these could be in video form. (HTML7)*

#### RESULTS FROM THE QUESTION “HOW USEFUL DO YOU THINK THE WORK ↔ HEALTH TOOLBOX WOULD BE FOR DEVELOPING GOOD JOBS IN YOUR ORGANISATION?”

In response to the question ‘How useful do you think the Work ↔ Health Toolbox would be for developing Good Jobs in your organisation?’, the majority of participants responded favourably (10 indicated it was ‘probably useful’, three indicated it was ‘very useful’). Four participants were undecided and only three gave unfavourable responses (two for ‘probably not useful’ and one for ‘definitely not useful’).

Some participants indicated that the material on Good Jobs was thought provoking and positive. For example:

*We already have a range of policies and products in place to support our employees but I found info there that got me thinking about whether we could do more to support our staff (HTML2)*

*It provides a good framework of ideas which can be easily digested and taught (HTML13)*

There were three areas in which the feedback revealed the Toolbox could be improved in relation to developing Good Jobs. The first of these concerned targeting information at the correct level in the organisation, and may be an issue of web-site layout and navigability for different kinds of end-users (e.g., line managers, HR/OHS managers). As the following two quotes illustrate, some end-users seemed to feel developing Good Jobs needed a mandate, or at least a means of seeking permission to do so, from senior management.

*The information in the Good Jobs is very interesting and important. However, we were wondering as this is more about culture change, is that information more suitable for a corporate or HR audience. Although we appreciate that culture change has to be from bottom up as well, often the initiatives are driven at a high level. The information is about identifying what makes a good job and what can be changed to improve jobs however often the aspects that require change require corporate buy in. Perhaps ideas/strategies as to how to approach higher management levels with ideas for changes would be helpful. (HTML7)*

*Needs to be targeted at different organisational levels, a lot of the content is policy formulation (HTML14)*

In a follow-up interview, HTML14 indicated that the writing style suggested the intended audience comprised intellectual, professional practitioners rather than line managers, and

suggested providing material for line managers that focused on the ‘nitty-gritty’ of what to do and to tone down some of the more ‘intellectual stuff’.

Other areas for improvement also imply there are issues concerned with conveying the right messages. Some participants stated that there was no need to develop Good Jobs in their organisation, because the organisation already does this. For example:

*Coming from a [public sector] environment, we already have a set of well-defined policies and procedures covering all aspects of [absence management]. In addition we can also call on the professional services of [two healthcare providers], not only when managing employee absences of a more complex and/or protracted nature but also in the delivery of specific workshops aimed at improving staff awareness and understanding of [our recent] and other "health in the work place" initiatives. As a consequence and although the Work ↔ Health Toolbox would offer an informative and practical reference point for companies/organisations where health-based guidance and information was under-developed or less well defined, the potential merits within my own organisation may be less obvious (HTML3)*

*[Our organisation] are particularly pro-active in providing support and reasonable adjustments within the workplace. (HTML5)*

In both these quotes (in which material in square brackets indicates changes to preserve anonymity), the participants seem to make little distinction between Good Jobs and a supportive work place, perhaps indicating the need for more signposting. In the next quote, a participant indicates that there is no further need to develop Good Jobs in the participant’s organisation. In this instance, the Toolbox may need to give a clearer indication that where Good Jobs have already been developed, there is no need to develop them further (or at least developing Good Jobs by using top-down, policy led approaches):

*We already undertake time and expense to make our jobs "good" and I am not sure how much further we can take it. (HTML9)*

In one of the follow-up interviews, a participant (OPEN21) indicated one solution to this problem might be to tailor messages for two kinds of audiences: Those with problems, and those without problems.

The last area where the Toolbox could be developed concerns overcoming the perceptions that jobs cannot be changed or that they are a low priority, for example:

*Although managers within my organisation seek to engage employees and create a good working environment, developing Good Jobs is not a priority. (HTML10)*

*Because the concept of a good job is open to considerable interpretation - it implies the role can be changed, which might be impossible. Rather than an improvement in employee engagement which is tangible and achievable (HTML15)*

*The organisation is split between field operations and design. The design component is vitally important in getting the workplace designed with the end user in mind. The [health & safety] managers always appear to be having an uphill struggle. This aspect relates to getting initiatives moving and therefore the reception which is likely to be given to this tool could well be mixed. (HTML18)*

This last quote indicates that the messages need to be tailored to overcome resistance amongst some stakeholders, and the two preceding quotes may suggest that potential

resistance to the notion of Good Jobs may be overcome by tying the notion of Good Jobs more tightly to engagement, and other positive 'soft' aspects of performance, like learning and skills development.

#### RESULTS FROM THE QUESTION "HOW USEFUL DO YOU THINK THE WORK ↔ HEALTH TOOLBOX WOULD BE FOR DEVELOPING SUPPORTIVE WORKPLACES IN YOUR ORGANISATION FOR PEOPLE WITH COMMON HEALTH PROBLEMS?"

In response to the question 'How useful do you think the Work ↔ Health Toolbox would be for developing Supportive Workplaces in your organisation for people with common health problems?', the majority of participants responded favourably (seven indicated it was 'probably useful', six indicated it was 'very useful'). Five participants were undecided and only two gave unfavourable responses (both 'probably not useful').

Positive responses to the open ended questions pointed to the proactive nature of the Toolbox and the presentation of useful information. For example:

*I liked the way you linked your advice for staff with MSD/stress/mental health issues - because the issues behind them are basically the same - and I particularly liked your 'can do', proactive approach/tone. (HTML2)*

*There are systems explained that can hopefully bypass the usual way in which the "sick" are treated. For instance employers working in conjunction with GPs would be very helpful and in most cases would inevitably unearth a lot of unnecessary suffering (HTML13)*

Two of the areas for improvement were similar to those identified for the material on developing Good Jobs. That is, participants indicated targeting the correct kinds of end-users and dealing with perceptions that organisations already have systems in place (or access to systems), so no further action is needed. The following two quotes are illustrative of each of these themes in the data:

*In my organisation the toolbox would only ever be used as guidance for managers' discretionary use, the best way to create a supportive work place is by redefining HR & company procedures. (HTML12)*

*I think there is ample resource out there, including from HSE which is comprehensive and easily understandable. (HTML15)*

As with Good Jobs, these areas for improvement may be best addressed through changes to web-site layout and navigability for different kinds of end-users, and ensuring that Toolbox indicates clearly that the intention is to help organisations develop Supportive Workplaces, not replace existing good practices in proactive organisations.

A few participants also indicated that the material on Supportive Workplaces would benefit from changes to the presentation, use of graphics and/or other media in place of text, and navigability:

*The information contained within Supportive Workplaces is excellent and probably the most relevant to line managers. The practical advice and action plans are excellent. Perhaps better signposting to this section as the area to find practical management would ensure that line managers accessed it easily. Also, perhaps there could be video case studies of discussions with employees and the process of*

*returning someone to work to assist line managers learning. As some line managers may be fearful of raising health issues with workers a video may alleviate some of these fears if they can see it in practice. (HTML7)*

*Don't know if people would have the time to work their way through it as its very wordy. Perhaps should be accompanied by a pdf guide and structured as a process leading you to resources like the stress management guidelines (HTML14)*

#### RESULTS FROM THE QUESTION “WHAT DO YOU THINK IS THE BEST ASPECT OF THE WORK ↔ HEALTH TOOLBOX, AND WHY?”

Participants listed a number of positive features that could be retained or even enhanced in the next phase of Toolbox development. These included its comprehensive coverage, the detail and accuracy of the information provided, the orientation of the Toolbox towards taking action, the proactive attitude conveyed in the Toolbox, and the presentation. These positive features are illustrated in the following quotes:

*I think it covers all things for all organisations. (HTML12)*

*I think the tool box is well researched and does provide some useful guidance. (HTML10)*

*Resource list - can see all the information and can easily dip into what is needed. (HTML14)*

*The overviews and the actions as these were the bits that would probably help with identifying if a problem existed and then how we might deal with it. I suspect having looked at the actions I'd then go back at look at the other supporting info. (HTML19)*

*The general 'tone' of the content. It doesn't pander to negative attitudes. I really like the positive, can-do, practical approach. (HTML2)*

*The section on Supportive Workplaces has most resonance. In times gone by our efforts were invariably channelled solely on managing the cases of those individuals who were absent from the work. More recently however there has been increasing acceptance of the need to devote similar attentions to the actual prevention of absence. Ultimately the employer will always have a vested interest (not least for financial reasons!) in optimising the levels of employee attendance. Similarly and if we also accept that "a happy workforce is a productive workforce", the Supportive Workplaces guidance will undoubtedly add value and provide a ready reference check list for organisations to consult and take forward. (HTML3)*

*In general the layout is good and user friendly. I particularly liked the resource library (which is a site index by another name). This is available from the header line on the first page and would make navigation easy. (OPEN22)*

Only one participant could not identify any positive features:

*Undecided. In all honesty I can't think of anything specific. (HTML16)*

#### RESULTS FROM THE QUESTION “WHAT DO YOU THINK NEEDS MOST IMPROVEMENT, AND WHY?”



Participants identified a number of areas for improvement. In respect of content and language, some participants felt that the Toolbox could use more business friendly language, especially in relation to the notion of ‘Good Jobs’:

*I think the language needs to be much more business friendly and focused on achievable, tangible aims. If an SME owner is worried about an employee or someone on long-term sick I don't think they need all the detailed background - just a bit of focused info about work being good for health, role in supporting employees to stay in work and back to work. There is a lot of Good Jobs philosophy on here which I don't think is necessary. The IOD/HSE guidance is a good example of a core actions, good practice breakdown that's what I would suggest for this. (HTML15)*

In an interview, one participant (HTML10) indicated business engagement might be easier to achieve if the limits to organisational action were acknowledged. HTML10 indicated there may be circumstances in which it is not possible to change duties because the person with a common health problem did not have or did not want to acquire the skills to do alternative work.

One participant (OPEN21), who represents a leading industry body, commented on business friendly language and the notion of Good Jobs being problematic in several places in her feedback:

*Finally, on the why page can I suggest the language is shifted away from obligation ‘you got to’ ‘you ought to do it’ – which is true I grant you, to a more positive message. The page begins with it being good for business – so stick with that message, make the business case around improved staff morale, reduced absence rates etc. (OPEN21)*

*Broadly I would say the two key messages for line managers and employees are work is good for health and investing in absence/health management makes business sense. Those are the narratives to craft it around – particularly if you're communicating with SMEs without strong HR departments or employees who may be under the impression that staying away from work is better for their health and they can only return when 100% fit, which of course we know is not the case and actually does more harm than good (as you point out in the toolbox) (OPEN21)*

*Good Jobs: this language is fairly alienating to employers and right from the off you are risking business disengaging from the Toolkit. The definition of a good job as being ‘one that is free of the things that get in the way of the work being comfortable and satisfying: things such as unhelpful policies, poor communications, major hassles, injustices’ is pretty subjective and in all honesty what job could ever be free of major hassles? If there is one, I'll be there like a shot!! One person's ‘good job’ is someone else's idea of a nightmare – and while employers can and should be making reasonable adjustments to accommodate employees the fact is they can't change the nature of the work. I'd strongly suggest that this language is revised, especially because the evidence is that work is good for health. (OPEN21)*

In a follow-up interview with the OPEN21, the participant indicated that crafting a narrative around the business case may make more prominent use of statistics and figures concerning absence in the Toolbox, although not at the top-level. OPEN21 felt that the two-way relationship between health and work (and that work is good for health) needed more emphasis to engage businesses. OPEN21 also indicated that the phrase “you ought to do it,

*you you've got to do it and you'll be glad you did it"* need to be mapped clearly onto moral and legal cases, and that the legal case needed to be made as part of the business case.

In relation to Good Jobs, OPEN21 did not make any concrete suggestions concerning how to engage businesses on this issue, but rather thought the term was loaded, nebulous, and did not allow for a standard approach. As indicated in the responses to earlier questions, the material on Good Jobs may need to be tied tightly to notions of engagement, learning and skills development: Each of these areas might also be seen as areas to develop to motivate workers and provide workers with the skills to deal with the demands of their work. In an interview with another participant (HTML10), HTML10 indicated it might be an idea to do so, and went further to suggest the Toolbox might want to acknowledge some of the features of Good Jobs may reduce non-sickness related (i.e., voluntary) absence as well as genuine sickness absence. It may also be appropriate to emphasise more the bottom-up nature of developing Good Jobs through minor process improvement at group and individual level, and to link Good Jobs to notions such as total quality management and lean thinking, that are predicated on workers solving problems and making minor improvements to working practices. That is, rather than just involving senior managers setting policies to encourage the organisation to develop Good Jobs, there is also a place for Good Jobs to be developed, within the parameters of normal organisational processes, through workers and line managers making improvements to jobs in a similar way to which some advanced manufacturing practices encourage incremental process innovation for productivity and efficiency purposes. HTML10, in his interview, indicated part of the problem of 'Good Jobs' was that there are limits to how much autonomy and skill use can be given in some kinds of work (e.g., machine paced manufacturing) and some people may not desire or be able to cope with increases in decision making authority and skill use. HTML10 did indicate that acknowledging that jobs can be improved through minor, incremental process improvement might have some resonance with managers. HTML10 also indicated that 'engagement' could be achieved through leadership, communication and establishing a clear vision for the business, all of which could be emphasised further in the notion of 'Good Jobs'.

Two participants made specific comments about the content of the Toolbox as follows:

*I have completed the Health Work Questionnaire but failed to see the point of it.* (OPEN22)

*Definition of common health problems page: I was interested in where you got your stats on absence from – particularly the two graphs, which I guess don't have references on them because of the formatting. But I think you need to reference the multifactorial nature of absence in this – lifestyle choices, personal issues all affect absence rates which I think are falling on average, rather than rising, according to our research anyway. 'Despite better working conditions and better access to health care, the number of people with symptoms has not reduced. More importantly, the number of people claiming disability has actually increased. Whatever we've been doing up to now, it clearly hasn't provided an effective answer.' Chronic health problems are an issue that stretches way beyond work and I'm sure the intention wasn't to lay all of society's ills at the door of employers but it could give that impression. Disability claims have risen for a multitude of reasons, as the Frost/Black report showed, for reasons that are related to failures in the benefits system, not to do with work.* (OPEN21)

In a follow-up interview, OPEN21 indicated that she felt the multiple factors involved in the aetiology and prognosis of common health problems should be given greater emphasis in the Toolbox, and that greater clarity should be given to identifying causes of common health problems other than work. She also felt that the Toolbox needs to make clearer that employers do not have sole responsibility for resolving common health problems. In respect of the passage in the Toolbox “*Whatever we’ve been doing up to now, it clearly hasn’t provided an effective answer*”; OPEN21 felt that it needed to be clear that this referred to society and not employers.

As was the case with a number of other questions, some participants indicated that the Toolbox would benefit from less text, more graphics, other media and some interactive features:

*It needs to be more graphical and give some examples which can be related to* (HTML1)

*We thought the content, theory, action points and advice contained on the website are excellent. We felt that perhaps the amount of information could be overwhelming to line managers who are coming from a smaller knowledge base and that perhaps some of the content in Good Jobs was more appropriate for corporate levels. We thought that as there is so much content to get through to find practical advice there is a risk that you may lose some of the audience in the process. To ensure line managers access the practical information perhaps the links to practical information could be better and the content more interactive.* (HTML7)

*It is too wordy. I think it needs to be more visual; keep people's interest.* (HTML17)

Also as outlined in the answers to other questions, some participants indicated that the Toolbox could improve its navigability in order to ensure end users can find the information and tools more appropriate for their situation quickly:

*The excellent ideas and main points need to be more obvious - an abrupt "sale" sign type tactic of high jacking the readers mind needs to be implemented - we as managers and employers need to be captivated by these new ways of looking at both treating and preventing sickness* (HTML13)

*It needs to be more user friendly, more concise and more relevant to line managers. Currently this tool box would be more useful for a HR manager when setting policies.* (HTML10)

In an interview, one participant (OPEN21) indicated that links to other specific HSE guidance would be better made in the resources library. In another interview, a participant (HTML14) suggested that the Toolbox ought to provide a straightforward, structured process for line managers to follow, that focused on the practical things to do rather than why some things needed to be done. HTML14 suggested that the process be broken down into steps with different jumping in points. For example, he suggested a different starting point for people new to the Toolbox, a different starting point for people with existing knowledge or experience of managing common health problems, and a different starting point for people with no existing problems with absence or illness to manage, but who were seeking to improve working conditions and systems in their organisation or team. HTML14 also indicated benchmarking diagnostics might be a useful first stage to help managers decide which would be the most appropriate point to start from. HTML14 also indicated that the Toolbox needs to emphasise more the ‘dipping-in’ aspects of the Toolbox (i.e., that

different resources will be used on different occasions) and that clearer signposts need to be in place so that managers can identify which resources to access for particular circumstances and tailored to specific types of users (e.g., HRM, line management, SME managers). Another interviewee (HTML10) indicated that any staged process should be phrased as ‘five simple steps’.

There were some comments concerning the appearance of the web-site:

*Possibly just to brighten up the appearance of the website - perhaps use a few images, maybe a bit more use of colour.* (HTML2)

*Some of the colours used in the layout make text difficult to read* (HTML6)

In a follow-up interview, one participant suggested that engaging a professional web-designer may iron out many of the issues concerning appearance, use of graphics, and navigability (HTML14).

Just one participant provided an assessment of the Toolbox that indicated many areas needed to improve:

*The format, layout, word content.* (HTML16)

However, a number of participants also provided positive comments when asked to indicate areas for improvement, for example:

*I think the Toolbox gives all the right messages.* (HTML5)

*Works well* (HTML11)

*I was generally happy with all areas* (HTML19)

## GENERAL DISCUSSION

For most questions on the web-based questionnaire, the majority of participants provided favourable responses on the Work ↔ Health Toolbox on the closed questions. Participants identified positive aspects of the Toolbox as: easy navigability; links to more detailed and useful information; use of plain English; scientifically accurate and up to date; thought provoking; the proactive nature of the Toolbox; the comprehensive coverage; and the presentation. These features should be retained or even enhanced in the next version, especially because some participants contradicted others over issues such as navigability and clarity of language/presentation.

The data indicated a number of areas in which the Toolbox may be improved. The first of these concerned navigability and targeting: That is, some participants felt that the Toolbox needed clearer links for different kinds of end users (line managers, senior managers, OHS/HR managers, those with problems, those without problems) to ensure speed and accuracy of access to the most appropriate information for different end users.

There were issues concerning the presentation, with some participants requesting: less text and less wordy language; reductions in the amount of detail; use of more graphics and diagrams; incorporation of interactive features into the Toolbox; use of video case studies; incorporation of an explicit staged process – perhaps laid out as a diagram; and reconsidering the use of blue text. Engaging a professional designer in subsequent phases of Toolbox development may help to address some of these issues. In relation to combining issues of navigability, detail (which some participants said was a positive feature), and comprehensive coverage, it may be worth contemplating adding a fourth, succinct, top-layer to the Toolbox with clear signposts for different end users. This fourth layer may reconcile the minority of participants who thought that navigability of the Toolbox should be improved with the majority who thought the Toolbox was at least ‘probably’ easy to navigate, and also retain the level of detail some participants felt was a strength of the Toolbox.

Some participants indicated that the Toolbox may need to use more business friendly language, and one participant in particular opining that the legal case ought to be made as part of the business case. It could be argued that the moral case also needs to be made as part of the business case, and crafted around notions of corporate social responsibility. Some of the comments indicated that the Toolbox needs to signal clearly that its intention is to help organisations develop healthy and Supportive Workplaces, and the intention is not to replace existing good practices in proactive organisations or to imply that employers are the sole cause/treatment for common health problems. However, most of the concerns regarding ‘business friendly’ language surfaced in relation to Good Jobs. The issues concerning Good Jobs surfaced in several ways. First, some participants did not make too much of a distinction between Good Jobs and Supportive Workplaces. Second, some participants indicated developing Good Jobs might be a low priority or even judged by managers to be unrealistic given organisational needs or the preferences of individual workers. Third, some managers seemed to think developing Good Jobs required a mandate from senior management. This is not to say that Good Jobs cannot be developed through senior

management changing organisational policy, but that managers and workers may be able to make some adjustments to jobs to make them 'good' or at least improve jobs.<sup>24</sup>

Together, these issues may indicate that the material on Good Jobs needs to be tied less to health, to differentiate Good Jobs from Supportive Workplaces, and more to engagement, learning and skills development: Each of these areas might also be seen as areas to develop to motivate workers and provide workers with the skills and resources to deal with the demands of their work. It might be signalled more clearly that engagement, learning and skills development is something workers and managers should strive towards as part of naturally occurring incremental, improvement processes (as seen in lean practices and total quality management for example). The role of leadership, communication and establishing a team/organisational vision in creating Good Jobs may also need to be emphasised to a greater degree. The material on Good Jobs may also include a checklist indicating the features of a 'good' job and the features of a 'bad' job.

It should be noted, that although some participants expressed reservations about the notion of 'Good Jobs' or at least how Good Jobs were presented, the material related to Supportive Workplaces was generally well received.

## REFERENCES

Clegg, C.W., & Spencer, C. (2007). A circular and dynamic model of the process of job design. *Journal of Occupational and Organizational Psychology*, 80, 321-339.

King, N. (2004). Using templates in the thematic analysis of text. In Cassell, C., & Symon, G. (Eds.), *Essential Guide to Qualitative Methods in Organizational Research*. London: Sage.

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<sup>24</sup> Note that recent developments in job design research do indicate workers and managers are able to shape job characteristics incrementally, informally and without changes in organisational policy or senior management mandate. See for example Clegg and Spencer (2007).

## SURVEY

1a. Is **Work ↔ Health Toolbox** laid out in a way that is easy to follow?

Definitely yes      Probably yes      Undecided      Probably no      Definitely no

1b. Please explain why you chose that answer.

□

2a. Is the content of **Work ↔ Health Toolbox** understandable?

Definitely yes      Probably yes      Undecided      Probably no      Definitely no

2b. Please explain why you chose that answer.

□

3a. How useful do you think the **Work ↔ Health Toolbox** would be for developing Good Jobs in your organisation?

Very useful      Probably useful      Undecided      Probably useful      not useful      Definitely useful      not useful

3b. Please state your reasons for your answer briefly below.

□





## **TEMPLATE**

### CODES FOR ANSWERS TO Q1

Easy to navigate

Links to more information

Complex links and too much detail

More graphics

Colouring

Miscellaneous

### CODE FOR ANSWERS TO Q2

Plain English

Technically correct

Amount of text

Simplify prose and navigation

Use of other media in Toolbox

### CODE FOR ANSWERS TO Q3

Anticipatory - HRM/job specification

Thought provoking/positive

We already do this

Limits to action

#### CODES FOR ANSWERS TO Q4

Positive

Targeting HRM

We already do it

Improved presentation

#### CODES FOR ANSWERS TO Q5a

Comprehensive

Information

Action orientation

Attitude

Presentation

Negative

#### CODES FOR ANSWERS TO Q5b

All round negative

Specific aspects of content

More graphics and interactive/Fewer words

Targeting

Language (and general dislike of 'Good Jobs')

Aesthetics

Miscellaneous (not useful) including positive



## **14. APPENDIX 6**

### **14.1.WEBSITE**

#### **CONTENTS**

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# Health<-->Work

## the toolbox for managing common health problems at the workplace

<a href="#">Toolbox Home</a>	<a href="#">Knowledge</a>	<a href="#">Good Jobs</a>	<a href="#">Supportive Workplaces</a>	<a href="#">Resource Library</a>
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Ill-health and injury have a substantial impact on the workplace, and the majority of this is due to [common health problems](#). People often struggle to stay at work with a health problem, or find it difficult to get back after absence. Yet it is the workplace that can give them the most help. And that is good for business.

Maintaining health at work must be a priority for every workplace. Healthy work comes from good jobs, whilst a supportive workplace reduces absence.

This website contains the tools to create good jobs and a supportive workplace. It is a 'one stop shop' for employers and managers of all shapes and sizes. It's laid out so you choose just the information that's right for you.

The intention is to help all the players manage health at work and enhance work ability through problem-solving actions. It provides what's needed to achieve the ideal underlying the idiom ... *work should be comfortable when we are well and accommodating when we are ill or injured* (Hadler 1997).

The [health<-->work](#) culture (healthy workplaces = healthy workers) needs to be firmly embedded in your organisation. It's an aspirational thing: good jobs for everyone, and support for workers when they need it.

The toolbox takes a positive stance on helping people stay at work with health problems and injury, irrespective of what caused them. You'll find information, case studies, tools and templates. They are presented at differing levels of complexity to suit your needs; different tools for different kinds of organisations and for use by different people.



## This Website *is* the Toolbox

It contains a variety of tools to help you. These 'hang' from a framework that consists of three key areas: **Knowledge**, **Good Jobs**, and **Supportive Workplaces**. For each of these key areas there are three sections giving you an **Overview**, information in **Detail**, and a clear description of what **To Do**. All nine of these sections act as interventions themselves, and contain links to more detail about the ideas and actions. Full access to specific tools is available in the [Resources](#) section.

## WHO it is for

The toolbox is for **you**. It is aimed at the entire management chain in every type of workplace, from the smallest to the largest. The main focus is everyone who serves as a line manager at any level, from top to bottom.

Since it is crucial to get all the key players onside, **everyone** in and around the workplace will need at least some of the tools.

## WHY this is for you

Helping you and your workforce deal with health at work is good for everyone and is [good](#) for **business**.

It's the right thing to do and you'll be thanked for doing it. **Everyone** benefits.

## WHAT you need to do

It's a 3-part process

- Get the **Knowledge**
- Provide **Good Jobs**
- Provide a **Supportive Workplace**

Getting that wrong is all too easy and is costly: the toolbox makes it simple to get it right.

**ENSURE** everyone who functions as a line manager at any level of the workplace - **from top to bottom** - has access to this toolbox and knows how to use

it.

## **HOW** to use this toolbox

Each of the three main sections ([Knowledge](#), [Good Jobs](#), [Supportive Workplace](#)) is divided into three types of information:

1. Overview
2. In Detail
3. What To Do

Begin by familiarising yourself with all three **Overview** sections, then go on to look at the **In Detail** and **What To Do** sections

Remember, this **health<-->work** toolbox is a **resource** you can come back to as often as you like. It will be especially useful if you, or one of your workers, develops symptoms of a [common health problem](#). You can use it as a 'just-in-time' source of information and advice.

**USE** this toolbox to:

- Look up specific information
- Learn new techniques and strategies
- Get useful stuff from the [Resource](#) library

Don't know what **Common Health Problems** are? Look at [this](#) first.

go to **KNOWLEDGE**      **GOOD JOBS**      **SUPPORTIVE WORKPLACE**

# Health<-->Work

## the toolbox for managing common health problems at the workplace

### WHO it is for

BACK

The toolbox is for **you**. It is aimed at the entire management chain in every type of workplace, from the smallest to the largest. The main focus is everyone who serves as a line manager at any level, from top to bottom.

Since it is crucial to get all the key players onside, **everyone** in and around the workplace will need at least some of the tools.

We must all [commit](#) to the **Health<-->Work** culture. Success is most likely if responsibility and ownership of **work-relevant** \*\* common health problems has to be shared between employer and employee.

Go to the [Health<-->Work Culture Tool](#) for more detail. It contains advice for senior management, HR staff, etc

For larger companies and organisations there is [specific advice for engaging senior management](#), with practical suggestions for what senior managers and human resources managers can do.

\*\* **Work-relevant** refers to any injury or health complaint that is experienced at the workplace to a greater or lesser extent, and which in turn impact on work performance, irrespective of why and where they started. Work-relevant problems interfere with your ability to do your usual job. It doesn't matter what cause them, or whether they started at work, at home, or on the sports field. The problem is that you cannot do what you would normally do at work.

# Health<-->Work

## the toolbox for managing common health problems at the workplace

### WHY this is for you

Helping you and your workforce deal with health at work is good for everyone and is [good](#) for **business**.

BACK

It's the right thing to do and you'll be thanked for doing it. **Everyone** benefits.

### Making the Case for Health & Work

Ill health and minor injury costs the UK at least £100 billion each year. If you need convincing, or you need to convince anyone else, the case for looking after health is:

#### **You've got to do at least some of it**

As an employer you have a duty under Health and Safety at Work etc. Act 1974 to ensure, so far as is reasonably practicable, the health, safety and welfare at work of your employees.

#### **You ought to do it**

Because it will mean you are a good and responsible employer and your staff will want to work for you.

#### **You'll be glad you did**

It'll save you money.

Because you can

- Increase employee commitment and job satisfaction
- Increase productivity
- Attract and retain the best staff
- Have less working time lost due to absence
- Improve customer satisfaction
- Enhance your brand/reputation
- Have fewer accidents
- Reduce financial and other costs associated with absence

[Find out if you have got the Health<-->Work Message](#)



# Health<-->Work

## the toolbox for managing common health problems at the workplace

### WHAT you need to do

[BACK](#)

It's a 3-part process

- Get the **Knowledge**
- Provide **Good Jobs**
- Provide a **Supportive Workplace**

Getting that wrong is all too easy and is costly: the toolbox makes it simple to get it right.

**ENSURE** everyone who functions as a line manager at any level of the workplace - **from top to bottom** - has access to this toolbox and knows how to use it.

**CHECK:** Your ability to follow the principles of this toolbox can be checked easily:

- *'I can't do anything about work-relevant common health problems'* = not following the principles
- *'I do it because I have to'* = following the principles
- *'I do it because it's important'* = getting it right

# Health<-->Work

## the toolbox for managing common health problems at the workplace

### HOW to use this toolbox

BACK

**This website is the Toolbox** - it contains a variety of tools to help you. These 'hang' from a framework that consists of three key areas: **Knowledge**, **Good Jobs**, and **Supportive Workplaces**. For each of these key areas there are three sections giving you an **Overview**, information in **Detail**, and a clear description of what **To Do**. All nine of these sections act as interventions themselves, and contain links to more detail about the ideas and actions. Quick access to specific tools is available in the [Resources](#) section.

Each of the three main sections ([Knowledge](#), [Good Jobs](#), [Supportive Workplace](#)) is divided into three types of information:

1. Overview
2. In Detail
3. What To Do

Begin by familiarising yourself with all three **Overview** sections, then go on to look at the **In Detail** and **What To Do** sections

Remember, this **health<-->work** toolbox is a **resource** you can come back to as often as you like. It will be especially useful if you, or one of your workers, develops symptoms of a [common health problem](#).

### USE this toolbox to:

- Look up specific information
- Learn new techniques and strategies
- Get useful stuff from the [resource library](#)

If you don't feel confident that you know what is meant by **Common Health Problems** then be sure to read [this](#) first.

**Remember** the goal is to reduce the occurrence and impact that [common health problems](#) have on you and everyone at your workplace.

### Persuade Others to Use This Toolbox

Collect relevant information and data as a way of creating an internal business case. This usually involves describing the issues with common health problems and pointing out there is room for improvement

### Create a Learning Organisation

As has often been observed 'the only constant thing in life is change'. Organisations and all the people who work in them are constantly changing. An organisation that **learns** is more productive and capable of important aspects like growth and innovation. Try to consider what might help your organisation - whether it be small, medium, or large - to learn about common health problems and make progress by providing good jobs and acting as a supportive workplace.

### Two Types of Intervention

There are two types of intervention in this toolbox

- (1) Tools for changing the culture
  - the target is everyone
  - this needs to be started as a 'top down' intervention
- (2) Tools for changing the workplace
  - the target is both line managers and workers
  - this begins as a 'ground up' intervention

(1) is necessary to facilitate (2)

### When the Toolbox Applies

The principles are applicable at any time, but it is important to focus on two aspects

**Before any problems arise**

This is the time to be proactive by making jobs as agreeable and comfortable as possible

**Immediately problems arise**

This is when you need to respond rapidly with an approach that is already worked out by making the workplace temporarily accommodating

# Health<-->Work

## the toolbox for managing common health problems at the workplace

<a href="#">Toolbox Home</a>	<a href="#">Knowledge</a>	<a href="#">Good Jobs</a>	<a href="#">Supportive Workplaces</a>	<a href="#">Resource Library</a>
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### Knowledge - Overview

To reduce the occurrence and impact that [common health problems](#) have on you and your workers, you need to know about the nature of the problems and the role of the workplace. This part of the toolbox gives you the key knowledge that you need: facts and the underlying principles. It will help you make sense of the relationship between health and work, and gives you ideas on what can and can't be done and what you should and shouldn't do.

### 5 key items of Knowledge

Armed with this information, you'll grasp the principles, but you'll need to read some more detail to fully understand the [health<-->work](#) message and be able to apply it across your workforce.

- **Work is usually good for our health and wellbeing.** But, we all get common health problems at times – things like feeling stressed, anxiety, depression, back pain, minor injuries. They can occur whatever job we have. Mostly we can cope and carry on at work – that's generally the best way to recover.
- **Most work is not dangerous** – so long as it complies with the Health & Safety Regulations. Work is not usually a major cause of common health problems, yet they account for most long-term sickness absence. Clearly we have not been doing the right things to maintain health at work and prevent work loss.
- **Work may become difficult when we have a health complaint or injury.** Helping workers stay at work or get back quickly is the best policy. The longer someone is off work the harder it is for them to get back, and the more it costs.
- **Some people struggle to stay at work or get back quickly.** That's because they face obstacles, not because they have a more serious health problem. Good management at the workplace is crucial for overcoming the obstacles.
- **Providing good jobs that are as comfortable as possible and accommodating workers in a supportive workplace when they have health complaints is the way to reduce the burden of health complaints at work.** It is not that difficult to do, and will have tangible benefits. The starting point is to ensure your entire workforce is onside with the [health<-->work](#) message.

### Actions

1. Commitment to the [Health<-->Work](#) culture.
2. Decide what information needs to be available to everyone.
3. Arrange things so everyone knows where to find the [knowledge](#) they need, and are able to access it easily, quickly and repeatedly: think about making it available in printed and/or electronic format. You could also make posters.
4. Ensure the organisation and all in it have worked out (1) an approach to minimise health complaints (collectively through making the jobs good) and (2) to rapidly and effectively help colleagues who are struggling to work because of their health complaint (with temporary support and accommodation). That is, be **proactive** not reactive.
5. Find out if you've got the message across.

**Joe's story:** *We're a small manufacturing outfit with a mix of jobs: design work and production mainly. Talking to a chap from a similar company down south I realised we had a lot more sickness absence than they did. We looked into it and realised that most of the problem was related to everyday health complaints, and some of the staff were having frequent absences. I had a chat with them and realised they had a pretty negative view on work and health. I had a great guidance leaflet on a government website that explained the issues, busted some myths and gave some useful advice. First off I made sure all the staff read it, and then I got the managers onside to make life a bit more comfortable. They also started supporting people with their health complaints. There was a positive response from staff, and people don't seem to be complaining as much about their health at work. Just getting the right knowledge helped us take a big step forward.*

go to

**KNOWLEDGE WHAT TO DO**

**KNOWLEDGE IN DETAIL**

**GOOD JOBS**

**SUPPORTIVE WORKPLACE**

# Health<-->Work

## the toolbox for managing common health problems at the workplace

<a href="#">Toolbox Home</a>	<a href="#">Knowledge</a>	<a href="#">Good Jobs</a>	<a href="#">Supportive Workplaces</a>	<a href="#">Resource Library</a>
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## Knowledge - In Detail

Common health problems in the workplace extract enormous societal, commercial, and personal costs, yet the adverse consequences can usually be avoided through relatively low-cost workplace interventions.

### 5 key items of Knowledge

It's important to grasp the **principles**, but you'll also need to know details to fully understand the **health<-->work** approach and be able to get it across to everyone at your workplace.

- **Work is usually good for our health and wellbeing.** But, we all get common health problems at times - stress, depression, back pain, minor injuries. They can occur whatever job we have. Mostly we can cope and carry on at work - that's generally the best way to recover.
- **Most work is not dangerous** - so long as it complies with the Health & Safety Regulations. Work is not usually a major cause of common health problems, yet they account for most long-term sickness absence. Clearly we have not been doing the right things to maintain health at work and prevent work loss.
- **Work may become difficult when we have a health complaint or injury.** Helping workers stay at work or get back quickly is the best policy. The longer someone is off work the harder it is for them to get back, and the more it costs.
- **Some people struggle to stay at work or get back quickly.** That's because they face obstacles, not because they have a more serious health problem. Good management at the workplace is crucial for overcoming the obstacles.
- **Providing good jobs that are as comfortable as possible and accommodating workers in a supportive workplace when they have health complaints is the way to reduce the burden of health complaints at work.** It is not that difficult to do, and will have tangible benefits. The starting point is to ensure your entire workforce is onside with the **health<-->work** message.

## We all get common health problems at times

We all experience common health problems and minor injuries at some stage during our lives, and this is not confined to working age. The most common are:

Mental health [e.g. depression; anxiety; feeling stressed]

Musculoskeletal [e.g. back pain; neck pain; upper limb disorders]

Other complaints that interfere with work [e.g. blood pressure; asthma]

The symptoms of common health problems often recur, usually without rhyme or reason. They have substantial impact on workplaces because the symptoms are often **work-relevant**. That is, they are relevant to our ability to work and be productive, but are not usually due to the work itself.

## Work is usually good for our health and wellbeing

### Principle

We all get common health problems at times - feeling stressed, anxiety, depression, back pain, neck pain, minor injuries, etc. They can occur whatever job we have. Mostly we can cope and carry on at work and that's generally the best way to recover. Ask yourself, do you think that you or other people need to be somehow 'protected' from work when you have symptoms of common health problems, or is work usually the best place to get on with recovering?

### Quick Facts

Work is an important part of life. Work is good for physical and mental health. Not being in work for long periods can lead to worse health and shorter lives. This is important to all of us as individuals, to our families and friends, to employers and businesses, and to our society as a whole.

Our goal for a healthy life must include a healthy working life. To achieve this we need to know how to manage common health problems, and prevent them interfering with our ability to work and stay productive.

The nature of work is important: good work is good for health and wellbeing. A good job is a comfortable job in a supportive work environment, where the workplace accommodates people struggling with work-relevant symptoms.

### Practical Implications

- This toolbox aims to encourage everyone to cultivate good jobs by making them comfortable and to generate supportive workplaces that accommodate people while they recover from common health problems.

- The people who can make this happen are line managers, supported by senior management establishing the right 'culture'.
- We will know it has been successful by reducing the number of cases requiring healthcare, and reducing the amount of long-term sickness absence.

## Most work is not dangerous

### Principle

So long as it complies with the Health & Safety Regulations, most modern work is not truly dangerous. It may have some unpleasant or uncomfortable aspects, but work is not usually a major cause of common health problems. Despite this, they account for most long-term sickness absence. Clearly we are not doing the right things to maintain health at work and prevent work loss.

### Quick Facts

Work is not usually a major cause of common health problems, yet they account for most long-term sickness absence. Clearly we are not doing the right things to maintain health at work and prevent work loss.

Common health problems can occur whatever job we have.

We do need work to be safe

We do not need to be 'protected' from our work

### Practical Implications

- There is a lot that can be done to make our working life a healthy one. This is neither time-consuming nor resource intensive.

## Work may become difficult when we have a health complaint or injury

Health complaints and minor injuries can be irritating or even distressing to any of us. They can interfere with ability to work and be active, but they are not 'severe' in a medical sense and there is no reason to expect they will not improve. In fact, most people remain at work or return quite quickly, and they come to no harm. Those who find themselves struggling or going off work don't actually need to – if they get a little help from the organisation.

**Line Managers** can arrange temporary flexibility at work to make it possible to stay at work, or to return safely and early.

**Workers** can discuss what will work for them with their line manager and with their healthcare provider.

## Mostly we can cope and carry on at work

### Principle

Common health problems are work-relevant because the symptoms can interfere with your ability to do your usual job, although they do not always do this. You need to know that helping someone to stay at work or to get back quickly is the best policy. The longer someone is off work the harder it is for them to get back, and the more it costs.

### Quick Facts

Most episodes of common health problems are short-lived and people can stay at work or need only a short time off.

Paradoxically, most long-term sickness absence is actually due to these problems. This should **not** happen, especially if we were all doing the things we know can prevent prolonged sickness absence. The reasons people stay away from work for long periods is driven more by **obstacles** that are psychosocial in nature, than by the severity of illness or injury.

The graph below illustrates how common health problems affect people and industry. Basically, what it shows is that most people get symptoms, but only for some does work become problematic. Most people can and do cope with their health at work. Only a minority struggle, and very few need sick leave. But, and it's a very big but, the number of people taking time off work and staying off work has been going up and up.

The really important thing to grasp is that these numbers should not be going up across our society, and that extended sick leave for common health problems **can be prevented** and needs to be prevented.



## Practical Implications

- This is important to you as a line manager because there are things you can easily do to reduce the chances your workers will need time off, and you need to especially focus on preventing it turning into long-term absence (a disaster for everyone). When any of your workers have long periods of sickness absence there is an effect on overall productivity through loss of skills, the need to find cover, lack of experience in newer staff, or the need to ask others to work overtime. There is invariably extra cost to your organisation/company, and there is also a collective impact on our society and all taxpayers. A few simple things can make people feel better and be more productive.
- This is important to you as a worker because there are things you can do to prevent the need for time off work, and especially a long time off. Extended periods off work results in substantial reduction in quality of life, and people usually experience more health problems as time goes by. It becomes much harder to get back into work, and this is made worse by deterioration in skills and confidence along with the feeling of isolation from work. All of this extra suffering tends to extend to family members as well, compounding the problem.

## Helping people to stay at work or get back quickly is the best approach

### Principle

Some people struggle to stay at work or get back quickly. That's because they face obstacles, not because they have a more serious health problem. Good management at the workplace is crucial for overcoming the obstacles. Providing a supportive workplace that allows temporary changes to job tasks is the best course of action.

### Quick Facts

The longer someone is off work the harder it is for them to get back, and the more it costs.

We now have good evidence that returning to work as soon as possible actually helps recovery. It is the best way to avoid long-term sickness.

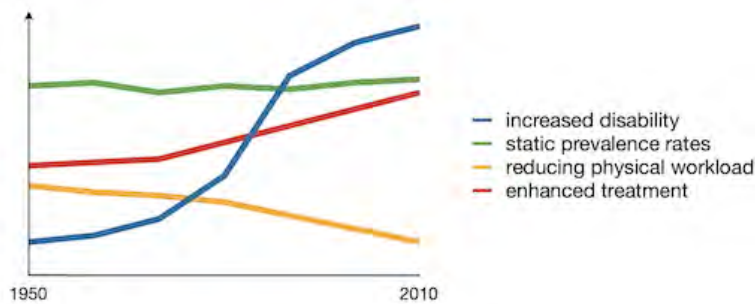
## Obstacles delay getting back to work

Good management at the workplace is crucial for overcoming the obstacles.

## Reducing the Burden of Health Complaints at Work

### Principle

Providing good jobs that are as comfortable as possible and accommodating workers in a supportive workplace when they have health complaints is the way to reduce the burden of health complaints at work. It is not that difficult to do, and will have tangible benefits. The starting point is to ensure your entire workforce is inside with the **health<-->work** message.



### Quick Facts

Common health problems should **always** be manageable: the paradox is that so many end up on long-term sick. That is costly for your organisation, for the workers themselves, and for society.

Despite better working conditions and better access to health care, the number of people with symptoms has not reduced. More importantly, the number of people claiming disability has actually increased. Whatever we've been doing up to now, it clearly hasn't provided an effective answer.

The longer people are off work, the less likely they are to get back – the slide into worklessness is all too easy. Fortunately there is a lot you can do to help: quickly, cheaply, and effectively.

It's crucial to step in and help without delay. We now have a much clearer picture of what needs to be done. The toolbox makes it possible for you to play your part to make this happen.

### Practical Implications

- Common health problems in the workplace extract enormous societal, commercial, and personal costs, yet the adverse consequences can usually be avoided through relatively low-cost workplace interventions.

## Using the Knowledge

Remember our goal is to prevent escalation of work-relevant common health problems. It should be able to operate 'just in time' to reduce the incidence of these problems, and their developing or getting worse. It should strike a balance between avoiding incautious common health problem reporting and avoiding inhibition of reporting that warrants healthcare.

We need to learn what to do and how to identify the various problems and enablers to these action plans.



go to

[KNOWLEDGE WHAT TO DO](#)

[KNOWLEDGE OVERVIEW](#)

[GOOD JOBS](#)

[SUPPORTIVE WORKPLACE](#)

# Health<-->Work

## the toolbox for managing common health problems at the workplace

<a href="#">Toolbox Home</a>	<a href="#">Knowledge</a>	<a href="#">Good Jobs</a>	<a href="#">Supportive Workplaces</a>	<a href="#">Resource Library</a>
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## Knowledge - What To Do

### Actions

1. Commitment to the **Health<-->Work** culture.
2. Decide what information needs to be available to everyone.
3. Arrange things so everyone knows where to find the knowledge they need, and are able to access it easily, quickly and repeatedly: think about making it available in printed and/or electronic format. You could also make posters.
4. Ensure the organisation and all in it have worked out (1) an approach to minimise health complaints (collectively through making the jobs good) and (2) to rapidly and effectively help colleagues who are struggling to work because of their health complaint (with temporary support and accommodation). That is, be **proactive** not reactive.
5. Find out if you've got the message across.

### Action 1. Getting Ready

The starting point is for everyone in the workplace to [adopt](#) the **health<-->work** culture. This requires [commitment from senior management](#).

**TIP:** Use the [Health<-->Work Questionnaire](#) to find out whether you, your workers and line managers understand the fundamental relationship between health and work. If the level is low, then you should ensure everyone gets access to 'The Knowledge' as many times as necessary to get the full message. In larger organisations, use the results from this measure to quantify and justify any resources you need to get the message across.

All workplaces need to be safe, and there is ample guidance to the various Regulations. In addition to safety, complying with the Regulations helps to make work more comfortable. You should highlight how well the workplace complies with the Regulations. It shows you care and gives the workforce confidence that you aim to provide them with good jobs.

The **things that make work good for health go beyond safety**: it's about reasonable and supportive management.

This toolbox is not centred on avoiding harm (though by providing good jobs you can expect a healthier workforce). Rather, it takes a positive stance on helping workers work with health problems.

You need to ensure everyone in your management chain is fully informed, with shared beliefs and shared values – everyone committed to ensuring that the organisation provides good jobs and a supportive workplace.

Everyone in the workplace is responsible for health and safety. There is a dual responsibility shared between workers, their line managers, and senior management. The ideal goal is always to foster a team approach to health and wellbeing throughout all workplaces.

**CHECK:** Find out whether there is a visible commitment to the **Health<-->Work** culture, the necessary resources have been allocated, and there is a plan to regularly focus on common health problems.

### Action 2. Information for Everyone

It is not practical for everyone to know everything about common health problems. We need to concentrate on the key concepts and practical steps. That is the goal of this toolbox. It also serves as a resource to come back to when needed.

**TIP:** The minimum information involves **five** key principles:

#### FIRST PRINCIPLE: Work is usually good for our health and wellbeing

We all get common health problems at times - feeling stressed, anxiety, depression, back pain, neck pain, minor injuries, etc. They can occur whatever job we have. Mostly we can cope and carry on at work and that's generally the best way to recover. Ask yourself, do you think that you or other people need to be somehow 'protected' from work when you have symptoms of common health problems, or is work usually the best place to get on with recovering?

#### SECOND PRINCIPLE: Most work is not dangerous

So long as it complies with the Health & Safety Regulations, most modern work is not truly dangerous. It may have some unpleasant or uncomfortable aspects, but work is not usually a major cause of common health problems. Despite this, they account for most long-term sickness absence. Clearly we have not been doing the right things to maintain health at work and prevent work loss.

### THIRD PRINCIPLE: Work may become difficult when we have a health complaint or injury

Common health problems are work-relevant because the symptoms can interfere with your ability to do your usual job, although they do not always do this. You need to know that helping someone to stay at work or to get back quickly is the best policy. The longer someone is off work the harder it is for them to get back, and the more it costs.

### FOURTH PRINCIPLE: Some people struggle to stay at work or get back quickly

That's because they face obstacles, not because they have a more serious health problem. Good management at the workplace is crucial for overcoming the obstacles. Providing a supportive workplace that allows temporary changes to job tasks is the best course of action.

### FIFTH PRINCIPLE: Good jobs reduce the burden of health complaints at work

Providing good jobs that are as comfortable as possible and accommodate workers in a supportive workplace when they have health complaints is the way to reduce the burden at work. It is not that difficult to do, and will have tangible benefits. The starting point is to ensure your entire workforce is onside with the **health<-->work** message.

**CHECK:** Can everyone in the workplace describe the 5 key principles, and where to get more information when it is needed?

## EVERYONE Needs to Understand How to Manage Health at Work

We all get health problems, and a lot of the time they are not medical issues. When it comes to common health problems, healthcare professionals can do just so much. Certainly some people need reassurance from healthcare professionals and help with relief of symptoms. That, though, does not help them with work.

What happens in and around the workplace determines whether people cope or succumb. Provide good jobs and workers will cope better and work their way through many episodes of ill-health or injury. Despite this, some will inevitably struggle to cope. This is the time to support the individual: accommodating workers with common health problems means they either don't go off sick or can soon return.

A useful way to understand how the workplace can affect health behaviours is to think in terms of obstacles. The obstacles work at two levels – the group and the individual. A good job is one that is free of the things that get in the way of the work being comfortable and satisfying: things such as unhelpful policies, poor communications, major hassles, injustices, etc. A supportive workplace is one that recognises and tackles things that make it difficult for an individual to cope with their health problem at work: things like lack of modified work, inflexibility, social stigma.

**TIP:** The toolbox shows you how identify the obstacles and eliminate them. It's not terribly complex or time consuming. In fact, it's rather straightforward - it just needs to be managed. Making it happen depends on everyone doing what's needed when it's needed – and avoiding anything that could block the process.

## EVERYONE Needs to Know About Obstacles and How Best to Tackle Them

Obstacles occur in three main domains:

- Person: the things that people believe and how they react
- Workplace: things that make the job unpleasant or unsupportive
- Context: inflexible policies and processes

**TIP:** The idea of overcoming obstacles stresses **ability** rather than **disability**, and shifts the emphasis to actions that facilitate work participation. In this sense, obstacles can be transformed into opportunities. People usually need help to overcome or navigate round obstacles. Problem-solving approaches by the key players working together are what help people cope with their health problems at work.

## EVERYONE Need to Undertand Myths are Obstacles, and Why it's Important to Identify and Address Myths

There are all manner of **myths** around the relationship between work and health. These myths are major obstacles to any attempt to make good jobs and supportive workplaces. If we are to move to a CAN-DO culture that recognises the value of work to health, the myths must be dispelled.

It is essential to change everyone's knowledge base – replace the myths with helpful information

Common workplace myths:

- Most health problems can be caused by work
- They are often made worse by work
- Sickness absence is necessary
- Can't return to work until 100% fit
- Return to work will carry further risk or prejudice a claim

**TIP:** Bust the **myths** in your workplace! This will help everyone recognise that the toolbox is worth using.

## Action 3. Give Everyone Access to Information and the Toolbox

### Factual Information

Ensuring everyone in your organisation understands that the 'obstacles' idea is crucial to effective action.

**TIP:** The *Work & Health* and *Health & Work* leaflets explain it in simple terms – ensure everybody can access them.

### All line managers and senior managers should read the **Work & Health** leaflet

If line managers have the right knowledge, they will be confident and empowered to develop a positive culture around work and health. You'll find some helpful tools for doing that by reading the leaflet.

[download a copy](#)

### All staff, workers, and employees should read the **Health & Work** leaflet

If your workers believe that work is good for health, and that they can do something about it they will be more receptive to you helping them stay at work with a health problem, or get back quickly if they need time off.

[download a copy](#)

A key idea to get across is that **work is generally good for our health and wellbeing**. Of course, that does depend on the nature of the work – it is good jobs that are good for people.

**CHECK:** Can everyone get access to these leaflets, and do they have any questions that need to be answered or issues to be discussed.

## Action 4. Ensure There is a Proactive Approach

### What to do for your line managers and managers

If managers are to help people with health problems at work, they need to know some basic information. They don't need medical knowledge, but they do need to understand the relationship between common health problems and work. That way they will gain the confidence to know that they can do a lot to help their colleagues recover at work – safely and to everyone's benefit. It's about working with their colleague to find ways of staying at work or getting back quickly from absence. It's also about making the jobs in their department good jobs.

**TIP:** Line managers can facilitate, or sabotage, provision of good jobs for their staff. It doesn't matter what level of seniority, this always holds true. Which do you do? Ask yourself: "are you a facilitator or a saboteur"?

### What to do for your workers

Usually, the people who stay in work with common health problems, or who return to work quickly, have a positive attitude to work and health. Instilling this positive attitude to minor health problems is important – but it is also important to support people to get that attitude. People with the right kind of attitude:

- Tend to like their work and want to stay in work – creating good jobs can help here
- Look to make improvements rather than focusing on the difficulties in improving things
- Tend to like to solve problems and persevere in their attempts to do so – supporting workers to solve their own problems helps create good jobs and a supportive workplace
- Realise that common health problems don't go on forever, and realise they can proactively reduce their chances of experiencing common health problems
- Seek out positive support from others – to build their own optimism, being round people who see the positives and the things that can be done can help

**CHECK:** Have you taken a proactive approach, or are you waiting for problems to arise before knowing what to do?

## Action 5. Find out if you've got the message across

### Start With a Basic Approach

You could ask a few questions, before and after you've given people access to knowledge. Here is one way:

*Thinking about health complaints like stress, depression, back pain, and minor injuries:*

*Do you think they should stop people from working and that the best way to manage them is long-term sick leave?*

*Do you think we can do things in this organisation to reduce them happening, and when they do to help people to cope at work and recover more quickly?*

### Use a Systematic Approach

You can also use the simple [Health<-->Work Questionnaire](#) questionnaire to find out how well you, your line managers, or your workers understand the **health<-->work** message. This may be especially useful if you are a larger organisation and want more detailed information about specific departments or a larger number of people. Try checking **before and after** you've given them access to the Knowledge.

## Ongoing Actions - Keeping All Players On-side in an Improved Workplace Culture

Helping workers with [common health problems](#) is about more than just healthcare or safety, it's about providing good jobs and a supportive workplace. The beneficial effects of work on physical and mental health outweigh the risks of work and the harm of prolonged sickness absence. Making a difference is possible – and everyone benefits.

Achieving it demands a fundamental shift in how we think about common health problems – in the workplace, in health care, and in society.

It is crucial that everyone uses the same ideas about work health, shares common goals and works together. That needs good communication: this is what good managers do well. They can promote good jobs and a supportive workplace, using the toolbox.

Make it clear to everybody that the [work<-->health](#) message is part of working in your organisation.

The scientific evidence is clear: ensure your workplace subscribes to the [health<-->work](#) culture.

Use this toolbox to learn about [Good Jobs](#) and [Supportive Workplaces](#)

Review the sustainability of management support, at least every year or two.

go to [\*\*KNOWLEDGE IN DETAIL\*\*](#)

[\*\*KNOWLEDGE OVERVIEW\*\*](#)

[\*\*GOOD JOBS\*\*](#)

[\*\*SUPPORTIVE WORKPLACE\*\*](#)

# Health<-->Work

## the toolbox for managing common health problems at the workplace

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### Good Jobs - Overview

To reduce the occurrence and impact that [common health problems](#) have on an organisation it is important for all workers to have **good jobs**. This part of the toolbox gives you a full understanding of what is needed. It will help you make sense of the relationship between health and job quality, and gives guidance on what can be done.

Making sure jobs are as good, satisfying, and comfortable as they can be is an aspirational goal for every workplace. It's something we need to continuously work towards. Providing your workforce with **good jobs** should be your default position. It applies to all the people in the organisation – all the time. Stated simply, everyone in your workplace should be able to say *'I have a great job'*. If they can, then they will enjoy better health, as well as being happier and more productive.

A good job is where your people say things like *'I'm happy with my job'* or *'I love my job and I like doing it here'*. It's quite possible for people to like their job but not their colleagues or workplace. It's also possible to like the people and workplace but dislike the job. The trick to making good jobs is to ensure your colleagues find both aspects agreeable – maybe not perfect, but acceptable and satisfying. Having a good job is about this job, not the general idea of 'good work'.

Good jobs help people to be 'resilient'. This means the structure of the job and the way it's organised helps people deal with unavoidable discomfort and irritation.

### 5 Things You Need to Know About Good Jobs

- **A good job is not the same as an ideal job.** Not all jobs can be perfect. It is a matter of making the working conditions reasonable within the context of the job: it's a question of balance. Although people have different preferences, for the most part, most people agree on the features that make up a good job.
- **Job satisfaction is important to us all – good jobs are satisfying jobs.** A satisfying job has a sense of purpose, gives enjoyment, and meets expectations. You know you're providing good jobs when your workers say they would choose the same job and workplace again!
- **It's the simple things that make for good jobs**, starting with open communication across the organisation, and treating workers and co-workers with respect. Workers need to feel they have a say in how things are run, and that management will listen. They need to feel appreciated and part of a team with a common goal. Good jobs are fair jobs. Good jobs resist an 'us and them' culture.
- **Good jobs come from good management.** Senior management needs to be overtly committed to ensuring the organisation provides the best jobs it can. In providing good jobs you should find that what you get back is more than you put in! All the organisation's line managers need to show the same commitment - line managers hold the key to good jobs.
- **The characteristics of good jobs are:**
  - Balanced demands and a safe work environment
  - Effective and supportive line management
  - Feeling of being a valued and respected member of a team
  - Opportunities to use and develop skills
  - Support and opportunity for workers to solve their own problems
  - Support to make improvements to the job
  - Opportunities for social interaction

There are others things of course, but these are the features that people say make a job comfortable, agreeable and satisfying. Importantly, they are also the things that help people to be resilient, so they can cope at work with common health problems and minor injuries. Provide good jobs and you will get less sickness absence.

### How this Works

Commitment to the [Work<-->Health](#) culture leads to workplaces that are **healthy and safe** and this helps to reduce both the occurrence and impact of common health problems.

Good jobs encourage workers to develop skills and coping strategies to deal with the unpleasant and uncomfortable aspects of every job that are **unavoidable**.

Providing good jobs is an initiative aimed at **groups of workers**. It's about managing things so that **everyone** in the organisation has a good job. It's primarily to do with creating the right infrastructure to benefit groups of workers, yet recognising the needs of individuals.

**Senior Management sets the approach. Line Managers make it happen. Workers contribute to the process.**

There are key **actions** for each of these groups: senior managers, line managers, and workers.

## Actions

### Senior Managers

In larger companies and organisations creating the infrastructure may be delegated to others, e.g. HRM, but senior management involvement is **essential** to set the aspiration.

- Initiate the process and be proactive about providing good jobs
- Incorporate the good jobs aspiration into line manager training and support
- Ensure everyone in the workplace has contributed to finding the best combination of approaches to providing good jobs throughout the different parts of the business or organisation
- Review regularly and seek to improve

### Line Managers

- Find out whether you are providing good jobs. Use guided questioning to determine whether the jobs you manage are sufficiently comfortable and engaging.
- Identify potential improvements and make changes, recognising that creating good jobs is an aspirational goal to keep working toward.
- Identify where skills need to be developed to help workers cope with unavoidable aspects of jobs that are unpleasant or uncomfortable.
- Communicate effectively to senior management and workers about what can be realistically achieved toward providing good jobs.

### Workers

- Participate in open communication about how to make good jobs
- Question line managers when the process of providing good jobs is not occurring
- Respect and support your colleagues

**Ruth's story:** *I work in a call centre, and I love my job. People are surprised by that. They think call centres are really stressful and not somewhere you'd want to work. Well, all I can say is it depends on who you work with. That's a big part of it for me: I feel that I work with the company not for it. Sure, it's stressful sometimes – I work in returns and obviously the callers are irritated and can be demanding. But, the way I was trained to look at it was that they have a problem that only I can solve – they need someone to guide them through the process of getting the right replacement, fast. Our managers take the time to talk about the job and like us to suggest improvements to the scripts and things. We get regular breaks and if we get stressed out with a really dodgy customer, we're encouraged to take a couple of minutes out for a walk around or a grumble with a colleague. So, stress is controlled and we don't get many people on long-term sick leave. Yes it's a good job with a good company.*

go to [GOOD JOBS WHAT TO DO](#)

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# Health<-->Work

## the toolbox for managing common health problems at the workplace

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### Good Jobs - In Detail

There is no doubt that work is good for our health and well-being. But it has to be 'good' work, which means providing good jobs. So, if we are to reduce the occurrence and impact of [common health problems](#) in the workplace, we need to be providing **good jobs** for all workers. Making sure jobs are as agreeable, satisfying, and comfortable as they can be is an aspirational goal for every workplace. It's something we need to continuously work towards. Providing your workforce with **good jobs** should be your default position. It applies to all the people in the organisation – all the time. Stated simply, everyone in your workplace should be able to say *'I have a great job'*. If they can, then they will enjoy better health, as well as being happier and more productive.

A good job is where your people say things like *'I'm happy with my job'* or *'I love my job and I like doing it here'*. It's quite possible for people to like their job but not their colleagues or workplace. It's also possible to like the people and workplace but dislike the job. The trick to making good jobs is to ensure your colleagues find both aspects agreeable – maybe not perfect, but acceptable and satisfying. Having a good job is about this job, not the general idea of 'good work'. Good jobs help people to be **resilient**, to bounce back when things get tough. This means the structure of the job and the way it's organised helps people deal with unavoidable discomfort and irritation.

Good jobs are jobs that engage and motivate workers. Good jobs encourage workers to develop their skills and learning in work, and enable workers to make on-the-job improvements in how they perform their work so that they can be more productive. Good jobs are jobs that are satisfying and agreeable. It is in everyone's interest to think about how jobs can be improved to make them better.

And we're not talking about major changes to making jobs better – it is relatively easy to make small scale changes that improve work, in the same way that small scale improvements in processes are used in techniques such as lean practices and total quality management. Making a series of small changes over time can transform jobs, workers' health, satisfaction, motivation and engagement with work. All that is required is that organisational members at all levels buy into the notion of improving work.

### 5 Things You Need to Know About Good Jobs

- **A good job is not the same as an ideal job.** Not all jobs can be perfect. It is a matter of making the working conditions reasonable within the context of the job: it's a question of balance. Although people have different preferences, for the most part, most people agree on the features that make up a good job.
- **Job satisfaction is important to us all – good jobs are satisfying jobs.** A satisfying job has a sense of purpose, gives enjoyment, and meets expectations. You know you're providing good jobs when your workers say they would choose the same job and workplace again!
- **It's the simple things that make for good jobs**, starting with open communication across the organisation, and treating workers and co-workers with respect. Workers need to feel they have a say in how things are run, and that management will listen. They need to feel appreciated and part of a team with a common goal. Good jobs are fair jobs. Good jobs resist an 'us and them' culture.
- **Good jobs come from good management.** Senior management needs to be overtly committed to ensuring the organisation provides the best jobs it can. In providing good jobs you should find that what you get back is more than you put in! All the organisation's line managers need to show the same commitment - line managers hold the key to good jobs.
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## Actions

### Senior Managers

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- Initiate the process and be proactive about providing good jobs
- Incorporate the good jobs aspiration into line manager training and support
- Ensure everyone in the workplace has contributed to finding the best combination of approaches to providing good jobs throughout the different parts of the business or organisation
- Review regularly and seek to improve

### Line Managers

- Find out whether you are providing good jobs. Use guided questioning to determine whether the jobs you manage are sufficiently comfortable and engaging.
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- Identify where skills need to be developed to help workers cope with unavoidable aspects of jobs that are unpleasant or uncomfortable.
- Communicate effectively to senior management and workers about what can be realistically achieved toward providing good jobs.

### Workers

- Participate in open communication about how to make good jobs
- Question line managers when the process of providing good jobs is not occurring
- Respect and support your colleagues

## Good Jobs

### Principle

A good job is not the same as an ideal job, but it is much more than [good work](#). Not all jobs, if any, can be perfect. It is a matter of making the working conditions reasonable within the context of the job. This is a question of balance. Although people have different preferences, for the most part, most people agree on the features that make up a good job.

### Quick Facts

Good jobs are safe, healthy, sustainable, satisfying, rewarding, and [much more](#). The idea of good jobs is not an absolute – one size doesn't fit all. To some extent it is a matter of perceptions. But, there is an underlying foundation of reasonableness. What is acceptable or tolerable to one may not be to another. That's why it is important to ask workers what they need, and also point to what they might do themselves.

Providing good jobs involves everyone acting in the right way: senior managers, line managers and workers. The workplace culture should be about care and support, balancing demands and control, yet with expectations that everyone must contribute.

One of the most important relationships anyone has at work is with their line manager. Good line managers are enthusiastic and inspirational – they generate job satisfaction and motivation, and that raises productivity.

Good management is also going to be good for workers' health. The things that good managers do, such as clarifying objectives, involving people in decisions, providing support, and encouraging skills development, are the kind of things that also create good and satisfying jobs.

Supportive management is also important for helping people cope with common health problems, enabling them to stay at work or get back quickly from absence. Obviously, poor management will be counterproductive.

### Practical Implications

- To improve the way you manage, you need to get all layers of management on side. This will make building good jobs and supportive workplaces so much easier – especially because supportive management is a key feature of both good jobs and supportive workplaces. You need to make sure line managers have the knowledge, time, space and permission to take health seriously.
- In order for line managers to know and act on the work health message, the attitude your organisation needs to project is: **All line managers should see their own health and their workers health as an important business topic.**
- Line managers need to be proactive in managing health. Ask yourself these questions:
  - Are you proactive in creating good jobs?
  - Do you foster a good team spirit?
  - Are you a good role model, visible and accessible?
  - Do you listen to workers, and involve workers in decisions whenever possible?
  - Do you give people clear direction, then allow them to use their own initiative in meeting objectives?

Of course managers with a good management style may already be proactive in managing health – possibly without realising it.

### What's in a Word? 'Good Jobs' versus 'Good Work'

The idea of **good work** is an important one. It goes beyond just ensuring that jobs do not injure people or make them ill. It is also about the way work is organised, including things such as fair rewards, security fulfilment and appreciation by society. Initiatives to produce good work happen mostly at the level of policy, regulation, and legislation. Work that is both 'good' and safe has become an expected minimum standard, but it is not sufficient to fully support the health and well-being of workers. However, all the features required for 'good work' may be in place, yet the job may still not be a good one. A good **job** is safe, healthy, sustainable, satisfying, rewarding, and much more. The provision of good jobs happens in workplaces. It is each person's actual job ... your job, my job, etc. To have a good job the right things must be done in this workplace, now.

# Job Satisfaction

## Principle

Job satisfaction is how people feel about their jobs and different aspects of their jobs. It is the extent to which people like (satisfaction) or dislike (dissatisfaction) their jobs.

## Quick Facts

Job satisfaction is important to us all – good jobs are satisfying jobs. A satisfying job has a sense of purpose, gives enjoyment, and meets expectations. You know you're providing good jobs when your workers say they would choose the same job and workplace again.

## Practical Implications

- There are three key questions: what contributes to job satisfaction; what are the health effects, if any; and how might job satisfaction be enhanced?

### 1. Contributions to job satisfaction

More is known about what makes jobs dissatisfying than satisfying. Decreasing job satisfaction is associated with working too many hours, administrative burdens, heavy workload, lack of time, lack of recognition. Things like diversity of work, line manager leadership style, fulfilment, and having good relationships with colleagues are considered features that can enhance job satisfaction.

### 2. Health effects of job satisfaction

It is likely that job satisfaction can influence common health problems, for better or worse. Importantly, though, job satisfaction is associated with fewer complaints about work-relevant health problems and less sick leave.

### 3. Enhancing job satisfaction

The most important point to remember is that there are many factors that affect job satisfaction and that what makes workers happy with their jobs varies from one worker to another and from day to day. This complexity means there is no simple formula to help people be happier and more satisfied at work. Remember that job satisfaction is not the same thing as overall 'life satisfaction'. People can be happier in one area than the other. The focus for good jobs is to enhance the sense of satisfaction at work.

- It is a good idea to evaluate the impact of any initiatives or changes on the level of job satisfaction experienced by workers. A simple measure is to ask 'How satisfied are you with your job?' Use this before and after to make comparisons: use a 1-5 rating (e.g. 1=extremely dissatisfied 2=quite dissatisfied 3=neither satisfied nor dissatisfied 4=quite satisfied 5=extremely satisfied)

# It's the simple things that make for good jobs

## Principle

Focus on the basics: starting with open communication across the organisation, and treating workers and co-workers with respect. Workers prefer to feel they have a say in how things are run, and that management will listen. They need to feel appreciated and part of a team with a common goal. Good jobs are fair jobs. Good jobs repel an 'us and them' culture; working with colleagues reduces antagonism and resentment.

## Quick Facts

Good jobs involve a variety of features so there is no 'silver bullet'. The best approach is to use a combination of actions embedded in a continuous process that self-improves. Senior management input is needed to kick-start this.

Some actions are directed at improving workers' skills and some are directed at changing the tasks people do and how people work together. Often it's just small improvements in a few places that can do the trick. You definitely won't need to tear up your business model.

## Practical Implications

- You need to let your workforce know the organisation is committed to providing them with the best jobs you reasonably can. You might want to emphasise these aspirations. Try doing things like putting up posters stating what good jobs are like and what the organisation is doing about it.
- What's best for your workplace or organisation depends on factors such as how big it is and the sector it operates in. When thinking about what to do, take the nature of the organisation and the people who work in it into account.

# Good jobs come from good management

## Principle

While this may be self-evident, remember that good management involves everyone: Senior Management sets the approach. Line Managers make it happen. Workers contribute to the process.

## Quick Facts

Good jobs come from good management. This is why senior management needs to be overtly committed to ensuring the organisation provides the best jobs it can.

In providing good jobs you should find that what you get back is more than you put in! All the organisation's line managers need to show the same commitment - line managers hold the key to good jobs.

## Practical Implications

- The toolbox is not here to tell you how to manage your business, but it does give you the right tools to make jobs good. It provides a set of principles that we know contribute to **health and wellbeing**. The important ones to focus on are:
  - Be supportive of workers.
  - Be consistent. Do your solutions mean other organisational processes can function as intended or even be improved?
  - Be responsive to the needs of workers.
  - Ensure practices are acceptable to workers, line managers, and all relevant stakeholders.
  - Include workers in consultation on matters that affect them.
  - Be flexible. Are generic solutions capable of being adapted for specific circumstances, and can procedures and work be changed rapidly to accommodate workers should things get worse or be rolled back if things get better?
  - Show due respect and fairness to everyone in the organisation.
  - Ensure solutions are worth investing in. Maybe line managers or workers can come up with something just as effective that is easier and/or less costly to implement?
- Some of these you may already do. Some might not be appropriate in your case. Of course, you might find better solutions than these. Remember, asking workers how they would improve things can help you to come up with creative and novel actions too. This list is not a checklist, it is intended to get you thinking about good jobs, and to work out what **you** can do.

## Characteristics of good jobs

### Principle

Good jobs are interesting and motivating. Different people have different things that motivate and interest them. For example, some people are interested in helping customers, whereas others like solving technical problems. Alternatively, it can be the social contact with colleagues that is most important. Good jobs allow people to pursue these interests, provided they are reasonable and consistent with the work unit and organisational goals.

The content that makes up a good job includes **all** the characteristics of [good work](#) and includes seven **additional** features

1. Balanced demands and a safe work environment
2. Effective and supportive line management
3. Feeling of being a valued and respected member of a team
4. Opportunities to use and develop skills
5. Support and opportunity to solve their own problems
6. Support to make improvements to the job
7. Opportunities for social interaction

There are others things of course, but these are the features that people say make a job agreeable and satisfying. Importantly, they are also the things that help people to be resilient, so they can cope at work with with common health problems and minor injuries. Making jobs good will lead to less sickness absence.

### Quick Facts and Practical Implications

#### 1. Balanced demands and a safe work environment

Good work is a question of balance: the jobs are challenging and motivating, but not too difficult or too easy. There is enough work to stop people feeling bored, but the pace of work is not so fast that people can't work to an adequate or safe standard in normal working hours. The physical environment at work is suitable for the tasks and (reasonably) comfortable.

Work that is not good may be either too difficult or too easy for people. There may not be enough to do to sustain people's motivation and attention, or there may so much to do that it is not possible to finish things properly in a timely fashion (which may interfere with the work-life balance). The physical environment may be uncomfortable and there might be obvious and unmanaged threats to physical safety.

Implications for practice:

- Work that is challenging and motivating, but not too difficult or too easy
- Physical environment is suitable and comfortable

#### 2. Effective and supportive line management

For good jobs, managers need to have open, regular communication with colleagues, offering support when it is needed and treating all workers fairly. Offering support does not always mean 'a shoulder to cry on'. It can be a lot more concrete than that – such as offering advice on how to complete tricky work tasks, finding out about skills development opportunities. It also means being prepared to intervene to help solve grievances of all types, including personal disagreements, unacceptable behaviours, or complaints about policies.

Implications for practice:

- Effective and supportive line management
- Communicate regularly and well
- Offer support when it is needed
- Treat workers fairly

#### 3. Feeling of being a valued and respected member of a team

We all have a basic need to feel appreciated, respected and valued and this is equally important at work. Many surveys have indicated the number one reason why people choose to leave their jobs is a lack of appreciation. Just as an under-appreciated worker is more likely to leave a job, an under-appreciated team

member is more likely to leave a team.

Implications for practice:

- Praise individuals and teams by giving feedback on success, and saying 'well done' and 'thank you' when appropriate
- Praise in public and private, multiple venues reinforce the sense of appreciation
- Be specific, sincere, and do it frequently enough

These are all simple but highly effective.

#### 4. Opportunities and support to use and develop skills

Good jobs provide the support and opportunities to overcome difficulties and develop. People will feel reinforced by their work colleagues when they have problems, and the team will swap advice on how to tackle difficult work problems. People will feel they are treated fairly. People will be clear on their job responsibilities. People will be able to make decisions relevant to their work and appropriate to their levels of skill. People will have opportunities to practice a variety of skills relevant to the work and develop these skills further. This might be through training, but also through on-the-job learning. People will have some idea of how their work and development will pan out over a foreseeable time frame.

Work that is not good will offer few or no opportunities to take decisions relevant to workers' tasks and levels of skills. There will be little support from co-workers and people will feel unfairly treated. There will be little or no opportunity to use and develop a range of skills, and workers will not be clear on their responsibilities or what the future holds.

Implications for practice:

- Workers are able to make decisions
- Clear responsibilities
- Team swaps advice
- Fair treatment
- Clarity on how work and development will pan out

#### 5. People have the support and opportunity to solve their own problems

Problems do occur at work – such as difficult customers, equipment breaking or conflicts with other work teams. For jobs to be good, workers need to be able to cope with problems when they occur. This can mean having the skills and ability to take decisions to solve problems in a timely manner and have support from others if needed. It can also mean the opportunity to take breaks from particularly demanding problems or work within the working day in order to 'recharge' batteries and look at problems anew.

Implications for practice:

- Provide support, skills and opportunities to take decisions, so that people can tackle the work problems they come across when they occur.
- Ensure changes do not compromise others' work or objectives.

#### 6. People can and are supported to help themselves to make their own work better

Each person has slightly different interests and desires, abilities to solve problems and each person experiences work differently. One way to take these differences into account is to encourage work groups and individuals in making their own jobs better. People will need the skills, support and opportunities to do so, and will also have to negotiate with others, so that any changes to work do not compromise the work of others, the work unit or organisational goals.

Implications for practice:

- Provide support, skills and opportunities for people to make their own jobs better
- Ensure changes do not compromise others' work or objectives.

#### 7. Opportunities for social interaction

Individual preference for social interaction varies widely, and also changes throughout a working day. We all recognise the truism that 'no person is an island', but also recognise that sometimes solitude is desirable and necessary to get things done. In general though social interaction at work is a positive influence, and has the potential to enhance collaboration, make work more interesting. It can provide a richer emotional experience where each worker feels included, and foster a better understanding of common values and purpose. The ability to successfully manage social interactions with colleagues at work can influence productivity and career advancement, especially in work settings with greater emphasis on interpersonal than technical skills. Clearly people are less effective if they can't get on with others no matter how adept they are in their particular area of expertise.

Implications for practice:

- Ensure people communicate and interact in a supportive manner
- Ensure people do not intrude on others' privacy when they need to concentrate on completing important tasks

**Ellen's story:** *I think we realised that to get the best out of people we need to make sure they were in the best possible health. Most companies will do something about obvious physical risks but we thought it shouldn't end there. Actually our major problem isn't with physical health – modern working practices have seen to that. That's different from when I first started. I'm the health and safety manager – everyone knows me and everyone knows I have the full support of the Chief Exec. I get the time I need to make sure people are OK. Any everyone knows they can have a bit of banter with me about 'health and safety gone mad'. But they can also come and see me with they have problems, and we can usually work something out pretty easily. If we need to talk to other people we do, and we do it professionally without attaching any blame. We do have policies and we do have checks. We keep the checks simple, but we make sure we act and then review the actions with staff. The important thing is that I make sure people are aware of the policies and the checks are done. For some of the obvious physical risks, if checks aren't done, I come down on whoever is responsible like a ton of bricks. That permeates through to the other policies – people start taking health seriously across the board. I also keep people involved by doing little things – the odd staff survey or focus group, going round doing checks with people, one-off training events and the like.*

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# Health<-->Work

## the toolbox for managing common health problems at the workplace

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## Good Jobs - What To Do

Commitment to the **Work<-->Health** culture leads to workplaces that are **healthy and safe** and this helps to reduce both the occurrence and impact of common health problems.

Good jobs are comfortable, agreeable and engaging. In addition, they nurture skills and coping strategies to deal with the unpleasant and uncomfortable aspects of every job that are **unavoidable**.

Providing good jobs is an initiative aimed at **groups of workers**. It's about managing things so that **everyone** in the organisation has a good job. It's primarily to do with creating the right infrastructure to benefit groups, yet recognising the needs of individuals.

**Senior Management sets the approach. Line Managers make it happen. Workers contribute to the process.**

There are key **actions** for each of these groups: senior managers, line managers, and workers.

### Actions

#### Senior Managers ... [>> go](#)

In larger companies and organisations creating the infrastructure may be delegated to others, e.g. HRM, but senior management involvement is **essential** to set the aspiration.

- Initiate the process and be proactive about providing good jobs.
- Incorporate the good jobs aspiration into line manager training and support.
- Ensure everyone in the workplace has contributed to finding the best combination of approaches to providing good jobs throughout the different parts of the business or organisation.
- Review regularly and seek to improve.

#### Line Managers ... [>>go](#)

- Find out whether you are providing good jobs. Use guided questioning to determine whether the jobs you manage are sufficiently comfortable and engaging.
- Identify potential improvements and make changes, recognising that creating good jobs is an aspirational goal to keep working toward.
- Identify where skills need to be developed to help workers cope with unavoidable aspects of jobs that are unpleasant or uncomfortable.
- Communicate effectively to senior management and workers about what can be realistically achieved toward providing good jobs.

#### Workers ... [>>go](#)

- Participate in open communication about how to make good jobs.
- Question line managers when the process of providing good jobs is not occurring.
- Respect and support your colleagues.

## Senior Management Action 1. Initiate the process and be proactive about providing good jobs

Good jobs involve a **combination** of features so there is no 'silver bullet'. The best approach is to use a combination of actions embedded in a continuous process that self-improves. Senior management input is needed to kick-start this.

**TIP:** Some actions are directed at improving workers skills and some are directed at changing the tasks people do and how people interact or work together. Often it's just small improvements in a few places that can do the trick. You definitely won't need to tear up your business model.

You need to let your workforce know the organisation is committed to providing them with the best jobs you reasonably can. You should emphasise these aspirations. Try doing things like putting up posters stating what good jobs are like and what the organisation is doing about it.

Keep an eye on the atmosphere in your organisation: unusually high levels of grievances, sickness absence or lateness, as well as any drop in productivity, are signs that you may not be providing good jobs.

### To Do List for Senior Managers

- Ensure the **health<-->work** agenda is clearly identified in the values held by the organisation
- Identify trends across the company or organisation (e.g. using absence reports)
- Optimise responsiveness to common health problems across the organisation, by line managers, and departments such as human resources and occupational health (when it is available)
- Ensure procedural justice
- Establish and maintain effective policies and good communication practices about health problems
- Involve the workforce

**CHECK:** Have you made it clear to everyone that you are committed to providing good jobs?

## Senior Management Action 2. Incorporate the good jobs aspiration into line manager training and support

Make sure the ability to [determine whether good jobs are being provided](#) is part of line manager training. Managers should communicate closely with line managers and the workforce, to offer support when it is wanted and ensure all are treated fairly. This goes well beyond offering moral support and encouragement, and includes practical things like offering advice on how to complete tricky work tasks, finding out about skills development opportunities.

**TIP:** Evaluate the amount and quality of line manager support across the organisation and in specific departments.

**CHECK:** Can people across the organisation cope with the approaches to providing good jobs? Is additional training and support required?

## Senior Management Action 3. Ensure everyone in the workplace contributes to the good jobs approach

By now you should realise that providing good jobs is not merely a 'tick the box exercise'. You can't simply say '**I've done that**'. What you can do is to ensure that you have established the right milieu for the [work<-->health](#) culture and that you have a **process** that ensures everyone in the workplace embraces and contributes to the good jobs initiative.

What might stop us making this solution work and how do we overcome these obstacles? This might mean developing contingencies to get round some obstacles, or it might mean consulting with relevant stakeholders to ensure smooth implementation.

**TIP:** To make this process work properly it may be necessary to be creative about involving HRM, external consultants, HSE, or trade union representatives.

**CHECK:** What action has been identified to make the jobs good right across the organisation?

## Senior Management Action 4. Review regularly and seek to improve

The overall goal of reducing common health problems, and minimising their impact, needs to be regularly monitored and reviewed.

**TIP:** Identify the key success factors, such as better working practices, improved productivity, development of key skills, improved communications practices. Keep an eye out for unintended consequences, e.g. making the jobs good in one area is having adverse effects on other organisational systems.

Three questions for senior managers to consider

1. Is the good jobs initiative responsive to the needs of workers and the nature of the work?
2. Is the good jobs initiative acceptable to workers, line managers and others who may be affected by any changes? Note, other people may need to be consulted.
3. Is the good jobs initiative worth investing in, and has it given a return on investment?

**CHECK:** What are the key steps in taking this approach and when should they occur? When do we have interim reviews to check progress and deal with any difficulties in implementing actions? When do we have a comprehensive review of the approach?

Senior managers are **also** line managers and workers. This means the sections below also apply to **all** senior managers.

## Line Manager Action 1. Find out whether you are providing good jobs.

Having a good job is about **this** job, not the general idea of 'good work'.

A good job is where your people say things like '*I'm happy with my job*' or 'I love my job and I like doing it here'. It's quite possible for people to like their job but not their colleagues or workplace. It is also possible to like the people and workplace but dislike the job. The trick to making good jobs is to ensure your colleagues find both aspects agreeable – maybe not perfect but acceptable and satisfying.

**Tip:** One simple question can tell you if someone finds their job satisfying – if they are satisfied (happy), you can take it that they like their job and the place they work.

ASK: '*How satisfied are you with your job in general?*'

1=extremely dissatisfied 2=quite dissatisfied 3=neither satisfied nor dissatisfied 4=quite satisfied 5=extremely satisfied

**In making good jobs you should find that what you get back is more than you put in!**

**Check:** Are you providing good jobs?

How do you find out if you are providing good jobs? You could start by simply asking yourself, your workforce, and managers a few simple questions.

ASK: '*Thinking about your work and work conditions overall, would you say you have a good job?*'

If they say 'no', or things like 'work could be better', or 'it's alright', you need to find out why. Use these follow-up questions:

- What are work demands and work conditions really like here?
- How good are the opportunities and support to use and develop skills here?
- Are line managers effective and supportive here?
- Can people cope when problems occur at work?
- Do we try to make it interesting for people who work here?
- Can workers help themselves to make their jobs better here?
- Have we succeeded in avoiding an '*us and them*' culture?

Then ASK people these two questions:

*What could the workplace reasonably do to make your job better?*

*How can the workplace help you to make your job better?*

Larger organisations may want [more detailed information](#) about what their workers in various departments think about their jobs.

## Line Manager Action 2. Identify steps toward good jobs and make the changes

You need to find out more than whether you are providing good jobs. You also need to identify **areas that could be improved** and **ways to make these changes happen**.

Good jobs come from good management. This means your role as a line manager is pivotal - at all levels of the organisation or company, from bottom to the top.

Remember, your goal is to help people to be more resilient so they can cope at work with common health problems and minor injuries. By improving the quality of jobs you will get less sickness absence.

Because the variety of jobs, workers, and organisations is huge there is no simple formula for working out what will make jobs more agreeable and satisfying. The best thing to do is to go through a checklist of effective interventions and select the ones that fit.

The types of effective interventions can be targeted at the whole organisation, a subset (e.g. a department or a team), and to some extent to individual workers. It's important to get the 'big picture' right, so let's start with interventions for the whole company and then go from there.

### CHECKLIST: Effective Interventions Across an Organisation or Company

#### Essential interventions to consider:

- Job design and redesign – can you enhance job enrichment, job enlargement, developed decision making?
- Workload reallocation - can you use inter-departmental meetings to improve workload distribution?
- Establish support groups - for example, problem-solving circles
- Communications and briefing - do you have good communication and briefing channels, and is there a simple method for workers to get their ideas heard?
- Performance feedback - is this done in a constructive way that focuses on improvement?

#### Even better interventions to consider:

- Semi-autonomous work teams - can you devolve some responsibility and decision-making?
- Professional development and retraining support - do you support opportunities to use and develop skills?
- Coaching and mentoring - do you encourage broadening of skills transfer from more experienced staff to others?
- Team functioning - do you encourage and support teamwork?

#### Other interventions worth considering:

- Problem-solving support - do you offer opportunities for line managers and workers to improve their problem-solving abilities? Can these be applied to making good jobs?
- Flexible working - can you offer things like family-friendly policies, or allow workers some flexibility to cope with life problems outside of work?
- Social networking - do you encourage social interaction, building trust and working relationships with mutual respect?
- Negotiation skills - do you support learning ways to negotiate positively?
- Assertiveness skills - do you support positive communication based on the ability to be assertive?
- Line manager support and training - do you offer communication skills, flexible management of resources?
- Feedback to line managers - do you encourage line managers to find out what colleagues think of their performance, and to improve what they do?
- Creating realistic expectations - does the recruitment and induction process give people a realistic picture of their job tasks and what is expected of them?

### CHECKLIST: Effective Interventions for Teams and Departments

#### Essential interventions to consider:

- Workload reallocation - can you use team or departmental meetings to improve workload distribution or conduct reorganisations?
- Work and task design - are there better workflows or ways of doing things that are more efficient?
- Coping skills training - do you encourage and support improved ways of coping with jobs and tasks? Do you help people deal with specific problems, e.g. coping with 'difficult' or angry customers?
- Performance feedback - is this done in a constructive way that focuses on improvement?

#### Even better interventions to consider:

- Problem-solving support - do you offer opportunities for staff to improve their problem-solving abilities, and to increase the likelihood they will persevere when faced with problems at work?
- Positive attitude - do you strive to make things better rather than focusing on difficulties to improving things?
- Negotiation skills - do you support learning ways to negotiate positively?
- Assertiveness skills - do you support positive communication based on the ability to be assertive? Can this be applied to making good jobs?
- Semi-autonomous work teams - can you devolve some responsibility and decision-making?

#### Other interventions worth considering:

- Social networking - do you encourage social interaction, building trust and working relationships with mutual respect?
- Team functioning - do you encourage and support teamwork and building effective teams?
- Worker involvement - do you encourage workers to understand they have a role to play in developing good jobs?

### CHECKLIST: Effective Interventions Small Groups and Individual Workers

#### Essential interventions to consider:



- Coping skills training - do you encourage and support improved ways of coping with jobs and tasks? Do you help people deal with specific problems, e.g. coping with 'difficult' or angry customers?

### Even better interventions to consider:

- Positive attitude - do you strive to make things better rather than focusing on difficulties to improving things? Can people cope when problems occur?
- Negotiation skills - do people negotiate constructively and positively?
- Assertiveness skills - can people cope when problems occur? Can workers help themselves to make their work more satisfying, comfortable or agreeable?

### Other interventions worth considering:

- Constructive feedback - is it encouraged in both directions, often called '360 degree feedback'?
- Using transferable skills - when it is needed, can people identify transferable skill and retraining opportunities?

**TIP:** Working out what will improve the quality of jobs is only the first step. You need to make it happen by choosing actions that are **effective**.

To...	... these actions can be effective
Optimise work demands and work conditions	<ul style="list-style-type: none"> <li>• Ensure obvious physical risks are controlled</li> <li>• Re-allocate tasks</li> <li>• Widen scope of work that is too easy</li> <li>• Clarifying work roles</li> <li>• Workload planning</li> </ul>
Optimise opportunities and support to use and develop skills	<ul style="list-style-type: none"> <li>• Review and clarify career and development paths</li> <li>• Identify special projects for people to develop and use new skills</li> <li>• Different training activities</li> <li>• Mentoring</li> </ul>
Improve line management competencies	<ul style="list-style-type: none"> <li>• Communities of practice for line managers</li> <li>• Line manager training, coaching or mentoring</li> <li>• Providing better information and support to line managers</li> </ul>
Improve people's ability to cope with problems at work	<ul style="list-style-type: none"> <li>• Problem-solving skills training, e.g. using problem-solving circles and knowledge exchange meetings</li> <li>• Mentoring</li> <li>• Networking events</li> <li>• Team-building</li> <li>• Encourage <a href="#">positive thinking</a> so people can solve problems if they give it a go and are supported</li> </ul>
Make things more interesting for people	<ul style="list-style-type: none"> <li>• Interdependent team working</li> <li>• Job enlargement</li> <li>• Special project work</li> <li>• Rotating round different tasks</li> </ul>
Help workers make their work better here	<ul style="list-style-type: none"> <li>• Flexible working practices and hours</li> <li>• Training in negotiation and communication</li> <li>• Regular team meetings to discuss work</li> <li>• Devolved decision making to groups and individuals</li> </ul>
Show you value your staff	<ul style="list-style-type: none"> <li>• Saying 'well done' and 'thank you'</li> <li>• Giving feedback on success</li> </ul>

**CHECK:** Have appropriate actions been identified and implemented? Does everyone know who is doing what and when?

Use this checklist to help:

- What actions have been identified to make the job more agreeable, and satisfying?
- Are these **responsive** to the needs of workers, **acceptable** to all involved, and **worth** investing time in?
- What enablers? How can these be encouraged, promoted and made use?
- What obstacles? How can these be effectively overcome or managed?
- Who needs to be involved?
- Who is doing what, and when?
- How will you know you have achieved success?
- When does it need reviewing?

Remember, appropriate actions are implemented by line managers **and** workers. This means, to be effective, line managers need to **include workers** in the process of identifying how to make good jobs.

## Line Manager Action 3. Identify coping skills to be developed for unavoidable aspects of jobs

The concept of good jobs includes building resilience to cope with the unavoidable aspects of work that may seem unpleasant or uncomfortable.

This is important because some aspects of our jobs are unpleasant or uncomfortable and this cannot be avoided. Different people find different things easy or difficult to contend with. Individuals find some aspects of work harder or easier to tolerate on different days, or at different times in the same day.

Problems do occur at work – such as difficult customers, equipment breaking or conflicts with managers or other work teams. For good jobs, workers need to be able to cope with problems when they occur. This can mean having the skills and ability to take decisions to solve problems in a timely manner and have support from others to help solve problems in a timely manner if needed. It can also mean the discretion to take short breaks from particularly demanding tasks or problems in order to 'recharge the batteries' and look at problems anew.

Good jobs help people to be more 'resilient'. This means the structure of the job and the way it's organised helps people deal with unavoidable discomfort and irritation.

The 'comfortableness' of a job is likely to influence a person's sense of job satisfaction. It follows that highly satisfied workers are more resilient in coping with less comfortable aspects.

Some aspects of our psychology can help provide a 'buffer' against developing common health problems, including mental health ones:

- personal resilience - our strategy for surviving and thriving in the face of workplace adversity. It includes sociability, confidence, optimism, hope, social support, problem-solving ability, flexibility in goal setting, and our ability to mobilise resources
- being psychologically flexible - how a person adapts to fluctuating situations and demands, reconfigures their mental resources, shifts perspectives, and balances competing needs
- positively reframing everyday stressors - trying to see things in a more positive light, looking for something good in what happened, accepting the situation, and ability to use humour to cope

**TIP:** The trick is to give people both the opportunity, and the support, to solve their own problems

**CHECK:** Are you helping people become more resilient at work?

## Line Manager Action 4. Communicate effectively about what can be realistically achieved

Remember, it's the simple things that make for good jobs, starting with open communication across the organisation, and treating workers and co-workers with respect. Workers need to feel they have a say in how things are run, and that management will listen. They need to feel appreciated and part of a team with a common goal.

Good jobs are fair jobs. Good jobs repel an 'us and them' culture.

### Line Managers Action Plan for Good Jobs

Line managers are **also** workers. This means the section below also applies to **all** line managers.

## Worker Action 1. Participate in open communication about how to make good jobs

Everyone should participate in the discussion about how to make jobs good, including workers.

Workers can discuss what will work for them with their line manager. This helps to foster a can-do atmosphere trying to make things better rather than focusing on difficulties to improving things. It helps if everyone knows that the chances of experiencing common health problems can be reduced by working together to create good jobs.

## Worker Action 2. Question line managers when the process of providing good jobs is not occurring

If there is no process for making good jobs you can ask your line manager why not. There is a role for everyone in having a positive attitude to work and health. Instilling this positive attitude to minor health problems is important – but it is also important to **constructively** support people to get that attitude.

## Worker Action 3. Respect and support your colleagues

Giving respect and support to your colleagues has a surprisingly large effect on everyone. Health and wellbeing at work is a **collaborative** affair. You can't do it by yourself, and you can't wait for someone to do it for you.

Seek out positive support from others and offer support to your colleagues. Wherever possible try to build optimism by being round people who see the positives and the things that can be done can help.

### Workers Action Plan for Good Jobs

**Stephen's story:** *I run a small manufacturing firm on a small town industrial estate. About 60 of us work here. You wouldn't really notice us if you drove by. We didn't set out to make jobs better, and health and job satisfaction were not top of our agenda. What we needed to do was survive. We needed to innovate – our sector was changing and we couldn't afford to change our 1960s machinery – so we needed to do something else, something different from our competitors. And that meant people had to work differently. But we suffered from low motivation, low confidence and there were a lot of grumbles. First off, I tried different incentives such as team awards and lunch vouchers to improve motivation. Turns out people weren't motivated because they weren't happy at work and they weren't confident. One of the biggest issues was poor relationships on the shop floor. Hand-over from the night shift was a tense affair most mornings. The night shift weren't working well and they weren't that experienced. If a problem occurred, they simply stopped working because they didn't know what to do. So the day shift came and the place was a mess and they needed to catch up. The more experienced staff worked the day shift, and they were the ones that knew how to fix the machines. So I got a couple of the experienced guys to put together a poster of how to fix the most common problems and then*

*the night staff tested that out. It certainly eased the tension between the day shift and night shift, because the night guys felt they were getting a bit of support. They were learning how to fix problems and the day shift guys didn't have to play catch up for the night shift any longer. It was also a good way of getting some of the experienced guys to use their skills in a different way and to pass those skills on. What a difference it made. So I felt happy to tackle confidence next. I wanted to get people to develop and use their skills. For some this meant training, even basic stuff like IT training or GCSE maths. We paid for people to go the college and gave them time off work to do so – it didn't cost us much. I also led problem-solving circles every Monday. That was a good way of getting sales and production staff to work on issues together, but I felt people could take a bit more initiative. Then a big surprise happened. One of our suppliers pointed out that he'd noticed that our people were helping each other to solve problems. This is what I wanted, but I didn't see it happening because they'd done it off their own backs and hadn't waited for me to re-organise people into teams. From that point on it was just a case of clarifying a few role descriptions and me supporting people to solve their own problems. The combination of these things really helped. We're a lot more innovative, and we've shifted our business model completely. The firm is on a very solid footing now. Everyone is more confident, more motivated, and a lot happier and healthier at work – including me.*

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[\*\*SUPPORTIVE WORKPLACE\*\*](#)

# Health <--> Work

## the toolbox for managing common health problems at the workplace

<a href="#">Toolbox Home</a>	<a href="#">Knowledge</a>	<a href="#">Good Jobs</a>	<a href="#">Supportive Workplaces</a>	<a href="#">Resource Library</a>
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### Supportive Workplaces - Overview

Even though you are providing good jobs, some of your colleagues or workforce are going to experience common health problems. It's inevitable. Most often this will be because of factors outside your control. Yet their problems may well be work-relevant: some will struggle to stay at work, and some of them will need time off. The notion of a supportive workplace is **recovering while working**.

The trick for you as a colleague, line manager or employer is twofold: (1) recognise those who are struggling with health problems – you want to help them stay at work; (2) quickly spot when someone goes off sick – you need to help them with an early return to work. This is good for them and good for the organisation, but it needs to be well managed. Of course, it is equally important that every worker take personal responsibility for their health.

### 5 Things You Need to Know About Supportive Workplaces

- **We all get health complaints: mostly they are not caused by work**, but work may become difficult in the face of the symptoms – i.e. the health complaint is work-relevant. Sometimes people can cope, sometimes they can't – it depends on the balance between person, the work and the health complaint. Supporting people with health complaints at work is about getting that balance right. It is not enough to just rely on doctors to help your colleague cope with work.
- **The reason some people have difficulty coping is mostly not that they have a more serious condition or injury, it's because they face obstacles** – things that make it difficult for them to cope. The obstacles fall into 3 categories: the **person** [beliefs and behaviours]; the **workplace** [job demands, lack of accommodation], the **context** [process delays, unhelpful policies]. A supportive workplace is one that helps this person, at this time, with this complaint – it is about recognising and overcoming obstacles.
- **You need to be able to do 3 things: identify** obstacles, develop a **plan** to overcome them, and take the appropriate **action**. It's not that complicated, more a matter of common sense. But, it helps if you have the right culture and policies. You need a framework for who does what and when, so good communication is crucial.
- **It is vital to act early, before the obstacles become entrenched**. Someone needs to act as a case coordinator or buddy – it could be the line manager. They will work with their colleague to figure out why they might be struggling - identify the obstacles and make a plan to tackle them. You must have a policy for who acts as the buddy – everyone must know who it is and what they can do.
- **Action points:** commit to a supportive workplace; provide information and advice (the knowledge); foster early reporting of work-relevant health problems; adopt a can-do approach; engage the person in identifying obstacles and making the work plan; assess the job and offer modified work if needed (just until they are back to normal); contact the doctor if necessary (use a [confidentiality waiver](#)); allow graduated return to work plans; keep in touch - monitor progress and revise the plan if there are any setbacks.

### Actions

Line managers and workers need to be able to:

1. Recognise when a colleague is struggling to cope with symptoms or injury
2. Respond to anyone who reports symptoms or is off work
3. Quickly and easily evaluate someone's work ability (i.e. how they feel they are coping with work and health)
4. Identify any obstacles to staying at work or getting back to work
5. Manage workplace obstacles
6. Arrange reasonable modifications to the job for a period of time (not for ever)
7. Help people build up gradually as they recover

**Kamala's story:** *I'm a line manager in a small company. We can't afford formal occ. health cover, but we can still help our colleagues cope with health at work. The senior management took some advice and introduced a simple protocol for supporting colleagues with work-relevant health complaints. The goal is to help them stay at work or get back quickly if they have to take time off. It's my job to put it all into action. Basically, I coordinate the process – I act as a case manager, a buddy if you like. I get informed as soon as a colleague is struggling or off work. We talk it through and look for the obstacles. We work out what my colleague can do, with a little help. If necessary, I liaise with the doctor or therapist (we use a simple confidentiality waiver) to help me figure out how best to*

*help my colleague with work tasks whilst they are getting treatment. I devise the Plan and timeline with my colleague and we sort out any temporary work modifications as a team. I use information leaflets to help explain things and bust the myths. I keep an eye on them just in case there are any setbacks. It's all common sense really - it works well!*

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# Health <--> Work

## the toolbox for managing common health problems at the workplace

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### Supportive Workplaces - In Detail

Even though you are providing good jobs, some of your colleagues or workforce are going to experience common health problems. It's inevitable. Most often this will be because of factors outside your control. Some will struggle to stay at work, and some of them will need time off. The notion of a supportive workplace is **recovering while working**.

The trick for you as a colleague, line manager or employer is twofold: (1) recognise those who are struggling with health problems – you want to help them stay at work; (2) quickly spot when someone goes off sick – you need to help them with an early return to work. This is good for them and good for the organisation, but it needs to be well managed. Of course, it is equally important that every worker take personal responsibility for their health.

If the workplace does not support its workforce, the slide to disaster is inevitable.



### 5 Things You Need to Know About Supportive Workplaces

- **We all get health complaints: mostly they are not caused by work**, but work may become difficult in the face of the symptoms – i.e. the health complaint is work-relevant. Sometimes people can cope, sometimes they can't – it depends on the balance between person, the work and the health complaint. Supporting people with health complaints at work is about getting that balance right. It is not enough to just rely on doctors to help your colleague cope with work.
- **The reason some people have difficulty coping is mostly not that they have a more serious condition or injury, it's because they face obstacles** – things that make it difficult for them to cope. The obstacles fall into 3 categories: the **person** [beliefs and behaviours]; the **workplace** [job demands, lack of accommodation], the **context** [process delays, unhelpful policies]. A supportive workplace is one that helps this person, at this time, with this complaint – it is about recognising and overcoming obstacles.
- **You need to be able to do 3 things: identify** obstacles, develop a **plan** to overcome them, and take the appropriate **action**. It's not that complicated, more a matter of common sense. But, it helps if you have the right culture and policies. You need a framework for who does what and when, so good communication is crucial.
- **It is vital to act early, before the obstacles become entrenched**. Someone needs to act as a case coordinator or buddy – it could be the line manager. They will work with their colleague to figure out why they might be struggling - identify the obstacles and make a plan to tackle them. You must have a policy for who acts as the buddy – everyone must know who it is and what they can do.
- **Action points:** commit to a supportive workplace; provide information and advice (the knowledge); foster early reporting of work-relevant health problems; adopt a can-do approach; engage the person in identifying obstacles and making the work plan; assess the job and offer modified work if needed (just until they are back to normal); contact the doctor if necessary (use a [confidentiality waiver](#)); allow graduated return to work plans; keep in touch - monitor progress and revise the plan if there are any setbacks.

## FACT: People can be helped to stay at, and return to, work

The pivotal thing is to provide a supportive workplace. There are seven key principles \*\*:

**FIRST PRINCIPLE:** The workplace needs to have a strong commitment to health and safety - demonstrated by behaviours of all workplace parties. It's not just what we say to ourselves and others, it's what we do. As the old saying goes "actions speak louder than words". This is a collaborative issue. Support is needed at senior management level, and from all the employees. This means workers, and their representatives, also need to support inclusion of stay at work and return to work policies. Importantly, it's not just a matter of management looking after workers - people need to take some personal responsibility for what happens to them. Everyone should aspire to being a copier rather than an avoider, and must engage with those who are helping them deal with their health at work.

**SECOND PRINCIPLE:** Employers need to offer modified work, i.e. an accommodating workplace - early and safely. This means providing appropriate modified work, and taking care to ensure there is not an awkward fit for the worker and others. Usually, this can simply be worked out between worker and manager. Simple ergonomic principles apply. Only if there is difficulty coordinating staying at or getting back to work is there any need to consult an ergonomist or health and safety professional.

**THIRD PRINCIPLE:** Case coordinators need to ensure the work plan supports the worker without disadvantaging co-workers and line managers - they may need training in case management skills (in-house or from external suppliers). These coordinators need to ensure the plan supports the worker without disadvantaging co-workers and line managers. Planning how to keep someone at work, or ease them back into the workplace, involves more than just matching the sick or injured worker's abilities to job tasks. It can be seen as a 'socially fragile process' where line managers and co-workers can be thrust into new relationships and routines. If it is not properly managed, this may involve resentment instead of cooperation. Here are good examples of potential problems: (1) the sick or injured worker may have to deal with co-workers who resent having to take over some of their work and therefore feel that the worker has managed to get an 'easier' job; and (2) line managers may be expected to get the job done and fulfil production rates in spite of accommodating a sick or injured worker, and can't see a way to offer the required accommodation. Workplaces that treat sick or injured workers as individuals who anticipate in the arrangements can avoid these pitfalls.

**FOURTH PRINCIPLE:** Line managers need to be comfortable about how to prevent extended sickness absence and work disability, and should be involved in developing plans for Stay at Work and Return to Work. They may need training in case management skills (in-house or from external suppliers). The minimum is to incorporate specific topics into safety training for line managers: (1) how to be positive and empathetic in early contacts with workers; (2) how to arrange modified work; and (3) how to follow-up and problem solve on a regular basis.

**FIFTH PRINCIPLE:** Employers and/or line managers should make early and considerate contact with the absent worker. This appears to be a core component of the process and should be done in a positive way. This means focusing on concern for the worker's well-being, and avoiding issues such as causation or blame.

**SIXTH PRINCIPLE:** Someone in the company/organisation should be given clear responsibility to coordinate stay at work and return to work to make sure it happens - a designated case coordinator or buddy. Alternatively, the coordination role can be performed by someone external, such as a professional case manager with a direct line of communication to the workplace. Either way, simply having good intentions is not enough. It's important that communications do not break down, and that key actions are not overlooked or forgotten - the case coordinator needs to ensure everyone involved in the work plan knows what is expected of them and when.

**SEVENTH PRINCIPLE:** Employers and healthcare providers (such as GP's, physiotherapists, and other practitioners) need to communicate about workplace demands. A key part of this principle is implementing the advice on a [fit note](#). Clearly it is important the 'left and right hand know what each other is doing'. Ideally the worker needs to participate in the communication between employers and healthcare providers. Obtaining the worker's consent is important - simple [confidentiality waivers](#) are useful.

\*\* adapted from Institute for Work & Health. *Seven 'principles' for successful return to work*. Institute for Work & Health, March 2007

## FACT: The workplace is very important

Work can be part of the recovery process. It provides all of us with important protective factors for our health, such as: routine, structure to day, social relationships, mental stimulus, self-esteem, activity, and a sense of wellbeing.

To achieve this we need to avoid the idea that work is a 'risk' and (potentially) harmful to physical and mental health. This is important because it leads to advice to stay off work, undue sick certification, over-cautious risk assessments, and the desire to somehow 'protect' the person from work. Certainly some work circumstances are dangerous and undesirable, but most work is beneficial for most people.

We need to shift the culture and **emphasise** that work is healthy, therapeutic and the best form of rehabilitation (while recognising that some work can be a hazard). This can be achieved by ensuring everyone gets advice and support to remain in, and return to, work (that is safe and healthy, described in the [good jobs](#) section).

**The Challenge:** *What can you do to help change the culture to one that values work as an important **outcome**, and avoids the fallacy of thinking that time off work is always in best interest of the person?*

### Avoiding the Slide to Disaster

If you really wanted to make sure that your employees do not come back to work you could

- Leave it all up to healthcare
- Pay no attention to people who are struggling with a health problem
- Do nothing and make no contact with absent workers
- Refuse to offer workplace modifications

**Ask Yourself:** *What will this failure cost you in time and hassle, and what will it cost your company/organisation? Remember this will include recruitment and retraining costs for when you have to replace someone who never returns to work, and overtime costs, agency costs or loss of morale for asking people do more work to cover for the absent colleague over an extended period. Also, don't forget the poor reputation that organisations with high absence and workforce turnover attract.*

The contribution of the workplace is vital. You may be surprised to learn that when it comes to helping people stay at, and return to, work the most powerful

influences comes from (in this order)

1. The **person** with the health complaint, **then**
2. The **line manager** (and the level of support and company policy he/she has to operate under), and **then**
3. Healthcare providers (including doctors, physiotherapists, etc.)

This means that one of the most important things any employer can do is to provide a supportive workplace that enables workers to recover from common health problems while working.

## Supportive Workplaces

The section [Supportive Workplace What To Do](#) outlines the practical techniques needed and provides access to the various tools that you will find useful. This part of the toolbox gives you the full understanding of what needs to be done to provide a supportive workplace, why, when, and to whom.

## We All Get Health Complaints, Only Some are Work-Relevant

### Principle

When people have health or injury problems the workplace plays an important role in their recovery. Whenever possible we need to help people stay at work, even part time. This maintains their work ability, their skills and daily routine. Most importantly it helps them to stay active and to build resilience and tolerance. If a worker does take sick leave for even a short time we need to help them start back at work as soon as possible. Again, this may be part-time to begin with, building back up to full-time.

### Quick Facts

We all get symptoms of common health problems at times. Some of us need to take a short time off work, and others don't. Some need to do things a bit differently at work for a while, others cope fine. It depends on the balance between person, the work and the health complaint. Supporting people with health complaints at work is about getting that balance right. It is not enough to just rely on doctors to help your colleague cope with work.

The longer someone stays away from work the harder it usually is to get back to work. Some never do - this disaster needs to be prevented.

### Practical Implications

- There are two crucial things that every line manager needs to know how to do:
  1. Provide reasonable adjustments to the job for a period of time (not for ever). This allows people with health and injury problems the opportunity to stay at work at least part-time, or to begin returning to work. As a line manager you can make a great difference by making it possible for your employee to stay on the job somehow, or to get back quickly and safely. As a worker you can make a great difference by helping to work out what will make this possible and sticking to the plan: it's always in your interest.
  2. Let people build up gradually as they recover. As humans we are not really like machines that are either on or off. Sometimes we need to be able to work back up 'through the gears'. This allows us to adapt to our symptoms, to increase our tolerance, and to regain our natural resilience. Participating in our usual activities is healthy (including work), even if we need to do some of them more slowly or in a different way for a few days or weeks as we recover.

## The Main Reason People are Unable to Stay Active and Working is Because They Face Obstacles

### Principle

It is a mistake to assume that the reason people don't stay at or return to work is simply because they have more serious illness or more severe injuries. The more important factors influencing work as an outcome are psychosocial. This refers to the factors that contribute to the **behaviour** of going to work.

There are factors that **increase** the chance someone can and will stay at or return to work. These positive influences are enablers or facilitators. We need to look for these and support them whenever possible.

Then there are factors that **reduce** the chance of staying at or returning to work. These are **obstacles**. We need to look for these and find ways to help people overcome them.

### Quick Facts

The reason people with common health problems become inactive and stay off work is mainly due to psychosocial obstacles.

The easiest way to look for obstacles is to use the [Person, Workplace, Context](#) framework.

### Practical Implications

- We all need some key skills as line managers and workers:
  - Identify** - identify anyone at work who is struggling to cope with symptoms of common health problems or minor injuries; identify anyone with a [fit note](#); identify anyone who is off work (i.e. reduced hours, or stopped altogether). There are two main ways problems at work can be identified: (1) The individual worker reports problems (e.g. to line manager, OH, or HR), takes time off work or seeks healthcare; or (2) Either the line manager, or a co-worker, notices changes in performance and behaviour. This means the worker may say something to you or other, or you or others may notice something. There are [signs](#) you can look and listen for.
  - Work Ability** - check people's work ability - how they feel they are coping with work and health.
  - Obstacles** - identify any obstacles to staying at work or getting back to work.
  - Plan and Do** - plan how to manage those obstacles, and put it into practice.
- The section [Supportive Workplace What To Do](#) describes each of these in detail.



## What's in a Word? 'Barriers' versus 'Obstacles'

The term 'barrier' is in common use to describe things that make it difficult or impossible to make progress in all sorts of areas of life. We want to avoid inadvertently encouraging people to feel it is impossible or too difficult to tackle a problem. That is, we don't want you to give up before trying! Barriers are deliberately constructed to stop access; obstacles are things that just happen to be in the way. The main reason we prefer the term 'obstacle' is because it does not give the impression of being solid and immovable. It may help to think of life like an 'obstacle course'. There are some obstacles that you can climb over or under, but others you have to find a way to get around. None of them should be thought of as impenetrable or unassailable. The principle is simple: with the right level of support, encouragement, and problem-solving it is possible for all of us to find ways to tackle the obstacles that get in the way of being active and working.

## You Need to be Able to Identify and Tackle Obstacles

### Principle

The most important thing for success is to identify obstacles to staying active and working, and plan to overcome these. Remember there are two types of obstacles: (1) modifiable – these are like hurdles to be overcome; (2) immovable – these are like roadblocks to be sidestepped. The three places to look for **obstacles** to staying active and working are the **Person**, their **Workplace**, and the **Context** in which they function.

### Quick Facts

The reason why some people take lots of time off work is usually **not** because they have a more serious health condition or more severe injury. It's not about what has happened to them. It's about why they don't recover in the normal way – and that is because they face obstacles to recovery and participation. Many of these are in the workplace.

Stay at Work and Return to Work doesn't just happen – **action is needed!**

- It is not helpful to rely on healthcare alone - it is not good enough to start thinking about work after healthcare has finished or failed.
- The workplace must be involved from day 1 to help people to continue working whilst recovering.

The flip-side of obstacles is things that act as positive influences on work outcomes: having respect for one's employer; feeling satisfied with your job; understanding your health problem; and, experiencing support or incentives from your work colleagues.

### Practical Implications

- **Identify obstacles** to staying active and working, that way you can plan to overcome them. There are two types of obstacles, those that are modifiable and those that are not. Avoid falling into the trap of assuming that immovable obstacles cannot be navigated around.
- The three places to look for obstacles to staying active and working are the Person, their Workplace, and the Context in which they function.
  - Person - thoughts, feelings, and behaviours
  - Workplace - workers, line managers
  - Context - family members, co-workers, company policies, etc.
- **Tackle obstacles** to staying active and working using the Identify, Plan, Action framework.

**Andy's predicament:** *It all started when I woke up with severe neck pain. The doc gave me tablets and told me to rest and stay off work - but I didn't get any better. I was sent for x-rays, which showed degeneration. Then I had to wait around to get treatment. The therapist said it was my job that caused it, so I shouldn't go back till I was fully fit. By that stage I started to get really worried - and feeling down. The family won't let me do anything, so I don't get out much. The people at work haven't been in touch, so I don't know what's happening about me getting back. People are saying I should put in a claim. This whole saga has just taken over my life - all I wanted was a bit of help...*

## Identify Problems Early, and Respond Rapidly

### Principle

Some people in every workplace will inevitably experience common health problems, even though good jobs reduce their frequency. The sooner they are identified the faster they can be dealt with and this reduces the impact on the workplace and helps maintain productivity. Identify anyone at work who is struggling to cope with symptoms of common health complaints or minor injuries. Identify anyone who is off work (i.e. reduced hours, or stopped altogether).

The key thing then is to respond, and to do so rapidly. Do this by:

- Identifying the obstacles to being active and working
- Providing appropriate workplace accommodations and modifications

This is the very core of what it means to have a **Supportive Workplace**.

### Quick Facts

When someone is ill or injured they **can** be helped to stay at or return to work, either part-time or full-time.

Delays result in worse outcomes.

### Practical Implications

- Always start with the work goal "Same job, Same workplace, and Full-time" unless there is a very specific reason not to (excluding symptoms of the health complaint or injury).
- This often requires temporary modification to their job, and this is what is called an 'accommodating workplace'.
- The option of changing the work goal (e.g. to a different job, or the same one with permanent modifications) is always available later. However, it should not be the first option and is not the best option for the worker.

## Actions

Line managers and workers need to be able to:

1. Recognise when a colleague is struggling to cope with symptoms or injury
2. Respond to anyone who reports symptoms or is off work
3. Quickly and easily evaluate someone's work ability (i.e. how they feel they are coping with work and health)
4. Identify any obstacles to staying at work or getting back to work
5. Manage workplace obstacles
6. Arrange reasonable modifications to the job for a period of time (not for ever)
7. Help people build up gradually as they recover

go to

[SUPPORTIVE WORKPLACE WHAT TO DO](#)

[SUPPORTIVE WORKPLACE OVERVIEW](#)

[KNOWLEDGE](#)

[GOOD JOBS](#)

# Health <--> Work

## the toolbox for managing common health problems at the workplace

<a href="#">Toolbox Home</a>	<a href="#">Knowledge</a>	<a href="#">Good Jobs</a>	<a href="#">Supportive Workplaces</a>	<a href="#">Resource Library</a>
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## Supportive Workplaces - What to Do

### Actions

Line managers and workers need to be able to:

1. Recognise when a colleague is struggling to cope with symptoms or injury
2. Respond to anyone who reports symptoms or is off work
3. Quickly and easily evaluate someone's work ability (i.e. how they feel they are coping with work and health)
4. Identify any obstacles to staying at work or getting back to work
5. Manage workplace obstacles
6. Arrange reasonable modifications to the job for a period of time (not for ever)
7. Help people build up gradually as they recover

### Before We Start

Remember the goal is to reduce detrimental effect of [common health problems](#) on the organisation and its workers. In addition to providing good jobs you can make it possible for people to recover while they stay working by providing a supportive workplace.

This means the workplace can accommodate people with health problems. By providing temporary modifications you make it **possible** for anyone to be able to stay at work, or return to work if they do need to have a short time off.

If you don't provide a supportive workplace it's effectively a showstopper. Here's the thing to remember - **providing temporary modifications at work is far more effective than relying on healthcare alone**. When it comes to helping people to keep working **you** can make this possible. Doctors, physiotherapists and other types of clinicians cannot.

The main aspect of a supportive workplace is just that - it offers support when it's needed. Job modifications are simple adjustments to the work or work organisation. The idea is to make things easier for the ill or injured individual with work-relevant symptoms. Job modifications can make the difference between being at work and being off sick. They need to be reasonable and temporary:

- **Reasonable** so that they are only used when needed and work well for both the employer and the employee
- **Temporary** so they only last as long as needed

Some type of job modification is nearly always possible; it's just a matter of figuring out the best balance of what and for how long. That needs the manager and worker to talk about it!

Supportive workplaces offer a classic 'win-win' scenario:

- Employers and line managers benefit from reduced levels and duration of sickness absence
- Workers benefit from faster recovery and less long-term problems

Supportive workplaces allow people to recover safely and quickly as soon as possible.

### Action 1. Identify Anyone Struggling to Cope With Symptoms at Work

Some people in every workplace will inevitably experience common health problems, though good jobs reduce their frequency. The sooner they are identified the faster they can be dealt with and this reduces the impact on the workplace and helps maintain both health and productivity.

**Struggling** at work is something that is going to be identified by the worker themselves, or by another person seeing them. This means you should identify anyone at work who is struggling to cope with symptoms of common health complaints or minor injuries.

**TIP:** The most likely way you will recognise that you or someone else at work is struggling will be because their behaviour or productivity has **changed**.

We need to distinguish someone who is struggling to cope and has a work-relevant problem from the informal 'grumbles' about work that everyone has from time to time. You need to distinguish pay attention to the struggling worker from the grumbler.

Someone who says things like *'I don't like this job'* is probably just grumbling, or having a bad day. However, if there is an obvious change in their behaviour - moving and doing tasks in an awkward or uncomfortable way, or productivity drops - this may be a sign that the person is struggling.

For mental health issues and difficulties dealing with stress there is a more [detailed list of things to look out for](#). Again, the key thing is to notice changes that may indicate a work-relevant problem developing.

**CHECK:** Can line managers pick up signs of someone struggling at work? Do you know where to go for more information?

## Action 2. Identify Anyone Who is Reporting Problems or is Off Work

Everyone has an 'off-day' at work from time to time when we experience symptoms of a common health problem. Nearly everyone bounces back and life goes as before. So far, so good. Occasionally people struggle to return to their previous level of productive activity, or the symptoms seem to grumble on and their ability to cope decreases.

The reason why it is so important to identify these people is because **you** (together with that person) can do some simple things to **prevent** the problems becoming bigger and lasting longer. As you will learn the two key ways to do this are to tackle obstacles and help people rebuild their resilience.

This means, in addition to identifying people who appear to be struggling you need to identify anyone who **says** they are having difficulties, and anyone who is less productive or taking time off work.

**TIP:** Every workplace needs to have a simple and straightforward process to log reports of common health problems, and to promptly identify anyone who is off work (or doing reduced hours).

Aim to be able to do this within hours, not days. **Identify Problems Early and Respond Rapidly**

**CHECK:** Is there an effective process for knowing **as early as possible** when any worker is on reduced hours or is off work (and has a [fit note](#)).

## Action 3. Quickly and Easily Evaluate Someone's Work Ability

Work ability is a measure of how people feel they are coping with work and health. The simplest way to evaluate it is to focus on how they feel they are coping with their work and health. Yes, there is a difference between what someone 'can do' and what they 'will do'. But, what we want to do here is get an overall idea of whether the person believes they are able to do their work. Remember, if you believe you can't do something you probably won't do it.

**TIP:** You can help to prioritise your colleagues who are likely to be most in need of help, by asking a simple question about how they rate their work ability. Work ability is a measure of how people feel they are coping with work and health.

*"Assume that your work ability at its best has a value of 10 points. How many points would you give your current work ability?"*

**completely unable to work - 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - work ability at its best**

If your colleague scores 8 to 10, they will probably be able to stay at work (or return to work) with little help. If they score 3 to 7, you need to look for obstacles, devise a plan and start acting – without delay. If they score 0 to 3, they may need quite a lot of help, and you may need to consider getting professional advice. Repeat the question every week or so: your colleague's score should be improving – if it's not you need to re-evaluate the **obstacles**.

**CHECK:** Do line managers know how and when to use the work ability question?

## Action 4. Identify Obstacles Making it Difficult to Stay at Work or Get Back to Work

The most important thing for success is to identify obstacles to staying active and working, and plan to overcome these.

### Two Types of Obstacles

- Modifiable – these are like 'hurdles' to be overcome
- Immovable – these are like 'roadblocks' to be navigated around

### Three Sources of Obstacles

The three places to look for obstacles to staying active and working are the Person, their Workplace, and the Context in which they function.

**TIP:** Remember **Identify, Plan, Action** - **identify** any obstacles, **plan** how to overcome them, and put this into **action**.

### [Guide to Identifying Obstacles](#)

### The Obstacles Question

A good way for line managers to pinpoint obstacles is to ask this question: *"What three things about your health problem and your work are affecting your work ability – in other words, what's making it difficult to stay at work, or get back to work?"*

The answers will help point you to the obstacles that your colleague is struggling with. You should ask this after the work ability question. It will flag up the most important and immediate things that you'll need to deal with.

**If your colleague has scored 8 to 10 on the work ability question** (see above, in Action 3), you may not need to look any deeper for obstacles, but remember new obstacles can crop up, so keep an eye on their work ability. If they scored 3 to 7 you will need to check the wider range of [obstacles](#). If they scored 0 to 2, you should consider getting professional help in identifying the obstacles and developing the plan].

Managers and who are more experienced may want to use stem questions to develop a conversation to identify less obvious obstacles. This sequence of 6 basic questions can reveal person, workplace and context obstacles:

1. What do you think has caused your problem?
2. What do you expect is going to happen?
3. How are you coping with things?
4. Is it getting you down?
5. When do you think you'll get back to work?
6. What can be done at work to help?

**CHECK:** Do line managers know where to get the [questions](#) they need to identify obstacles – do they know how and when to use them?

## Action 5. Manage Obstacles at the Workplace

Staying at work and getting back to work doesn't just happen – **action is needed!**

- It is not helpful to rely only on healthcare
- The workplace must be involved from day 1 to help people continue working whilst recovering

Remember the reason why some people take lots of time off work is usually **not** because they have a more serious health condition or more severe injury. It's not about what has happened to them. It's about why they don't recover in the normal way – and that is because they face obstacles to recovery and participation. Many of these occur in the workplace.

The knack for understanding obstacles is to use a problem-solving approach. To be effective in the real world, think about these three aspects

1. Identify obstacles to being active and working
2. Work out how these can be overcome or sidestepped
3. Get all players onside – so there is consistency, coordination and collaboration

TIP: Use the quick reference guides to obstacles for [Line Managers](#) and for [Workers](#)

### Effective Interventions - Tools for Supportive Workplaces

The toolbox has a wealth of guidance on tackling obstacles. Detailed information is available for each of the following:

- [Information and advice](#) about [health<-->work](#)
- [Promoting activity and work](#)
- [Dispel myths](#) about how common these problems are, symptoms, activity, and work
- [Transitional work arrangements](#)
- [Graded Stay at Work and Return to Work programmes](#)
- Negotiated job modifications, and how to end them
- [Stay at Work](#) and [Return to Work](#) planning
- Case coordination, case management
- Activity scheduling, progressive goals
  - Using [Activity Scheduling and Progressive Goals](#) for Common Health Problems
    - Scheduling Activities - Useful to maintain activity level when condition is acute
    - Working to Quota - Useful to increase activity level and build tolerance
    - Planning Activity – Useful when a worker has low mood or less motivation
- Self-help skills
  - [Tackling Common Health Problems - Quick Guide for Line Managers](#)
  - [Advice and Facts for Workers with Common Health Problems](#)

**CHECK:** Does everyone know what line managers **and** workers **CAN DO?**

### Line Managers Can

- Prevent harm
- Facilitate Stay at Work and Return to Work
- Maintain contact with the person
- Provide information about job tasks
- Identify potential selected duties
- Facilitate workplace accommodations, temporary modifications
- Enable graduated Return to Work

**TIP:** Use the resources - [Developing an Action Plan](#), [Developing a Stay at Work Plan](#), [Developing a Return to Work Plan](#)

### Workers Can

- Participate collaboratively with line manager
- Identify parts of your job you can still do
- Identify parts of your job you think you will have difficulty with
- Think about things you will need to discuss or negotiate with your line manager and co-workers
- Cooperate with your line manager
- Identify any other problems or obstacles that may make it difficult for you to stay at, or return to, work

**TIP:** Use the resources - [Developing an Action Plan](#), [Developing a Stay at Work Plan](#), [Developing a Return to Work Plan](#)

## Action 6. Provide Reasonable Modifications to the Job for a Period of Time (*not for ever*)

There are lots of different terms used to describe workplace accommodations, including alternative duties, modified work, selected duties and 'light duties'.

The most important thing about workplace accommodations is that they should be **temporary** not permanent.

- Temporary job modifications allow the person to continue working while they recover
- Permanent job modifications mean that the person has a new job description

The key practical issue is to work out what is **reasonable** in the way of temporary job modifications. There is no formula for this!

### Temporary

Supportive workplaces generally need only provide reasonable job modifications or adjustments for a limited period of time.

Graduated (graded) programmes to return to full-time work are effective, and usually simple to set up and manage. For common health problems and minor injuries they require periods of days, or a few weeks at most.

### Reasonable

A reasonable accommodation is any modification or adjustment to a job or the work environment that enables a worker to perform essential job functions. The purpose is to enable the employee to stay at work, or return to work, while they are recovering from symptoms of common health problems.

Provision of reasonable job accommodation is the foundation of a supportive workplace. It is no one's interest to make, or agree, to unreasonable requests. This means that co-workers, line managers, and others should not be disadvantaged; and they should not experience excessive difficulties. It is all about common sense: *'what will make it possible for this person to stay at work (at least part-time)?'*

There are issues that may arise, such as:

- The sick or injured worker may have to deal with co-workers who resent having to take over some of his or her work and therefore feel that the worker has managed to get an 'easier' job.
- Line managers may be required to fulfil production quotas in spite of accommodating a returning worker, and may not have the work that such accommodation requires fully acknowledged.

These can be dealt with effectively. Workplaces should create individualised plans that anticipate and avoid these pitfalls, and will be much more likely to have better outcomes.

**TIP:** Use the resource on providing temporary [Workplace Accommodations](#).

**CHECK:** That you have looked at the resource on providing [Reasonable Adjustments](#).

## Action 7. Let People Build Up Gradually and Steadily as They Recover

A key collaborative role for line managers and workers is to establish, negotiate, and monitor both 'stay-at-work' and 'return-to-work' programmes.

As humans we are not really like machines that are either on or off. Sometimes we need to be able to work back up 'through the gears'. This allows us to adapt to our symptoms, to increase our tolerance, and to regain our natural resilience. Participating in our usual activities is healthy, even if we need to do some of them more slowly or in a different way for a few days or weeks as we recover. Be clear about the goal for activity and work.

### Return to Work Goals

When someone is ill or injured they can be helped to stay at or return to work, either part-time or full-time. The possible goals for work involve combinations of:

- The job – it can be the Same, Modified, or Different
- The workplace – can be the Same, or Different

Always start with the work goal **"Same job, Same workplace, and Full-time"** unless there is a very specific reason not to (other than symptoms of the health complaint or injury). This often requires temporary modification to their job.

The option of changing the work goal (e.g. to a different job, or the same one with permanent modifications) is always available later. However, it should not be the first option and is not the best option for the worker.

**TIP:** Use the resources [Techniques to increase tolerance and resilience](#) and [Graduated return to work and activity](#)

### Graduated or Phased Return to Work

One of the most successful strategies in helping people to return to work, following extended absences, is to implement a graduated or phased programme that involves an increase in work hours, work tasks, or both. Sometimes this reaches a plateau where maximum improvement has been reached; sometimes it allows accurate determination of ability to return to previous job tasks, or the need for being moved into another role. In the absence of a job opening it can also be used as a job trial to demonstrate employability to a prospective employer.

There are two key variables: (1) amount and type of job tasks to begin with, and (2) the rate of increase over a specified duration. This is best achieved through careful consideration of the job description and any potential safety issues. It's a question of balance. For the best success, it is important to ensure that the plan supports the returning worker without disadvantaging co-workers and supervisors.

## Finally: A Quick Round-Up

Remember that it is **you** who can make a difference.

The basic principle to always follow is *do not let what you cannot do interfere with what you can do* \*

\* attributed to John Wooden

### Ways to Make a Difference

#### DO

- Be enabling and facilitating
- Focus on ability, not disability
- Emphasise what the person can (still) do

#### AVOID

- Sabotaging activity and work, or encouraging disability
- Asking about how the person has been feeling
- Suggesting the person uses their symptom (e.g. pain, fatigue) as their only guide to activity and work

**Zoë's story:** *Things had been upsetting me at work in the office for a while, nobody seemed to realise that I was feeling so down and not myself. Things seemed to just pile up on me one after the other. My father died last year and I had to organise everything to get my mum into a care home, both the kids needed more help with school work and one of them got into trouble with the teachers, my husband got promoted at work but now he seems to have to do more hours than before. I couldn't concentrate, was irritable and grumpy a lot of the time, had trouble sleeping, and started to lose weight. My GP said she thought I was getting depressed and suggested I take some pills. It just got worse at work, the office was so busy and the boss seemed to expect me to do more and more, just when I felt I was getting slower and slower, a bit like wading through treacle really. What I really needed was for him to understand that I was going through a tough spot in my life right now and it would really help if I could work more flexible hours while I got back on top of things. It all came to a head last week when I broke down in a flood of tears. Anyway, the upshot was that he turned out to be so much more understanding than I thought, and I'm now working flexi-time for the next 4 weeks, then we're going to review it and see if I can cope with my usual hours after that. I'm so relieved, I was terrified of not being able to go to work, and then maybe ending up losing my job.*

go to

[\*\*SUPPORTIVE WORKPLACE OVERVIEW\*\*](#)

[\*\*SUPPORTIVE WORKPLACE IN DETAIL\*\*](#)

[\*\*KNOWLEDGE\*\*](#)

[\*\*GOOD JOBS\*\*](#)

# Health<-->Work

## the toolbox for managing common health problems at the workplace

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The underlying principle for this toolbox was inspired by the approach promulgated by Nordin Hadler that *work should be comfortable when we are well and accommodating when we are sick or injured*

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## Resources by Section

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### Other

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## Actions for Good Jobs

### Senior Managers

- In larger companies and organisations creating the infrastructure may be delegated to others, e.g. HRM, but senior management involvement is essential to set the aspiration.
- Initiate the process and be proactive about providing good jobs.
- Incorporate the good jobs aspiration into line manager training and support.
- Ensure everyone in the workplace has contributed to finding the best combination of approaches to providing good jobs throughout the different parts of the business or organisation.
- Review regularly and seek to improve.

### Line Managers

- Find out whether you are providing good jobs. Use guided questioning to determine whether the jobs you manage are sufficiently comfortable and engaging.
- Identify potential improvements and make changes, recognising that creating good jobs is an aspirational goal to keep working toward.
- Identify where skills need to be developed to help workers cope with unavoidable aspects of jobs that are unpleasant or uncomfortable.
- Communicate effectively to senior management and workers about what can be realistically achieved toward providing good jobs.

### Workers

- Participate in open communication about how to make good jobs.
- Question line managers when the process of providing good jobs is not occurring.
- Respect and support your colleagues.

**Senior Management sets the approach. Line Managers make it happen. Workers contribute to the process.**

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### Actions for Supportive Workplaces

Line managers and workers need to be able to:

- Recognise when a colleague is struggling to cope with symptoms or injury
- Respond to anyone who reports symptoms or is off work
- Quickly and easily evaluate someone's work ability (i.e. how they feel they are coping with work and health)
- Identify any obstacles to staying at work or getting back to work
- Manage workplace obstacles
- Arrange reasonable modifications to the job for a period of time (not for ever)
- Help people build up gradually as they recover

**Supportive workplaces allow people to recover while they are working**

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### Actions for the Knowledge

Commitment to the **Health<-->Work** culture.

Decide what information needs to be available to everyone.

Arrange things so everyone knows where to find the knowledge they need, and are able to access it easily, quickly and repeatedly: think about making it available in printed and/or electronic format. You could also make posters.

Ensure the organisation and all in it have worked out (1) an approach to minimise health complaints (collectively through making the jobs good) and (2) to rapidly and effectively help colleagues who are struggling to work because of their health complaint (with temporary support and accommodation). That is, be proactive not reactive.

Find out if you've got the [message](#) across.

# Health <--> Work

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### Are You Providing Good Jobs?

Larger organisations may want to seek more detailed information about what their workers in various departments think about their jobs.

This can usually be accomplished by guided questioning between the line manager and individual workers and groups of workers on a regular basis during one-to-one performance reviews, team meetings and more informal meetings.

Positively framed questions are best. Use these to determine whether jobs are as good, satisfying, and comfortable as they can be. The main areas to consider are:

#### Physical Aspects of the Job Affecting Groups of Workers

- Hygienic conditions
- Physical conditions (e.g. heat, temperature, light, noise, etc)
- Equipment/physical resources

#### Psychosocial Aspects of the Job Affecting Groups of Workers

- Support/resources provided the line manager
- Considerate/supportive line manager
- Job resources – job control, skill development & use, variety in tasks, role and clarity about the future, co-worker support & behaviour, career and development.
- Opportunities for social contact
- Reasonable job demands
- Physical security and safety
- Lack of role conflict
- Organisational support for line managers
- Group perceptions of kit suitability
- Relationships (including co-worker support)

### Questions to Ask

#### Q1. What are work demands and conditions like?

Good jobs are 'balanced' with work that is challenging and motivating, but not too difficult or too easy. This means there should be enough work to stop people feeling bored, but the pace of work should not be so fast that people cannot work to an adequate or safe standard in normal working hours. The physical environment at work is safe and as agreeable as possible.

Jobs that are not so 'good' are those where the work is either too difficult or too easy; without enough to do to sustain motivation and attention; or, with so much to do that it is not really possible to finish things to a good and/or safe standard in normal hours or working hours may need to become excessively long (and possibly interfere with family life). The physical environment may be uncomfortable and there might be obvious and unmanaged threats to safety.

#### Q2. Are there opportunities and support to use and develop skills?

Good jobs provide support and opportunities to develop skills. This means people feel supported by work colleagues when they have problems, and the team swaps advice on how to tackle difficult work problems. People feel they are treated fairly, and are clear on their job responsibilities. In addition workers are able to make decisions relevant to their work, and appropriate to their levels of skill; and, have opportunities to practice a variety of skills relevant to the work and develop these skills further. This can be through training, but also through on-the-job learning. People should have some idea of how their work and development will pan out over a foreseeable time

Jobs that are not so 'good' are those that offer few or no opportunities to take decisions relevant to workers' tasks and levels of skills. There is little support from co-workers and people feel unfairly treated. There is little or no opportunity to use and develop a range of skills, and workers will not be clear on their responsibilities or what the future holds.

#### Q3. What do those I manage think I am like as a line manager?

For good jobs, managers need to communicate regularly and well with workers, and offer support when it is wanted. Offering support does not always mean 'a shoulder to cry on'. It can be a lot more concrete than that – such as offering advice on how to complete tricky work tasks, or finding out about skills development opportunities.

#### Q4. Can people cope when problems occur?

Problems inevitably occur at work, e.g. difficult customers, equipment breaking, or conflicts with other work teams. For good jobs, workers need to be able to cope with problems when they occur. This can mean having the skills and ability to take decisions to solve problems in a timely manner, and to have support from others to help solve problems in a timely manner. It can also mean things like having the opportunity to take breaks from particularly demanding problems

or work within the working day in order to 'recharge' batteries and look at problems anew.

*Q5. Is work interesting for people?*

Good jobs are sufficiently interesting and motivating to the people doing them. Different people have different things that motivate and interest them. For example, some people are interested in helping customers, whereas others like solving technical problems. Good jobs allow people to pursue these interests, provided they are reasonable and consistent with work unit or organisational goals.

*Q6. Can workers help themselves to make their work more comfortable and agreeable?*

We are all unique in some way or other, although we may have similarities too. This extends to our ability to solve problems and the way we each experience our work. One way to take these differences into account, is to support work groups and individuals make their own work more comfortable and agreeable. People will need the skills, support and opportunities to do so, and will also have to negotiate with others, so that any changes to work do not compromise the work of others, the work unit or organisational goals.

# Health<-->Work

## the toolbox for managing common health problems at the workplace

### The Business Case for Employers

[BACK](#)

Helping you and your workforce deal with health at work is good for everyone and is good for **business**.

It's the right thing to do and you'll be thanked for doing it. **Everyone** benefits.

#### Gaining a Competitive Edge

You are right to be concerned about your employees health and wellbeing.

You may be committed to providing a healthy workplace but be concerned about the costs and resources needed. Don't be. There is a good business case. The small investment in health and wellbeing makes commercial sense.

This toolbox is designed to help you reduce sickness absence, boost productivity and the quality of work.

Quantifiable benefits include

- sickness absence
- staff turnover
- accidents and injuries
- employee satisfaction
- company profile
- productivity
- claims
- competitiveness and profitability

The magnitude of the business benefits can vary significantly, and will depend not only on the type of organisation and approach involved, but also on the way in which it is implemented.

It has been estimated that the simple steps to improve the management of mental health in the workplace outlined in this toolbox, including prevention and early identification of problems, should enable employers to save 30 per cent or more of the costs for sickness absence, reduced productivity, and staff turnover (source: Sainsbury Centre for Mental Health).

# Health<-->Work

## the toolbox for managing common health problems at the workplace

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### Becoming Committed to Work<-->Health Culture

Workplace culture is *'the way things are done around here'*.

Often we fall into habits and keep doing things the same old way without ever stopping to think if it could be done better or more easily.

We all deserve to be able to do our work without risking injury or damage to our health. It is equally important that what we do at work does not adversely affect others.

The right workplace culture will minimise the likelihood of injury and health problems at work, because things will be consistently done in ways that are healthy as well as safe. The culture should be based on collaboration and cooperation. Of course, there are always times when the boss needs to be the boss. But, good bosses are committed to the work<-->health culture, and ensure it develops at all levels throughout the workplace - from bottom to top.

**TIP:** This is best achieved by fostering an organisation-wide team approach, based on a dual responsibility. This recognises the 'we're in it together' aspect. It is important to convey the idea that success is most likely if responsibility and ownership of work-relevant common health problems is shared between employer and employee.

In medium and larger organisations this inevitably means commitment from the senior management team, who can set expectations throughout the whole organisation. An 'us and them' culture is good for nobody and is a major obstacle to providing good jobs and supportive workplaces. A good workplace culture will prevent this.

### Engaging Senior Management

Getting 'buy in' at a senior level is a generic step that can usually be led by the senior manager responsible for occupational safety and health. Employee representative groups and trade union reps can provide useful prompts to ensure the process is started.

It is not possible to prescribe how to gain the backing of every organisation's senior management team. However, the process is easily guided by the generic information in this toolbox, enabling the building of a moral, legal and business case for minimising work-relevant common health problems and their impact. This is achieved by preventing escalation of work-relevant health problems early, effective, and targeted management.

**TIP:** Useful persuasion techniques to target senior management include posing two key questions. Ask these using the relevant collated data:

- Do we have a problem?
- Can we do better?

### Suggestions on how to define and prioritise actions through consensus

**Senior Management** - consider the following in addition to using available risk assessment guidance:

- Line management style that encourages participation, delegation, constructive feedback, mentoring and coaching.
- Communication practices should incorporate worker involvement, and processes to obtain staff feedback on their wellbeing.
- Information systems should make accurate information about work-relevant common health problems available.
- Line manager training should incorporate specific topics into regular safety training programmes:
  - how to be positive and empathetic in early contacts with workers.
  - how to arrange modified work.
  - how to follow-up and problem solve on a regular basis.

**Human Resource Managers** - consider the following in addition to using available risk assessment guidance:

- Adopt an organisation-wide approach to promoting the wellbeing of all employees, working in partnership with them. This approach should integrate the promotion of mental wellbeing into all policies and practices concerned with managing people, including those related to employment rights and working conditions.
- Promote a culture of participation, equality and fairness that is based on open communication and inclusion.
- If reasonably practical, provide employees with opportunities for flexible working according to their needs and aspirations in both their personal and working lives.
- Review the sustainability of management support.

**Occupational Health Staff** - consider the following in addition to using available risk assessment guidance:

- Establish ways of providing support and advice on developing and implementing organisation-wide approaches to promoting health and wellbeing.
- Collaborate with line managers at all levels and in all areas of the workforce, no matter the size of the group.

**CHECK:** The key outputs needed from senior management are

1. Visible commitment to work<-->health culture, in the first instance through providing 'permission' to the entire organisation and then with promotion of the culture through participation (e.g. problem-solving circles, communities of practice)
2. Resource commitment (e.g. a suitable organisation-wide communication strategy, and access to information and this toolbox)
3. Sustainable management support. It's a good idea to check workplace culture at least every two years



## Create Meaningful Incentives

Create a selection of meaningful incentives for using the toolbox relevant to different end-user groups. For examples, the business and legal case may have the greatest influence on senior managers, whereas the moral case may have more impact at the individual level.

# Health <--> Work

## the toolbox for managing common health problems at the workplace

BACK

### Common Health Problems

They're called "common" because they happen frequently. In fact, we all experience common health problems and minor injuries at some stage. These include:

- Mental health [e.g. depression; anxiety; feeling stressed]
- Musculoskeletal [e.g. back pain; neck pain; upper limb disorders]
- Other complaints that interfere with work [e.g. blood pressure, asthma]

Most episodes are short-lived and most people can stay at work or need only a short time off. Paradoxically, the majority of long-term sickness absence is actually due to these problems. This should not happen, especially if we were all doing the things we know can prevent prolonged sickness absence.

This is important to you as a **worker** because there are things you can do to prevent the need for time off work, and especially a long time off.

This is important to you as a **line manager** because there are things you can easily do to reduce the chances your workers will need time off, and you need to especially focus on preventing it turning into long-term absence (a disaster for everyone). A few simple things can make people feel better and be more productive.

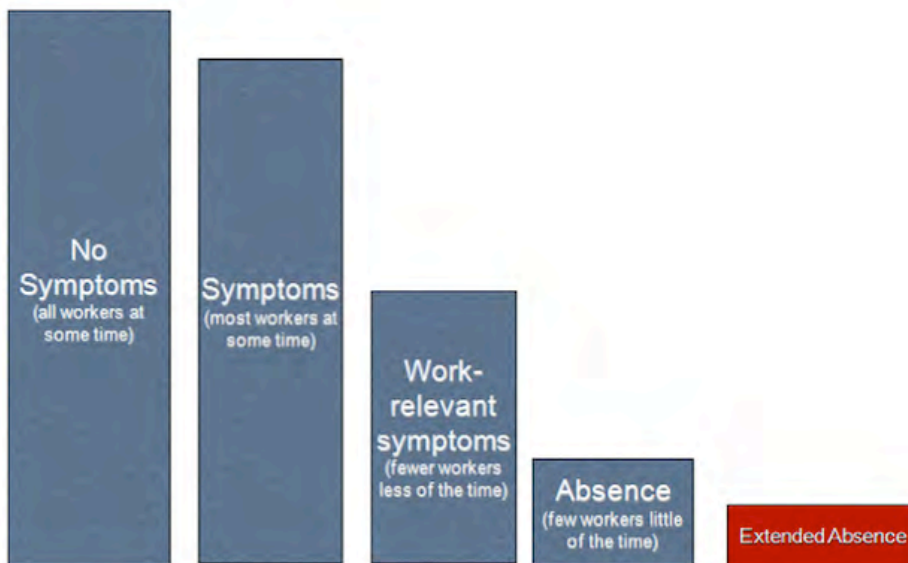
Common health complaints and minor injuries can be irritating or even distressing to any of us. They can interfere with ability to work and be active, but they are not 'severe' in a medical sense. They may have their ups and downs, but usually they settle down. In fact, most people remain at work or return quite quickly, and they come to no harm. Those who find themselves struggling or going off work don't actually need to – if they get a little help from the organisation.

**Line Managers** can arrange temporary flexibility at work to make it possible to stay at work, or to return safely and early.

**Workers** can discuss what will work for them with their line manager and their healthcare provider.

This graph illustrates how common health problems affect people and industry. Basically, what it shows is that most people get symptoms, but only for some does work become problematic. Most people can and do cope with their health at work. Only a minority struggle, and very few need sick leave.

But, **and it's a very big but**, the number of people taking time off work and staying off work has been going up and up.



The really important thing to grasp is that these numbers should **not** be going up across our society, and that extended sick leave for common health problems can be prevented and needs to be prevented. When extended absence does happen, it results in unnecessary suffering for workers and is very costly to our whole society.

This is important to **Workers** because being off work for long periods results in substantial reduction in quality of life, and people usually experience more health problems as time goes by. It becomes much harder to get back into work, and this is made worse by deterioration in skills and confidence along with the feeling of isolation from work. All of this extra suffering can also extend to family members.

This is important to **Line Managers** because when workers have long periods of sickness absence there is an effect on overall productivity through loss of skills, the need to find cover, lack of experience in newer staff, or the need to ask others to work overtime. There is invariably extra cost to your organisation/company, and there is also a collective impact on our society and all taxpayers.

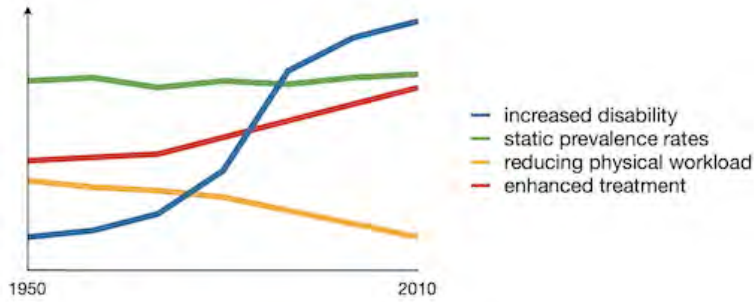
### The burden of common health problems

Common health problems should always be manageable: the paradox is that so many end up on long-term sickness absence.

Despite better working conditions and better access to health care, the number of people with symptoms has not reduced. More importantly, the number of people claiming disability has actually increased. Whatever we've been doing up to now, it clearly **hasn't** provided an effective answer.

The longer people are off work, the less likely they are to get back – the slide into worklessness is all too easy. Fortunately there is a lot you can do to help: quickly, cheaply, and effectively. It's crucial to step in and help without delay. We now have a much clearer picture of what needs to be done.

This toolbox makes it possible for you to play your part to make this happen.



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## Confidentiality Waiver

Download an example confidentiality waiver

[Confidentiality Waiver](#)

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## Developing an Action Plan

### Action plan

My activity goals (for example, I want to be able to do the dishes, go to the movies, take part in a social event etc)

I have difficulty with the following activities

While I am getting better, I can make these activities easier by

As I build myself back up to my usual activity level, I will make myself more comfortable by doing the following things (for example, listening to music to relax, sleeping with a pillow under my legs, walking 20 minutes a day etc)

I will measure my progress by

*Fill this section in two weeks later.*

I have made the following improvements and progress in building up to my usual activities

### My return to work plan

Parts of my job I can still do

Parts of my job I may have difficulty with

Ways I can get around these difficulties

Things I need to talk to my line manager or colleagues about

Other problems at work that I need to deal with, how I can solve them and who I need to talk to about them

Things I enjoy about my work

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## Developing a Stay at Work Plan

Effective Stay At Work Plans:

- Based on a [Stay at Work policy](#) - in an environment where staying at work is part of normal workplace practice
- Involve [temporary modifications](#) to duties and job tasks - for any work-relevant problem irrespective of where it began
- Include workers who are [able to work](#) only part-time - then build up to full-time as they recover

Closely related sections: [Developing an Action Plan](#) [Developing a Return to Work Plan](#) [Graduated Approaches to Work and Activity](#)

## Stay at Work

The purpose of Stay at Work is to support and enable an ill or injured worker to recover safely whilst working to the fullest possible extent.

In general, people with common health problems get better faster and have fewer long-term difficulties if they are able to recover while they are working in a safe and supportive workplace - sometimes with temporary modifications.

Stay at Work is an option if the person can work part-time **and** the line manager agrees to the reduced or modified work schedule.

Usually it is better for people with common health problems to stay at work than have to return to work. Sometimes, though, a short period off work is unavoidable, it is then important to start back at work as soon as possible, at least part-time. That, though, isn't the end-point - it's very important to have a **plan** for getting back to full-time.

The Stay at Work approach is entirely consistent with the emphasis on identifying obstacles early and tackling them effectively. Stay at Work requires the engagement of all key players - worker, line manager, clinicians, and others to ensure there is a coordinated approach to identifying and resolving obstacles to staying at work.

Someone has to take responsibility to identify any obstacles and to broker solutions so that recovery at work can commence as soon as is safe and practicable. If there are any concerns about risks associated with the job, a re-assessment may be required.

The plan should be simple and doable. As well as identifying the obstacles it will include detail on what the workplace can do to overcome them. That information may be very helpful for helping clinicians to encourage activity and participation in work. Clinicians, like GPs and physiotherapists are experts in diagnosis and treatment, but you're the workplace expert. Your help is needed for them to understand your workplace. Clinicians who do not get input from line managers may needlessly restrict a worker from staying at, or returning to, work.

People in and around the workplace often lack the confidence to deal with work and health issues. The information and guidance in the toolbox promotes appropriate confidence. You don't always need medical input to develop a Stay at Work plan. The worker may not be seeing a healthcare practitioner and there may not be a fit note. In these circumstances, it's really a matter of common sense. But if you're concerned, you can always ask the clinician. Obviously, if there is a [fit note](#) the Stay at Work plan needs to take account of the doctor's advice.

It is possible to prevent needless disability by helping people to stay at work. One of the main benefits of a stay at work approach is that it prevents that 'disconnected' feeling workers encounter when they are off work.

**Practical Tip:** Much of today's work disability due to common health problems **can** be foreshortened or averted entirely. This is because work absence is hardly ever medically required for more than a few days after illness and injury. To make a positive difference, emphasise these:

- Being active during convalescence speeds recovery, while extensive work avoidance and "rest" tend to delay it.
- Prolonged absence or permanent withdrawal from work is bad for people's well-being -- mental, physical, social and economic.
- Prolonged withdrawal from work is usually being driven by psychosocial factors instead of medical ones.

## Successful Stay at Work Outcomes

- Identification of obstacles, and tackling these effectively.
- Maintenance of work, part-time if necessary.
- Using a graduated approach to increase from part-time to full-time work.

## FACT: People *can* be helped to stay at, and return to, work

The pivotal thing is to provide a supportive workplace. There are [seven key principles](#) to follow.

## Develop a Stay At Work Policy

Create an environment where staying at work and returning to work are part of normal workplace practice:

- Accept and manage work injuries or illness originating at work in the same way as those originating elsewhere.
- Put in place steps that need to be taken when someone reports an injury or illness, and assign specific responsibilities to people involved.
- Develop a stay at work plan whenever a worker has any time off work for a few days, or reduces their hours at work.
- Provide [temporary suitable duties](#) whenever possible.
- Support and monitor the worker's progress while they stay at work recovering.
- Use [effective communication](#) to ensure everyone know what is being done, why, and for how long.

**Practical Tip:** It is good to involve workers in the development of a stay at work policy. Use a positive approach to explaining it and managing expectations by establishing a **Better at Work** initiative.

## What to Include in a Stay At Work Policy

- The benefits of the Stay at Work policy and both the short and long-term goals
- How Stay at Work will be managed
- Who is responsible for what and when
- How the policy is communicated
- A process for reviewing and improving the Stay at Work policy, including obtaining feedback from workers

**Line Managers** and **Senior Management** need to be aware of the benefits of a stay at work approach. It helps to establish a clear picture of what the person can and cannot do, and whether there are any obstacles to recovery.

**Workers** need to be aware of the benefits of a stay at work approach. It makes it possible to have a period of reduced work hours, alternative duties, putting in place physical aids, exploring suitable travel options, or helping the employer make temporary modifications to the workplace. These all help you as a worker by keeping you in the workplace and engaged with your usual life.

## Questions that may arise for Line Managers

*My worker wasn't injured or became ill at work, so do I have any influence over their return to work?* **Yes!** The impact that you, and the organisation, have on a non-work illness or injury is usually identical to that for a problem that started at work. This is because you still have a worker who is struggling to perform their usual duties and job tasks: they have a **work-relevant** problem. The line manager plays a key role in making it possible for the person to stay at work or return to work wherever the problem began. In general, you're still entitled to ask for information from your worker that enables you to help evaluate their [work ability](#). Always ask if you're unsure.

*Does it cost more to return an employee to work than it does to get a replacement?* **Probably not.** Helping someone to stay at work doesn't need to be expensive. It may be as simple as rearranging job tasks or equipment. In contrast, there can be a high cost if you replace a worker, due to advertising, recruitment time, loss of productivity while you're recruiting, retraining, possible increases in waste and effects on staff morale.

## Better At Work Checklist for Line Managers

- Is there a Stay at Work Policy?
- Did you make contact with your worker as soon as possible to offer Stay at Work option?
  - If it was not appropriate did you move to developing a Return to Work plan?
- Did your worker give you a fit note?
- Have you explained the Stay at Work process to your worker?
- Have you identified suitable temporary modifications?
- Have you discussed and agreed these with your worker?
- Have you identified obstacles to the worker staying at work?
- Have these been adequately addressed?
- Is there a timeframe for the Stay at Work plan?
  - When will it be reviewed and/or modified if necessary?

[Download a copy of the Better At Work Checklist for Line Managers](#)

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[Template for Line Managers](#)





# Health <--> Work

## the toolbox for managing common health problems at the workplace

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## Developing a Return to Work Plan

Effective Return to Work Plans:

- Based on a [Return to Work policy](#) - in an environment where supporting early return to work is part of normal workplace practice
- Involve [temporary modifications](#) to duties and job tasks - for any work-relevant problem irrespective of where it began
- Include workers who are [able to work](#) only part-time - then build up to full-time as they recover

Closely related sections: [Developing an Action Plan](#) [Developing a Stay at Work Plan](#) [Graduated Approaches to Work and Activity](#)

## Return to Work

The purpose of a Return to Work plan is to support and enable an ill or injured worker to recover safely whilst getting back to their usual.

In general, people with common health problems get better faster and have fewer long-term difficulties if they are able to recover while they are working in a safe and supportive workplace - sometimes with temporary modifications.

Return to Work - often abbreviated as RTW - is necessary whenever a person has a period away from work. The process may vary from simple to more complex. Either way, **it is vital that there is a return to work process.**

There is an overlap with the [stay at work approach](#) when a worker is increasing back to full hours and usual duties from reduced hours or modified work. The most effective way of doing this is usually with a [graduated return to work](#) although this is not always necessary for common health problems.

Usually it is better for people with common health problems to stay at work than have to return to work. Sometimes, though, a short period off work is unavoidable, it is then important to start back at work as soon as possible, at least part-time. That, though, isn't the end-point - it's very important to have a **plan** for getting back to full-time.

The Return to Work approach is entirely consistent with the emphasis on identifying obstacles early and tackling them effectively. Return to Work requires the engagement of all key players - worker, line manager, clinicians, and others to ensure there is a coordinated approach to identifying and resolving obstacles to staying at work.

Someone has to take responsibility to identify any obstacles and to broker solutions so that recovery at work can commence as soon as is safe and practicable. If there are any concerns about risks associated with the job, a re-assessment may be required.

The Plan should be simple and doable. As well as identifying the obstacles it will include detail on what the workplace can do to overcome them. That information may be very helpful for helping clinicians to encourage activity and participation in work. Clinicians, like GPs and physiotherapists are experts in diagnosis and treatment, but you're the workplace expert. Your help is needed for them to understand your workplace. Clinicians who do not get input from line managers may needlessly restrict a worker from staying at, or returning to, work.

People in and around the workplace often lack the confidence to deal with work and health issues. The information and guidance in the toolbox promotes appropriate confidence. You don't always need medical input to develop a Stay at Work plan. The worker may not be seeing a healthcare practitioner and there may not be a fit note. In these circumstances, it's really a matter of common sense. But if you're concerned, you can always ask the clinician. Obviously, if there is a [fit note](#) the Return to Work plan needs to take account of the doctor's advice.

It is possible to prevent needless disability by helping people to return to work. One of the main benefits of an early return to work approach is that it prevents that 'disconnected' feeling workers encounter when they are off work.

**Practical Tip:** Much of today's work disability due to common health problems **can** be foreshortened or averted entirely. This is because work absence is hardly ever medically required for more than a few days after illness and injury. To make a positive difference, emphasise these:

- Being active during convalescence speeds recovery, while extensive work avoidance and "rest" tend to delay it.
- Prolonged absence or permanent withdrawal from work is bad for people's well-being -- mental, physical, social and economic.
- Prolonged withdrawal from work is usually being driven by psychosocial factors instead of medical ones.

## Successful Return to Work Outcomes

- Sustainable resumption of productive activity.
- Identification of obstacles and effectively tackling them.

**FACT:** People *can* be helped to stay at, and return to, work

The pivotal thing is to provide a supportive workplace. There are [seven key principles](#) to follow.

## Develop a Return to Work Policy

Create an environment where staying at work and returning to work are part of normal workplace practice:

- Accept and manage work injuries or illness originating at work in the same way as those originating elsewhere.
- Put in place steps that need to be taken when someone reports an injury or illness, and assign specific responsibilities to people involved.
- Develop a return to work plan whenever a worker has any time off work for a few days, or reduces to part-time.
- Provide **temporary suitable duties** whenever possible.
- Support and monitor the worker's progress while they return to work while recovering.
- Use [effective communication](#) to ensure everyone knows what is being done, why, and for how long.

**Practical Tip:** It is good to involve workers in the development of a return to work policy. Use a positive approach to explaining it and managing expectations by establishing a **Better at Work** initiative.

## What to Include in a Return to Work Policy

- The benefits of the Return to Work policy and both the short and long-term goals
- How Return to Work will be managed
- Who is responsible for what and when
- How the policy is communicated
- A process for reviewing and improving the Return to Work policy, including obtaining feedback from workers

**Line Managers** and **Senior Management** need to be aware of the benefits of the return to work approach. It helps to establish a clear picture of what the person can and cannot do, and whether there are any obstacles to recovery.

**Workers** need to be aware of the benefits of the return to work approach. It makes it possible to have a period of reduced work hours, alternative duties, putting in place physical aids, exploring suitable travel options, or helping the employer make temporary modifications to the workplace. These all help you as a worker by keeping you in the workplace and engaged with your usual life.

## Questions that may arise for Line Managers

*My worker wasn't injured or became ill at work, so do I have any influence over their return to work?* **Yes!** The impact that you, and the organisation, have on a non-work illness or injury is usually identical to that for one that started at work. This is because you still have a worker who is struggling to perform their usual duties and job tasks: they have a **work-relevant** problem. The line manager plays a key role on making it possible for the person to stay at work or return to work wherever the problem began. In general, you're still entitled to ask for information from your worker that enables you to help evaluate their [work ability](#). Always ask if you're unsure.

*Does it cost more to return an employee to work than it does to get a replacement?* **Probably not.** Helping someone to return to work doesn't need to be expensive. It may be as simple as rearranging job tasks or equipment. In contrast, there can be a high cost if you replace a worker, due to advertising, recruitment time, loss of productivity while you're recruiting, retraining, possible increases in waste and effects on staff morale.

## Better At Work Checklist for Line Managers

- Is there a Return to Work Policy?
- Did you make contact with your worker at an appropriate time **\*\*** to offer a Return to Work option?
  - If it was not appropriate did you move to developing a Stay at Work plan?
- Did your worker give you a fit note?
- Have you explained the Return to Work process to your worker?
- Have you identified suitable temporary modifications?
- Have you discussed and agreed these with your worker?
- Have you identified obstacles to the worker staying at work?
- Have these been adequately addressed?
- Is there a timeframe for the Return to Work plan?
  - When will it be reviewed and/or modified if necessary?

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**\*\* Timing for making contact is an important issue.** However, there is no simple formula for deciding when to do this.

The fundamental principle is that the line manager should **not** allow communication with the worker to be interrupted. It is a common [myth](#) that contact with an absent worker is intrusive. Failure to make early contact with people who are off work leaves them isolated and unvalued, thus fostering uncertainty, distress or depression. Lack of contact means there is no chance to make a return to work plan, and no chance to discuss transitional working arrangements. Perhaps the single most important reason to take extra care in deciding when to make contact is when the worker had performance problems or other difficulties with the workplace before onset of a common health problem. It is important to avoid a situation where the worker feels that a Return to Work approach is being offered as something they are obliged to accept rather than something that is done in their best interests.

Making the return to work plan is quite different from the so-called return to work interview! The plan is made before return to actual work, but can be done in the workplace. The sick listed worker comes into work as soon as possible to discuss when and how to get back in a timely, safe and comfortable fashion. You don't need to wait for a fit note to start planning. Actually, your plans may help the doctor use the [fit note](#) to best effect, so the worker should let the doctor know what is possible at work.

**Practical Tip:** Continued contact with the workplace is crucial to the return to work process. At initial contact with the worker the focus should be in making it positive and un-pressured, and about building good-will and trust.

## Line Managers Should Avoid

- Allowing communication between line manager and worker to be interrupted
- Delaying the plan until actual return to work
- Trivialising the injury or illness
- Allowing modified duties to be beyond the capabilities of the worker
- Hindering communication with other key players (e.g. GP, rehabilitation professionals, professional case managers, etc.)

## Use of Third Parties for Return to Work Coordination

Any return to work plan and programme is based on the principle that the **employer can enable a coordinated return to work**. If this is not true, then return to work approaches will be undermined and suboptimal.

Some organisations may wish to 'out-source' the Return to Work process – use a case manager to coordinate developing and implementing a plan. This may be a third party case management provider, or it can be an internal process using case management approach, accessed by line managers.

The role of any return to work coordinator, or professional case manager, is to return the worker to appropriate employment in a timely, safe and cost efficient manner.

**Practical Tip:** Case management is a goal-oriented approach to keeping employees at work and facilitating an early return to work. There is good scientific evidence that case management methods are cost-effective through reducing time off work and lost productivity, and reducing healthcare costs.

## Line Managers Have a Key Role

There is very good evidence demonstrating that employers play a key role in the return to work process.

Interventions with a workplace-based component lead to improved return to work outcomes.

**Practical Tip:** The size of the effect will vary across different circumstances, but you should expect to achieve two-fold improvements in return to work rates.

## Four Key Tasks for Line Managers

1. Keep in contact with the injured workers and assist with an early RTW.
2. Agree on a RTW plan and RTW goals with the injured worker.
3. Offer workplace accommodation.
4. Communicate with healthcare professionals when necessary.

**Practical Tip:** the readiness of line managers to act as key players in the return to work process seems to depend on:

- Awareness of the importance of their role.
- Having the know-how and ability to be able to assist
- Motivation or incentive to participate

## Work Trials as Part of the Return to Work Process

Reasons to consider using a work trial include:

- Rebuilding work skills, self-confidence and establishing work routines following a longer absence.
- Building [resilience](#), or 'work hardening'. This involves offering a worker a programme aimed at progressively improving physical or psychological work tolerances.
- Learning alternative work skills. When a worker returns after an absence, sometimes things have changed. For example, the company may have been re-organised or re-structured, and it is necessary to adapt to different duties and job tasks.

**Kamala's story:** *I'm a line manager in a small company. We can't afford formal occ. health cover, but we can still help our colleagues cope with health at work. The senior management took some advice and introduced a simple protocol for supporting colleagues with work-relevant health complaints. The goal is to help them stay at work or get back quickly if they have to take time off. It's my job to put it all into action. Basically, I coordinate the process – I act as a case manager, a buddy if you like. I get informed as soon as a colleague is struggling or off work. We talk it through and look for the obstacles. We work out what my colleague can do, with a little help. If necessary, I liaise with the doctor or therapist (we use a simple confidentiality waiver) to help me figure out how best to help my colleague with work tasks whilst they are getting treatment. I devise the Plan and timeline with my colleague and we sort out any temporary work modifications as a team. I use information leaflets to help explain things and bust the myths. I keep an eye on them just in case there are any setbacks. It's all common sense really - it works well!*

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## Effective Communication

The key to effective communication is to:

- [Listen](#) well - it's usually more important than speaking
- Pay attention to your [body language](#) - it's often more important than what you say
- Use [assertive](#) skills - and avoid being aggressive or passive

## Effective Communication

Communication is both simple and complex, easy to do, and easy to mess up.

There are several steps in the process of communicating. Things can go wrong at any of these stages: formulating the message we intend to send; the message we actually send; the message as the hearer interprets it; the response of the hearer based on what he or she heard; and our reaction to the exchange of words, meaning and interpretation.

We have to send, receive, and process huge numbers of messages every day of different types and this is expanding in our information age. Effective communication is therefore a skill worth learning.

Effective communication is about more than just exchanging information. It requires you to also understand the emotion behind the information.

It's important to **listen** well, to recognise nonverbal signals (known as 'body language'), and to comprehend your own feelings while communicating.

Communicating effectively can improve teamwork, decision-making, caring, and problem solving. This happens by enhancing relationships with others whether it is at home, at work, or in social situations. It enables you to communicate even negative or difficult messages without creating conflict or destroying trust.

**Practical Tip:** To communicate effectively recognise the importance of listening, and make listening a key part of your group's culture. This is because when we confront difficult issues, listening is more important than speaking or any other form of expression.

The other half of the equation to active listening is assertive expression - speaking and expressing what you think, feel or want in a clear, true and non-defensive way.

## Body Language

The human species communicates at least as much through body language as with words, perhaps **more**. This refers to things like facial expressions, eye contact and the stance or movements of arms, hands and legs.

**Practical Tip:** try to be aware of your own body language and what it might mean to others.

You can practice watching body language the next time you are involved in a conversation with a group of people, or even while you are watching television. Look at the body language of one of the listeners and consider how it might affect the speaker. Check out the speaker's body language and see if it tells the same story as the words.

Body language can support effective communication. Examples include: an 'open body stance', sitting on the edge of your chair and focusing your eyes on the other person. The opposite effect can be achieved with body language such as: pointing with your index finger, wringing your hands, crossing your arms on your chest, and casting sideways glances.

## What to Avoid in Communication

There are ways that you can sabotage or block effective communication. These include things like:

- Giving advice when it is not asked for.
- Arguing or disagreeing with the speaker, analysing or interrupting.
- Having a 'me-too' approach such as "That's nothing, let me tell you what happened to me". Statements like these make the speaker feel unheard.
- Being judgmental, moralising, or preaching at people. Others may say something that appears to offend your value system. Set aside the judgment so you can listen.
- Using meaningless consolation comments, such as "It's going to be all right."
- Asking a direct question to satisfy your curiosity. The speaker will share more information when and if ready.

## Anger and Communication

You are bound to encounter feelings of anger and conflicts when working with groups of people. Anger is often a poorly understood emotion. It has a potent capacity to influence the effectiveness of communication between individuals and within groups.

Remember that anger can provide information and stimulate energy that can be used positively. It is also important to understand that other emotions, such as pain, fear, despair or frustration are often expressed as anger.

**Practical Tip:** It is worth learning how to express anger and how to receive it.

## Assertive Communication

Assertiveness means expressing your point of view in a way that is clear and direct, while still respecting others. Being assertive is different from being **aggressive** or using **passive communication**.

Communicating in an assertive manner can help you to minimise conflict, to control anger, to have your needs better met, and to have more positive relationships with friends, family and others.

It is a style of communication that many people struggle to put into practice, mostly because of confusion around exactly what it means.

People often confuse assertiveness with aggression because it involves sticking up for yourself, but the two are actually quite different.

**Practical Tip:** Assertiveness is **not** the same thing as being **aggressive**. It means expressing your point of view in a way that is clear and direct, while still respecting others. Communicating in an assertive manner can help you to minimise conflict, to control anger, to have your needs better met, and to have more positive relationships with colleagues, line managers, friends, family and others.

Learn the difference between assertiveness and aggression

### Assertiveness involves ...

Expressing your needs clearly but respectfully

Treating others with respect

Considering the needs of others as well as your own

Compromise

Building stronger relationships

Using clear language to get your point across

Enhances self-esteem

### Aggression involves ...

Forcing your needs or opinions onto others

Bullying or pushing others around

Only focusing on your needs

No compromise

Damage to relationships

Consequences like shouting or physical aggression

Damage to self-esteem

Assertiveness is also confused with **passive communication**. That involves:

- Not speaking up for yourself, either because you think your views don't matter or for reasons like trying to please everyone or 'keep the peace'.
- Putting your needs after the needs of others.
- Allowing yourself to be bullied or ignored.
- Often involves speaking quietly or with a hesitating voice, or with body-language like looking at the floor or shrugging the shoulders.
- Undermining your opinions with passive phrases like 'only if you don't mind', or 'it really doesn't matter that much to me' (when it does).

Passive communication also damages self-esteem and your relationships with others. They are much more likely to ignore your needs, and this usually leaves you feeling hurt or even angry with them for not treating you better.

## Practice Being Assertive

Assertiveness is a **skill** that requires practice. Try doing these:

- Find a way to state your point of view or request clearly.
- Tell the other person how you feel as honestly as you can, and remember to listen to what they say as well.
- How you say something is as important as what you say. Pay attention to the tone and volume of your voice. Try to speak at a normal conversation volume, rather than a shout or whisper, and make sure that you sound firm but not aggressive.
- Match your body language to what you are saying. Avoid giving mixed messages, like speaking firmly while looking at the floor. Try to communicate by looking the other person in the eye, while keeping a relaxed face.
- Avoid exaggerating and be factual rather than judgmental. For example you might say 'you are late for the second time this week' to a worker instead of grumping 'you're always late'.
- Use "I" in statements wherever possible, so that you can tell the other person how you feel rather than coming across as accusing. For example: 'I feel frustrated when I have to tidy up your tools' instead of 'you're a messy worker'.

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## Working with the Fit Note

The old 'sick note' has been replaced with the [fit note](#).

With the sick note, doctors could only advise their patient on whether their health condition meant that they should or should not work. In practice this meant many people who could benefit from working while recovering were advised that they could not work.

The fit note changes all that, and for the better!

Now the doctor can say 'you may be fit for work taking account of the following advice'. The key idea is that the focus is firmly on what the person **can** do, **not** what they **cannot** do.

### The Fit Note

**Statement of Fitness for Work**  
For social security or Statutory Sick Pay

Patient's name:

I assessed your case on:  and, because of the following condition(s):

I advise you that:  you are not fit for work.  
 you may be fit for work taking account of the following advice:

If available, and with your employer's agreement, you may benefit from:

a phased return to work  amended duties  
 altered hours  workplace adaptations

Comments, including functional effects of your condition(s):

This will be the case for  or from  to

I will not need to assess your fitness for work again at the end of this period. (Please advise as applicable)

Doctor's signature:

Date of statement:

Doctor's address:

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Of course the doctor can still say the person is not fit for work if there is a medical necessity. But with common health problems sick leave is often not needed - even if it is needed it should only be for a few days.

The fit note may be used to avoid sick leave for somebody who is actually able to Stay at Work if they get suitable support. It can also be used to help someone Return to Work in timely fashion, again, with the right support. How the workplace responds to the fit note is critical to successful Stay at Work or Return to Work.

The fit note gives you the confidence to make simple adjustments that can help the person recover while working. Importantly, these adjustments should be made in agreement with the worker. Employers do not have to act on the doctor's recommendations, but it would be foolhardy not to try everything possible to accommodate the worker.

### What advice might the doctor give?

The fit note lets the doctor give advice to the workplace on the sort of things that need to be done to help the person to Stay at Work or Return to Work - temporary modifications to the job or the way it's organised.

There are four basic options for the doctor's advice:

- a phased return to work
- amended duties
- altered hours

- workplace adaptations

The doctor will tick one or more of these. There is a box for the doctor to make additional comments offering more detail on the kind of things that may help. Remember, though, that the doctor does not know much about the actual work or workplace, and this section may be blank. So, you as the employer will need to **work out with the worker just what adjustments can be made.**

## What to do about it – translating the medical advice

Below are some examples of the sort of adjustments that have been found to be helpful. Some are more helpful for physical problems, while others are effective for mental health problems and people who feel stressed. It is down to the line manager and the worker to figure out the best adjustments to make, and how long to make them for.

### A phased return to work

- Gradually increase hours
- Alternate days
- Start back on a Wednesday
- Selected duties

### Amended duties

- Achievable goals, scheduled at start of day
- Reduce pace of work
- Reduce task frequency
- Increase task variety
- Co-worker as buddy

### Altered hours

- Flexible start/finish times
- Reduced work hours/days
- Additional rest breaks
- Allow work at home

### Workplace adaptations

- Reduce reaching
- Provide seating
- Reduce weights
- Different department

## Who does what, when?

Different people in different organisations will be responsible for receiving the fit note. In large organisations it might be the personnel department, whilst in SMEs it could be the boss. But, the people who actually make it happen will usually be the **line manager and the worker.**

It is crucial to have a system for working with the fit note. Someone needs to be responsible for identifying when a fit note is received. It might be when the worker has been off work and is returning or it may be while they are still at work – i.e. struggling with a work-relevant health problem. The worker and line manager need to be put together at the earliest opportunity to select the best adjustments and make them happen.

Remember, doctors only issue a fit note after seven days of sickness absence. For shorter periods of sickness absence, workers can self-certify. There is usually little point in waiting until the worker sees the doctor for a fit note before you do something. The same principles of early discussion and accommodation will generally apply during that self-certification period.

If you are uncertain whether staying at (modified) work is the right thing, you may want to suggest the worker checks with the doctor. What you may not realise is that the doctor will value your input. You can **let the doctor know the sort of adjustments that are available**, and what adjustments you and the worker think are going to be helpful. Unless you do this, doctors can usually only guess what someone's job actually involves. Of course, you need to do this with the worker's permission.

The fit note is a great opportunity for the key players – line manager; worker; doctor – to liaise and make recovering while working a reality. This helps the worker because work can often be part of the recovery, and it also benefits the employer by reducing sickness absence.



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## Graduated Return to Work and Activity

Graduated Programmes:

- Are an effective tool for workers to gradually build up both the type of duties performed and the hours worked
- Have three components - starting point, gradient, and duration

Closely related sections: [Developing an Action Plan](#) [Developing a Stay at Work Plan](#) [Developing a Return to Work Plan](#) [Resilience](#)

## WHY Graduated Programmes

FACT: People **can** be helped to stay at, and return to, work. The pivotal thing is to provide a supportive workplace. To achieve the best work outcomes there are [seven key principles](#) to follow.

A key tool is the [Graduated Return to Work Programme](#). These are sometimes abbreviated as 'GRTW' programmes and also known as **Graded Return to Work Programmes**. It's the same thing.

A graduated early return to work is a useful rehabilitation tool to enhance a worker's recovery. It enables injured workers to return safely to work before they have recovered fully. They can do modified or alternative work on a temporary basis and gradually resume their original job. The benefit is not only from the managed activity, but also at a psychosocial level, resulting in a faster and more durable recovery.

## WHO Graduated Programmes Are For

Graduated programmes are appropriate for those who can **return to work gradually**, within a **realistic timeframe**, and can **complete the programme** without setbacks.

This means they will suit ill or injured workers who are fit for selected/suitable duties. That is, they have a capacity to complete **some type of work**, but can't return immediately to their full pre-illness/injury job.

### Workers Suitable for Graduated Programmes:

**Include** when worker:

- is able to return to work on suitable selected duties and/or hours
- is unable to work at all - usually only applicable for the immediate acute period of common health problems
- has advice available about their current functional ability - what he or she can do
- has line manager who understands the tasks and requirements of the job and whatever modified or alternative duties can be made available

**Exclude** when worker:

- is able to continue normal work hours and duties

## WHO is Involved

**Line managers** and **senior management** should be aware that graduated return to work programmes help workers return to work sooner, reduce length of absence durations, and result in lower costs. For this reason, line managers should be willing to accommodate workers with temporary restrictions.

**Workers** are often unfamiliar with the benefits of early rehabilitation and the concepts of graduated return to work. This might make it difficult and time consuming unless they get access to the necessary [knowledge](#) about common health problems. Always ensure this happens!

Role for Others: In most cases common sense will dictate how much the worker does and how often. However, it may be appropriate to ask a professional case manager, an occupational health nurse, or an occupational therapist to devise the programme. If several parties are involved, a case conference may be needed to ensure everyone agrees to the plan and knows what is happening and when. As always, it is important to communicate effectively and keep all relevant parties informed to help ease the worker's transition back to the workplace.

## EFFECTIVE Graduated Programmes

The goal is simple - gradually build up both the **type of duties** performed and the **hours worked** until the person achieves the goal of pre-injury/illness full-time work, wherever possible.

Effective graduated programmes:

- Are based on functional capacity, what the person can and will do
- Are time bound, with a beginning and an end
- Are goal oriented
- Have clear accountabilities, defining who is responsible for what and when
- Engage all key players
- Are monitored, and revised when necessary

The aim is always to build duties gradually, within a realistic timeframe, and completing the programme without setbacks.

**Practical Tip:** While it is always important to promote activity and work, it is also important to ensure there is the best chance of **success**. The experience of failure in a stay at work, or return to work, programme can have a negative impact on all involved - with loss of confidence, and even worse an unwillingness to try again. This makes it very important to learn **how** to use graduated programmes effectively.

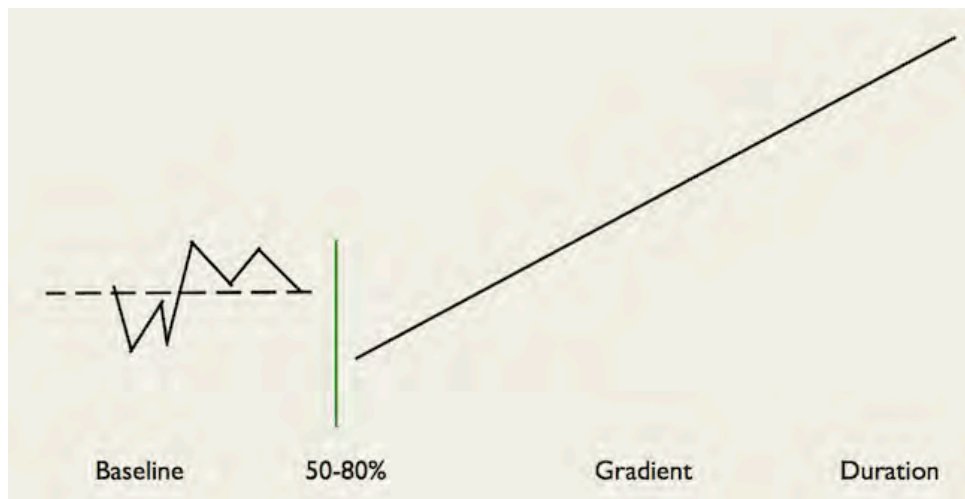
Graduated programmes are like 'working to a quota'. The idea behind this is summed up in the phrase 'do no more on a good day, and no less on a bad day'. The approach is aimed at reducing the learning relationship between symptoms (e.g. pain, fatigue, feeling stressed) and activity and work. This replaces the unsatisfactory symptom-contingent activity with time-contingent activity - this means it prevents symptoms of common health problems taking over your life and ruling everything you do!

The working to quota approach is used to disrupt an erroneous relationship between activity and symptoms levels from being learned. The purpose is to ensure a pre-set level of activity/work occurs irrespective of symptom intensity experienced, and then to gradually increase this over time as the body 'habituates' to the experience of the symptom, and recovery occurs. This means graduated programmes are a very useful way to build or rebuild tolerance and resilience.

## HOW to Use Graduated Programmes

There are **three components** to a graduated programme, and you need to learn how to do each of these:

1. Starting Point - manageable for the worker and guaranteed of success
2. Gradient - how fast the type of duties and number of hours worked will be increased
3. Duration - the period of time from start to finish



### Choosing a Starting Point for the Graduated Programme

The goal is to ensure the worker can cope with the initial workload and type of job tasks. This provides the springboard for a gradual and steady increase, while minimising the likelihood of setbacks.

Establishing the initial quota is a question of judgement, not formulaic. However, a practical approach is to list some key activities as tasks with the duration that they are performed. Work with your client to place these into a hierarchy from 'least problematic/concerning' to 'most problematic/concerning'. This allows you to develop a working baseline, based on a starting point of what the client feels they 'can do on a bad day'. This is used as your guide, not the client's. If necessary, start the client even slightly below this level. It is imperative that the client experiences success from the outset, and is not set up to fail.

**Practical Tip:** Try and work out what the individual is capable of, or has been doing, then start at somewhere between 50% and 80% of that level.

### Setting the Gradient for the Graduated Programme

The next step is to establish a gradient, so that small increments can be added at regular intervals (usually daily). Set an initial 'timetable' for at least a week, in collaboration with your worker. Ensure they have coping skills to manage fluctuations of symptom intensity, and that they have both a recording system and some kind of a reward, or praise, in place for when they successfully adhere to the plan. Set a review date.

**Practical Tip:** At the review, reset the activity schedule. It is imperative to maintain or increase activity level at this time, do not reduce demands. It is important that activity level is not reduced because the effect of this is to reinforce that symptoms are a 'threat', they are to be avoided, and that you do not trust that the worker to be able to cope.

### Setting the Duration for the Graduated Programme

The length of time required to build up to the same level as before illness or injury will vary according to several factors. What is needed is a 'Goldilocks amount' - not too little, not too much. The duration can be adjusted if necessary.

Defining the duration of any work-shortening or selected duties (rather than leaving it open ended) helps to establish clear expectations and will be less stressful to the worker, the line manager, and work colleagues. With this information, they'll be more likely to manage in the worker's absence or help out with duties the worker can't do.

**Practical Tip:** We all find it difficult to wait for long periods to achieve things, and gain that sense of achievement when we reach our goal. In general, it is much easier to plan a programme lasting a few weeks, not months. If a longer period is absolutely unavoidable for whatever reason, break down the goals into steps or sections. For example, if a case is complex, or there are multiple obstacles, progress may happen like this:

*Part-time suitable selected duties > THEN > Part-time usual duties > THEN > Full-time usual duties*

## Useful Variations in Graduated Programmes

It is often important to take into account practical real-life issues when setting up a graduated programme to help someone stay at or return to work. Common examples are the need to fit in with transport, or childcare arrangements.

This may influence initial decisions about how to distribute part-time hours across the days of the week. For example, if the goal is to commence with 15 hours, this could be done as:

- 5 hours on each of 3 days per week, e.g. Monday, Wednesday, and Friday
- 3 hours on each day of the week

When issue such as childcare or transportation are an issue, it might be practical to adopt specific working times, e.g. from 9.30 am to 2.20 pm.

**Practical Tip:** When working out how to start a graduated programme try to think about how it will work as it progresses. This is because there will invariably choices to make, some of which will suit the worker and the workplace more or less than others. For example if you start with 5 hours on 3 days per week, you could then choose to increase hours one of two different ways: (1) add more days per week, or (2) add more hours to the same 3 days. Each of these may have very real practical implications that you need to take into account.

If the worker's symptoms appear to be aggravated by their usual duties and job tasks, then these should be gradually reintroduced. This process is sometimes referred to as 'work hardening' or 'work conditioning'.

This means that in addition to gradually increasing the number of hours being worked it is necessary to gradually move from 'alternative' to usual duties and job tasks. One way to do this is to intersperse normal work duties that are within the workers' capacity with the alternative selected duties. The employer may be able to **temporarily** 'lighten' the job by selecting discretionary tasks, prioritising activities to match variations in work capacity, or providing simple tools such as lifting aids to reduce strain for the worker.

## Example ONE: Graduated programme with a set number of hours a day

This plan allows for a variety of work duties and tasks to be done, **including** normal duties.

Programme commences with a specific number of working hours per week in a pattern that allows for pacing and an appropriate level of resting. e.g. three mornings only.

As tolerance improves, extra half-days are added. The progressive extension of the working day to normal hours can be done with (1) larger increments on alternate days; or, (2) a small increase each day

Try to build into the plan breaks for rest and fitness activities (such as going to the gym) that can eventually be moved into the worker's own time, or discontinued altogether.

Potential advantages for the worker to this approach using shorter working hours include:

- help them to avoid fatigue, rush-hour traffic, and other energy demands
- signal to their organisations that they have not yet fully recovered
- encourage others (in both work- and non-work-related situations) to continue helping out
- ensure the workers have ongoing contact with the workplace

## Example TWO: Graduated programme with a set number of hours a week

This plan allows greater flexibility in the work schedule (than the plan using a set number of hours per day). It may not be possible to establish a rigid timetable for each day due to variability in the worker's symptoms, e.g. mental health problems such as depression.

Line managers may also have difficulty providing set number of hours per day. This might be due to the nature of the work. Some jobs don't lend themselves to regular shortened-hours routines, such as those with periods of intensive activity to meet deadlines, interspersed with quiet spells.

In these situations use a total number of hours per week, rather than a specific number of hours per day. This allows the worker to participate more when more work is available, within an overall target. Selecting discretionary tasks and prioritising work will help to match variations in work capacity.

## Monitoring progress

When problems arise in a graduated programme the focus should be on easing the duties rather than the hours at work, until the person is ready to move on. As long as they feel able to report any deterioration in symptoms, harm is unlikely to result.

**Practical Tip:** If there is any type of setback that results in the need to reduce hours or change the type of duties, **do not stop** the graduated programme altogether. Reset the programme, so that it starts again at a realistic level, e.g. 80% of what the worker is now able to do. If necessary adjust the gradient, or sub-divide the duration into separate goals.



# Health<-->Work

## the toolbox for managing common health problems at the workplace

BACK

### Introduction to the Health<-->Work Culture Tool

We know organisational culture is an important basis for how people act. Lessons from high hazard industries indicate that organisations with good safety cultures take proactive steps to ensure they go beyond their legal obligations. The result is fewer accidents, injuries and days lost due accident-related absence.

So why not establish a similar approach for common health problems?

Establishing a good culture around common health problems has many benefits. Culture pervades through an organisation and can make managing health a lot easier: If the culture is right, everyone – line managers, workers – will take it upon themselves to work towards minimising health problems and accommodating them when they do occur. With a good culture, you won't need to rely on people complying with instructions issued by human resources, the occupational health department or senior management.

A good organisational culture for health will help create attitudes:

- Good jobs can keep common-health problems to a minimum
- When health problems do occur, they can be easily be accommodated with minimum fuss
- People can usually manage their own health but can seek help if needed

It is good to share knowledge about what worked and what didn't in managing health, both within the organisation and also with customers and suppliers. Sharing good practice with customers and suppliers is the right thing to do, and helping them to improve health can help you too.

The toolbox can help you identify areas in which you can improve your organisation's culture so that health is easier to manage.

**What do we mean by 'culture' in the workplace? Put simply, it refers to 'the way things are done around here'**

### The Health<-->Work Culture Tool

Consists of a few simple questions. To get the best out of this, answer as honestly as you can.

- Consult with others in the organisation on what they think. This can involve members of the senior management team, workers, and anyone responsible for health and safety. If there are layers of management, unions or employee representation groups – consult with them.
- Ideally, each member of senior management team should think about these questions before discussing them collectively.
- Keep the discussion focused on improving things, not allocating blame for past misfortunes. Good cultures move forward, they don't dwell on the past.

*1. Do you already think that health = work and work =health?*

If not, why not?

*2. What are your organisational policies and practices like for health? Are they acted on?*

If you haven't got relevant policies, then you need to. But, having a policy isn't much use if people don't pay attention to it. If people don't pay attention to policies, then you need to think about how to encourage people to do so. It's more than simply 'ticking a box'.

*3. Are you mindful of health when developing other policies and practices?*

Not all business decisions are relevant to health – but are you aware of the ones that matter? You need to be mindful of decisions that might impact on health, for example decisions that increase people's working hours or change how they work. Also, be aware when developing new policies and practices that these can be opportunities to make developing **good jobs** and a **supportive workplace** easier rather than harder.

*4. Do you treat people with health problems fairly?*

Equal opportunities apply to all people, including those with health problems.

*5. Do you communicate and openly discuss how to prevent and cope with common health problems?*

Do senior and line managers take a lead in discussing health-related issues?

Do people challenge inadequate practice?

Do people let each other know about good practice?

Communication is important, and senior managers need to take a lead. For matters to improve, people must feel confident they can challenge inadequate practice where it occurs and be supported by senior management in doing this. People must also feel confident they can share good practice with each other, so that it is encouraged to spread across the organisation and onwards to customers and suppliers.

*6. Do you believe that people with health problems can be productive?*

### Potential actions for improving workplace culture

What's best for an organisation depends on things like its size and the sector it works in. When thinking about what to do, take into account both the nature of the organisation and the people working in it. Changes you make should be:

**Responsive** to the needs of workers and the nature of their work.

**Acceptable** to workers, managers, co-workers and other people at work who may be affected by the changes.

**Worth** promoting by giving the best return on investment when all things are considered including impact on co-workers and other organisational practices.

Here is a list of **actions** that could be useful. You may already do some of these. If so, think about whether you could do them better. Of course, you might find better solutions than these – the list is really only intended to get you thinking.

1. Establish discussion between workers and managers on the topic of common health problems, good jobs, and supportive workplaces.
2. Include common health problems as a standing item in existing human resources, occupational health and safety meetings, and senior management meetings.
3. Display organisational policies for health prominently.
4. Display information on days lost to health in the organisation – this will help people keep a tab on improvements at work.
5. Include health information in employee briefings and newsletters – make sure everyone has access to information on what workers and manager can do to improve health and minimise days lost due to common health complaints.
6. Provide managers and workers with training on how to communicate effectively (that is, assertively but respectfully), so they can share good practice and point out problems.
7. Encourage workers to engage in discussions around organisational operations and change, so that their views can be taken into account in how to ensure healthy working practices.

**Remember the most important action is to show visible signs of senior management commitment to a Health<-->Work culture**

## Improve Workplace Culture

**Do** emphasise that work is healthy, therapeutic, and can play an important role in recovery (while recognising that work can also be a hazard).

- **This means** you need to provide advice and support wherever possible to help people stay in, and return to, work. And, that work should be safe and healthy.

**Avoid** thinking of work as a 'risk' and (potentially) harmful to physical and mental health.

- **This means** you should avoid assuming that time off work is needed. Or, that you will be helping by 'protecting' the person from work.

# Health<-->Work

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## Health<-->Work Questionnaire

Find out if you, your workers, line managers, and senior managers have got the health & work message

### Two uses for the Health<-->Work Questionnaire

1. Find out whether workers and line managers understand the fundamental relationship between health and work. If the level is low, then you should ensure everyone gets 'the knowledge'. This measure may provide justification for the resources needed.
2. Measure improvement in understanding the relationship between health and work. For example, use it before and after. This can demonstrate cost-benefit from helping workers and managers getting 'the knowledge'.

### What do you think about Work and Health? Answer the following questions with TRUE or FALSE

- Coping with health problems whilst working leads to faster recovery
- Medical advice isn't always needed in order to stay at work with a health problem
- Carrying on at work with an injury or illness does not usually make it worse
- Work is good for our health and wellbeing
- Modified work is not always needed for an injury or illness at work
- It's OK to sort out job modifications with your line manager
- The Fit Note can help people stay at work with an injury or illness

[Download Health & Work Questionnaire](#)

[Download Scoring Instructions](#)

### Using the Health<-->Work Questionnaire

Each 'True' response is given a score of one, and each 'False' is zero. The total score ranges from zero to 7.

A score of zero indicates **little or no** understanding

A score of seven indicates a **good** understanding

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## Identify, Plan, Action Framework

Identify obstacles to staying active and working, so that you can plan to overcome these, and then put that plan into action.

**Identify, Plan, Action** - **identify** any obstacles, **plan** how to overcome them, and put this into **action**.

To be effective: Consistency, Coordination, and Collaboration

### Identify Obstacles

Looking for obstacles should be a routine activity by all key players. Think obstacles!

### Develop a Plan

The Plan is often simple: agreeing to a few straightforward goals and timelines, making sure everyone knows who is doing what and when, this enables coordinated actions

- my goals
- what can I still do
- obstacles to working
- who needs to do what and when

Key tasks:

- key players communicate
- tackle specific obstacles by taking specific actions
- each action has an agreed timeframe, responsible player allocated
- emphasise ability
- all players agree common goal and ensure supportive workplace
- copy of plan to all
- provision for revising plan when necessary

### Take Action

Use a stepped approach - 'just what's needed when it's needed'

- goals: set a time for starting back at work, and target timeframe for ending modified duties
- can do: list can-do tasks and jobs (not just can't-do)
- obstacles: what obstacles are getting in the way, and who will tackle them
- what and when: steps needed to overcome obstacles, timeline, coordinator

### Evaluate Progress

- use objective measures
- avoid subjective approaches
- ask 'what have you been doing?' not 'how are you feeling?'

Revise a plan when there is a lack of progress, indicates need to re-evaluate.



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## Identifying Obstacles

Identify obstacles to staying active and working, so that you can plan to overcome these. There are two types of obstacles, those that are modifiable and those that are not. Avoid falling into the trap of assuming that immovable obstacles cannot be navigated around.

### What Obstacles to Look For

The three places to look for obstacles to staying active and working are the Person, their Workplace, and the Context in which they function.

**TIP:** Remember **Identify, Plan, Action** - **identify** any obstacles, **plan** how to overcome them, and put this into **action**.

## PERSON

### Thoughts

- Catastrophising (focus on worst possible outcome, or interpretation that uncomfortable experiences are unbearable)
- Unhelpful beliefs and expectations about pain, work and healthcare
- Negative expectation of recovery
- Preoccupation with health

### Feelings

- Worry, distress, low mood (may or may not be diagnosable anxiety or depression)
- Fear of movement
- Uncertainty (about what's happened, what's to be done, and what future holds)

### Behaviours

- Extreme symptom report
- Passive coping strategies
- Seeking serial ineffective therapy

## WORKPLACE

### Employee

- Fear of re-injury
- High physical job demand (perceived or actual)
- Low expectation of resuming work
- Low job satisfaction
- Low social support or social dysfunction in workplace
- Perception of high job demand or feeling stressed by work

### Line Manager

- Lack of job accommodations or modified work
- Lack of employer communication with employees

## CONTEXT

- Misunderstandings and disagreements between key players (e.g. employee and employer, or with healthcare)
- Financial and compensation problems
- Process delays (e.g. due to mistakes, waiting lists, or claim acceptance)
- Overreactions to sensationalist media reports
- Spouse or family member with negative expectations, fears or beliefs
- Social isolation, social dysfunction
- Unhelpful policies/procedures used by company

## How to Look for Obstacles

### Ask these Useful Questions

1. What do you think has caused your problem?
2. What do you expect is going to happen?
3. How are you coping with things?
4. Is it getting you down?
5. When do you think you'll get back to work?
6. What can be done at work to help?

### **The Obstacles Question**

*"What three things about your health problem and your work are affecting your work ability – in other words, what's making it difficult to stay at work (or get back to work)?"*

You can use this question to help point you to the obstacles that your colleague is struggling with. You should ask this after the work ability question. It will flag up the most important and immediate things that you'll need to deal with.

**If your colleague has scored 8 to 10 on the work ability question** (see above, in Action 3), you may not need to look any deeper for obstacles, but remember new obstacles can crop up, so keep an eye on their work ability. If they scored 3 to 7 you will need to check the wider range of [obstacles](#). If they scored 0 to 2, you should consider getting professional help in identifying the obstacles and developing the plan.

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### Identifying Struggling Workers

Some people in every workplace will inevitably experience common health problems, even though good jobs reduce their frequency. The sooner they are identified the faster they can be dealt with and this reduces the impact on the workplace and helps maintain productivity. Identify anyone at work who is struggling to cope with symptoms of common health complaints or minor injuries. Identify anyone who is off work (i.e. reduced hours, or stopped altogether).

All **Line Managers** need to be able to:

- Identify any worker who is struggling to cope with symptoms of common health problems or minor injuries.
- Identify anyone with a fit note.
- Identify anyone who is off work (i.e. reduced hours, or stopped altogether).

All **Workers** need to be able to:

- Recognise when a colleague is struggling to cope with symptoms or injury

Struggling at work is something that is going to be identified by the worker themselves, or by another person seeing them. This means you should identify anyone at work who is struggling to cope with symptoms of common health complaints or minor injuries.

There are two main ways problems at work can be identified:

1. The individual worker reports problems (e.g. to line manager, OH, or HR), takes time off work or seeks healthcare.
2. Either the line manager, or a co-worker, notices changes in performance and behaviour. This means the worker may say something to you or other, or you or others may notice something. There are [signs of mental health problems](#) you can look and listen for.

**Practical Tip:** The most likely way you will recognise that you or someone else at work is struggling will be because their behaviour or productivity has **changed**.

We need to distinguish someone who is struggling to cope and has a work-relevant problem from the informal 'grumbles' about work that everyone has from time to time. You need to distinguish pay attention to the struggling worker from the grumbler.

Someone who says things like 'I don't like this job' is probably just grumbling, or having a bad day. However, if there is an obvious change in their behaviour - moving and doing tasks in an awkward or uncomfortable way, or productivity drops - this may be a sign that the person is struggling.

For mental health issues and difficulties dealing with stress there is a more detailed [list of things to look out for](#). Again, the key thing is to notice **changes** that may indicate a work-relevant problem developing.

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### MYTHS

Beliefs are central to our responses to a health problem, and influence what we do about it. Myths and legends abound, and are major obstacles to stay-at-work, and return-to-work. Many obstacles are related to these common myths. They are exceedingly pervasive, having negative effects on the behaviour of all involved, and the interactions between them.

Myths about [common health problems](#) need to be challenged and dispelled

[download a copy](#)

Myth	Reality	Why it Matters
<b>Symptoms (e.g. pain, fatigue, worry, stress) means serious illness, damage, or injury</b>	<p>This is not always the case: symptoms such can occur without disease or injury.</p> <p>Even when specific tissues are affected, activity and work are not precluded.</p> <p>Temporary discomfort or distress is often part of recovery.</p>	<p>Believing symptoms means harm results in activity-avoidance behaviour, which are obstacles for stay-at-work and return-to-work initiatives.</p> <p>Worrying about 'damage' and 'injury' is an obstacle to active interventions that see work as a therapeutic intervention.</p>
<b>Work/activity is the cause: something is damaged</b>	<p>Symptoms are common across the whole population, regardless of type of work.</p> <p>Work or activity can trigger symptoms, but most work is unlikely to cause substantial damage.</p>	<p>Erroneously blaming work leads to an undue concentration on simplistic explanations for the causes of symptoms, which gets in the way of effective interventions tailored to specific circumstances.</p>
<b>Work/activity will make matter worse</b>	<p>The actual condition is usually not made worse by continuing work (assuming control of significant risks).</p> <p>Work may become difficult or uncomfortable, but that doesn't mean it is doing harm.</p>	<p>Work is generally good for health and wellbeing, so the belief that work is inherently dangerous is unhelpful, and poses a major obstacle to helping people get back to work or stay at work.</p>
<b>Medical treatment is necessary</b>	<p>Most people, for most episodes of a common health problem, do not seek healthcare.</p> <p>Reliance on healthcare alone is not enough to help with return to work</p>	<p>Over-cautious behaviours can be powerful obstacles to recovery and return to work.</p> <p>Reliance on medical treatment alone negates the possibility of involving the workplace in helping people back to work.</p>
<b>Injuries and health problems must be rested</b>	<p>Quite the contrary – activity leads to faster and more sustained recovery and return to work.</p> <p>Temporary reduction of activity may be required, but long-term rest is detrimental.</p>	<p>Using rest as a treatment is a major obstacle to modern management strategies that encourage and support return to activity/work.</p> <p>Advising patients to take unnecessary rest can give the disadvantageous impression that the problem is serious.</p>

Myth	Reality	Why it Matters
<p><b>Sick leave is needed as part of the treatment</b></p>	<p>Often sick leave is not needed – staying at work is desirable, perhaps with some temporary modifications.</p> <p>The use of 'fit notes' is preferable to sick notes: emphasise what the person <b>can</b> do, not <b>can't</b>!</p>	<p>Helping people stay at work can contribute to their recovery.</p> <p>Injudicious use of medical certificates reinforces fears and uncertainty, and encourages reliance on rest, whilst fostering fears of activity.</p>
<p><b>Contacting an absent worker is intrusive</b></p>	<p>Continued contact with the workplace is crucial to the return to work process.</p> <p>If the approach is positive and un-pressured, workers are appreciative.</p>	<p>Failure to make early contact with people who are off work leaves them isolated and unvalued, thus fostering distress or depression.</p> <p>Lack of contact means there is no chance to make a return to work plan, and no chance to discuss transitional working arrangements.</p>
<p><b>No return to work till 100% fit and symptom free</b></p>	<p>This is clearly unrealistic and unhelpful - many workers can and do return with ongoing symptoms, and they do come to no harm.</p>	<p>Employers' policies that restrict work-return to those who are symptom free or fully fit for their usual work are counterproductive, and are a major obstacle.</p>

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## Tackling Common Health Problems - Quick Guide for Line Managers

Muscle and joint problems, stress, anxiety, depression

### Helping your workers stay active and working

You – the employer, line manager, or supervisor – have an important role to play: use this guide to help you help your colleagues

### What

Most people get problems such as episodes of muscle and joint pain, or feeling stressed or down. Sometimes the onset may be from physical activity but more often there's no obvious cause. Usually there is nothing to worry about: serious injury or damage is rare.

Recovery is expected but symptoms such as pain, fatigue, or worry may recur. Back pain is a good example: activity is generally helpful – prolonged rest is not; most people get better and back to work quickly – but some hit problems.

Muscle and joint pain is very costly when people are off work for too long. The old approach of staying off work actually makes matters worse. Early return to work is usually beneficial.

But people need help to stay at or get back to work. And, it's not enough to rely on doctors and other clinicians – the workplace needs to be accommodating.

People often struggle to get back to work. It's usually not because of a more serious injury. It's because they face obstacles: things about the person, the workplace, or the context.

### Identify Obstacles

You can spot the obstacles to activity and work by looking for things will get in the way. Mostly you'll be looking for workplace obstacles, but you need to work with the other players (doctors, health and safety reps, etc.).

Identification is about looking for unhelpful behaviours and circumstances. Anything about the person, the workplace or the circumstances (including influential others) that stands in the way of early return to work is an obstacle.

### Plan of Action

Goals: set a time for getting back to modified duties and to usual work.

Can do? list can-do tasks and jobs (not just can't do)

Obstacles: list what's getting in the way of getting back to work: job factors, personal factors, context factors – list who needs to tackle them

What and when? figure out the steps needed to overcome the obstacles, set a timeline: appoint someone to act as a support buddy/case manager.

### What To Do

Taking action is all about overcoming obstacles at work. It means providing an accommodating workplace, with helpful policies and coordinated actions. It's not complicated.

- Contact the absent person within a day or two
- Tell them the workplace will be supportive
- Point out the return-to-work buddy who will be their case manager (perhaps the supervisor)
- Ask the person to come in to work to sort out the return plan
- Ask the doctor what the worker can do:
- Get their permission to talk with the doctor: use a [confidentiality waiver](#) (the worker gives explicit written permission for (selected) people to talk freely with the doctor/therapist)
- Assess the job, and offer modified work (if necessary) for a fixed period
- Allow graduated return to work plans, that offer gradual increase in hours and participation
- Monitor progress: revise the plan if any setbacks

### Modified work

Early return to work can be helped by simple modifications to the person's job. This is a temporary step simply to gradually ease them into usual work. Getting over the obstacles:

Alter the work to reduce physical demands: e.g. reduce reaching; provide seating; reduce weights; reduce pace of work/frequency; enable help from co-workers; vary tasks.

Alter the work organisation: e.g. reduced work hours/days; additional rest breaks; graded return to work; home working

Flexibility: e.g. daily planning sessions with a buddy; allow time to attend healthcare appointments; help with transport

# Health<-->Work

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## Advice and Facts for Workers with Common Health Problems

Muscle and joint problems, stress, anxiety, depression

Helping you stay active and working

### Important information

- Activity and work are good for physical and mental health
- Physical problems (such as muscle and joint aches) and psychological problems (such as feeling stressed or down) are very common – pretty much everyone has them at some stage during their life
- These problems can be distressing and may make life difficult for a while
- Serious disease or injury with lasting damage is very rare
- Most episodes settle quickly, but the symptoms may crop up again
- It's best to stay active and continue working, or get back soon

### Identify obstacles to your recovery

Various things can get in the way of recovery and getting back to work and activity

#### Personal obstacles involve how you feel and think

- Unhelpful attitudes and beliefs about health and work
- Uncertainty
- Anxiety and depression
- Loss of routine and work habits

#### Work-related obstacles can block your return to work

- Loss of contact with work
- Negative attitudes by people at work
- Lack of job accommodations or modified work
- Misunderstandings and disagreements between you, your employer, and doctor/therapist

#### Health-related obstacles can confuse and delay

- Conflicting advice
- Waiting lists
- Prolonged sick leave
- Ineffective treatments

### Warning signs to watch out for

You are unlikely to recover and return to work if you

- Believe there is something seriously wrong
- Are unable to accept reassurance and help
- Avoid activity in case it makes things worse
- Get withdrawn and depressed
- Are fearful and uncertain about going back to work

The longer you are off work or not doing your usual activities, the harder it is to get back

### Make a plan to be active and working

The key is communication and action. There are two main issues:

(1) Recovery depends on working with the health professionals who are helping you, and on your own motivation and effort. Treatment can help to reduce your symptoms, but you are the one who has to get active – see activity as part of your treatment



**Ask yourself:** *What can I do to be a 'coper' and not an 'avoider'?*

(2) Returning to work depends on you and your employer working together, and that needs communication. The key thing is to stay in touch with the people at work – figure out what's needed to help you return

**Ask yourself:** *What obstacles are getting in the way of my going back to work, and who do I need to talk to about overcoming these (through problem-solving and negotiation)*

## Action!

### Put your plan into action

Set realistic goals - Give yourself a clear timeline for getting back to work and activity. Use weeks, not months

List what you can do - Have a 'can-do' approach, and avoid dwelling on what you can't do easily at present. You'll find you can do a lot of things – at work and leisure

Talk with your health professional – Discuss what you can do: work out ways to get active and back to work. Give them permission to talk with your employer

Increase activity – Do a little more each day for a little longer. Pace yourself: do no more on good days and no less on bad days

Changing your attitude and improving motivation – Don't get gloomy or anxious. Getting active will improve your confidence and you'll feel more positive

Talk with your employer – If your employer has not been in touch, make the first move. Temporary changes to your job are one of the best ways of making it possible to get back to work: sort out what's needed with your line manager

Put it all together – Make sure that you and your doctor and your employer all know what is happening and what you are planning. Tell them you want help to be a coper.

Don't just think about it. Just do it!

# Health<-->Work

## the toolbox for managing common health problems at the workplace

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### Antidote to self-defeating thinking on health<-->work

Be supportive and positive. You can use the following tips to help your staff to think positively about the impact of their health upon their ability to work. How they think about their health should then become an enabler and not an obstacle to their staying at work.

Encourage your staff to:

- If in doubt, give it a go... staying off work probably won't help
- Look for improvements not impediments or failure
- Take control of the problem; look for solutions
- Take a bigger perspective – it won't go on for ever
- Seek positive people, positive examples and avoid the 'ain't it awful'

# Health<-->Work

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## Principles of Good Jobs

### Good jobs

A good job is not the same as an ideal job, but it is much more than good work. Not all jobs, if any, can be perfect. It is a matter of making the working conditions reasonable within the context of the job. This is a question of balance. Although people have different preferences, for the most part, most people agree on the features that make up a good job.

### Job satisfaction

Job satisfaction is how people feel about their jobs and different aspects of their jobs. It is the extent to which people like (satisfaction) or dislike (dissatisfaction) their jobs.

### It's the simple things that make for good jobs

Focus on the basics: starting with open communication across the organisation, and treating workers and co-workers with respect. Workers prefer to feel they have a say in how things are run, and that management will listen. They need to feel appreciated and part of a team with a common goal. Good jobs are fair jobs. Good jobs repel an 'us and them' culture; working with colleagues reduces antagonism and resentment.

### Good jobs come from good management

While this may be self-evident, remember that good management involves everyone: Senior Management sets the approach. Line Managers make it happen. Workers contribute to the process.

### Characteristics of good jobs

Good jobs are interesting and motivating. Different people have different things that motivate and interest them. For example, some people are interested in helping customers, whereas others like solving technical problems. Alternatively, it can be the social contact with colleagues that is most important. Good jobs allow people to pursue these interests, provided they are reasonable and consistent with the work unit and organisational goals.

The content that makes up a good job includes all the characteristics of good work and includes seven additional features

1. Balanced demands and a safe work environment
2. Effective and supportive line management
3. Feeling of being a valued and respected member of a team
4. Opportunities to use and develop skills
5. Support and opportunity for workers to solve their own problems
6. Support to make improvements to the job
7. Opportunities for social interaction

There are others things of course, but these are the features that people say make a job comfortable, agreeable and satisfying. Importantly, they are also the things that help people to be resilient, so they can cope at work with common health problems and minor injuries. Making jobs good will lead to less sickness absence.

### What's in a Word? 'Good Jobs' versus 'Good Work'

*The idea of good work is an important one. It goes beyond just ensuring that jobs do not injure people or make them ill. It is also about the way work is organised, including things such fair rewards, security fulfilment and appreciation by society. Initiatives to produce good work happen mostly at the level of policy, regulation, and legislation. Work that is both 'good' and safe has become an expected minimum standard, but it is not sufficient to fully support the health and well-being of workers. Initiatives to produce good work happen mostly at the level of policy, regulation, and legislation. However, all the features required for 'good work' may be in place, yet the job may still not be a good one. A good **job** is safe, healthy, sustainable, satisfying, rewarding, and much more. The provision of good jobs happens in workplaces. It is each person's actual job ... your job, my job, etc. To have a good job the right things must be done in this workplace, now.*



# Health <--> Work

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## Principles of Supportive Workplaces

### People *can* be helped to stay at, and return to, work

The pivotal thing is to provide a supportive workplace using seven key principles:

**FIRST PRINCIPLE:** The workplace needs to have a strong commitment to health and safety - demonstrated by behaviours of all workplace parties. It's not just what we say to ourselves and others, it's what we do. As the old saying goes "actions speak louder than words". This is a collaborative issue. Support is needed at senior management level, and from all the employees. This means workers, and their representatives, also need to support inclusion of stay at work and return to work policies. Importantly, it's not just a matter of management looking after workers - people need to take some personal responsibility for what happens to them. Everyone should aspire to being a copier rather than an avoider, and must engage with those who are helping them deal with their health at work.

**SECOND PRINCIPLE:** Employers need to offer modified work, i.e. an accommodating workplace - early and safely. This means providing appropriate modified work, and taking care to ensure there is not an awkward fit for the worker and others. Usually, this can simply be worked out between worker and manager. Simple ergonomic principles apply. Only if there is difficulty coordinating staying at or getting back to work is there any need to consult an ergonomist or health and safety professional.

**THIRD PRINCIPLE:** Case coordinators need to ensure the work plan supports the worker without disadvantaging co-workers and line managers - they may need training in case management skills (in-house or from external suppliers). These coordinators need to ensure the plan supports the worker without disadvantaging co-workers and line managers. Planning how to keep someone at work, or ease them back into the workplace, involves more than just matching the sick or injured worker's abilities to job tasks. It can be seen as a 'socially fragile process' where line managers and co-workers can be thrust into new relationships and routines. If it is not properly managed, this may involve resentment instead of cooperation. Here are good examples of potential problems: (1) the sick or injured worker may have to deal with co-workers who resent having to take over some of their work and therefore feel that the worker has managed to get an 'easier' job; and (2) line managers may be expected to get the job done and fulfil production rates in spite of accommodating a sick or injured worker, and can't see a way to offer the required accommodation. Workplaces that treat sick or injured workers as individuals who anticipate in the arrangements can avoid these pitfalls.

**FOURTH PRINCIPLE:** Line managers need to be comfortable about how to prevent extended sickness absence and work disability, and should be involved in developing plans for Stay at Work and Return to Work. They may need training in case management skills (in-house or from external suppliers). The minimum is to incorporate specific topics into safety training for line managers: (1) how to be positive and empathetic in early contacts with workers; (2) how to arrange modified work; and (3) how to follow-up and problem solve on a regular basis.

**FIFTH PRINCIPLE:** Employers and/or line managers should make early and considerate contact with the absent worker. This appears to be a core component of the process and should be done in a positive way. This means focusing on concern for the worker's well-being, and avoiding issues such as causation or blame.

**SIXTH PRINCIPLE:** Someone in the company/organisation should be given clear responsibility to coordinate stay at work and return to work to make sure it happens - a designated case coordinator or buddy. Alternatively, the coordination role can be performed by someone external, such as a professional case manager with a direct line of communication to the workplace. Either way, simply having good intentions is not enough. It's important that communications do not break down, and that key actions are not overlooked or forgotten - the case coordinator needs to ensure everyone involved in the work plan knows what is expected of them and when.

**SEVENTH PRINCIPLE:** Employers and healthcare providers (such as GP's, physiotherapists, and other practitioners) need to communicate about workplace demands. A key part of this principle is implementing the advice on a fit note. Clearly it is important the 'left and right hand know what each other is doing'. Ideally the worker needs to participate in the communication between employers and healthcare providers. Obtaining the worker's consent is important - simple [confidentiality waivers](#) are useful.

### The workplace is very important

Work can be part of the recovery process. It provides all of us with important protective factors for our health, such as: routine, structure to day, social relationships, mental stimulus, self-esteem, activity, and a sense of wellbeing.

To achieve this we need to avoid the idea that work is a 'risk' and (potentially) harmful to physical and mental health. This is important because it leads to advice to stay off work, undue sick certification, over-cautious risk assessments, and the desire to somehow 'protect' the person from work. Certainly some work circumstances are dangerous and undesirable, but most work is beneficial for most people.

We need to shift the culture and emphasise that work is healthy, therapeutic and the best form of rehab (while recognising that some work can be a hazard). This can be achieved by ensuring everyone gets advice and support to remain in, and return to, work (that is safe and healthy, described in the good jobs section).

The contribution of the workplace is vital. When it comes to helping people stay at, and return to, work the most powerful influences comes

1. The person with the health complaint, then
2. The line manager (and the level of support and company policy he/she has to operate under), and then
3. Healthcare providers (including doctors, physiotherapists, etc.)

This means that one of the most important things any employer can do is to provide a supportive workplace that enables workers to recover from common health problems while working.

## We All Get Health Complaints, Only Some are Work-Relevant

When people have health or injury problems the workplace plays an important role in their recovery. Whenever possible we need to help people stay at work, even part time. This maintains their work ability, their skills and daily routine. Most importantly it helps them to stay active and to build resilience and tolerance. If a worker does take sick leave for even a short time we need to help them start back at work as soon as possible. Again, this may be part-time to begin with, building back up to full-time.

## The Main Reason People are Unable to Stay Active and Working is Because They Face Obstacles

It is a mistake to assume that the reason people don't stay at or return to work is simply because they have more serious illness or more severe injuries. The more important factors influencing work as an outcome are psychosocial. This refers to the factors that contribute to the **behaviour** of going to work.

There are factors that **increase** the chance someone can and will stay at or return to work. These positive influences are enablers or facilitators. We need to look for these and support them whenever possible.

Then there are factors that **reduce** the chance of staying at or returning to work. These are **obstacles**. We need to look for these and find ways to help people overcome them.

## You Need to be Able to Identify and Tackle Obstacles

The most important thing for success is to identify obstacles to staying active and working, and plan to overcome these. Remember there are two types of obstacles: (1) modifiable – these are like hurdles to be overcome; (2) immovable – these are like roadblocks to be sidestepped. The three places to look for obstacles to staying active and working are the **Person**, their **Workplace**, and the **Context** in which they function.

## Identify Problems Early, and Respond Rapidly

Some people in every workplace will inevitably experience common health problems, even though good jobs reduce their frequency. The sooner they are identified the faster they can be dealt with and this reduces the impact on the workplace and helps maintain productivity. Identify anyone at work who is struggling to cope with symptoms of common health complaints or minor injuries. Identify anyone who is off work (i.e. reduced hours, or stopped altogether).

The key thing then is to respond, and to do so rapidly. Do this by:

- Identifying the obstacles to being active and working
- Providing appropriate workplace accommodations and modifications

This is the very core of what it means to have a **Supportive Workplace**.

# Health<-->Work

## the toolbox for managing common health problems at the workplace

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### Principles of the Knowledge

#### Work is usually good for our health and wellbeing

We all get common health problems at times - feeling stressed, anxiety, depression, back pain, neck pain, minor injuries, etc. They can occur whatever job we have. Mostly we can cope and carry on at work and that's generally the best way to recover. Ask yourself, do you think that you or other people need to be somehow 'protected' from work when you have symptoms of common health problems, or is work usually the best place to get on with recovering?

#### Most work is not dangerous

So long as it complies with the Health & Safety Regulations, most modern work is not truly dangerous. It may have some unpleasant or uncomfortable aspects, but work is not usually a major cause of common health problems. Despite this, they account for most long-term sickness absence. Clearly we are not doing the right things to maintain health at work and prevent work loss.

#### Work may become difficult when we have a health complaint or injury

Health complaints and minor injuries can be irritating or even distressing to any of us. They can interfere with ability to work and be active, but they are not 'severe' in a medical sense and there is no reason to expect they will not improve. In fact, most people remain at work or return quite quickly, and they come to no harm. Those who find themselves struggling or going off work don't actually need to - if they get a little help from the organisation.

#### Mostly we can cope and carry on at work

Common health problems are work-relevant because the symptoms can interfere with your ability to do your usual job, although they do not always do this. You need to know that helping someone to stay at work or to get back quickly is the best policy. The longer someone is off work the harder it is for them to get back, and the more it costs.

#### Helping people to stay at work or get back quickly is the best approach

Some people struggle to stay at work or get back quickly. That's because they face obstacles, not because they have a more serious health problem. Good management at the workplace is crucial for overcoming the obstacles. Providing a supportive workplace that allows temporary changes to job tasks is the best course of action.

#### Reducing the Burden of Health Complaints at Work

Providing good jobs that are as comfortable as possible and accommodating workers in a supportive workplace when they have health complaints is the way to reduce the burden of health complaints at work. It is not that difficult to do, and will have tangible benefits. The starting point is to ensure your entire workforce is onside with the [health<-->work](#) message.

# Health<-->Work

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### Effective Problem-Solving

Problem-solving is a way to develop alternative strategies when obstacles arise.

It's old, well-used, and invariably true: the problem contains the answer! This means that when we focus on exploring the problem the solution will reveal itself.

Problem-solving means repeating the process of looking for solutions. The more you do this, the more you learn about the nature of the problem.

You may need to be patient. Problem-solving can take time. Remember that you can find **a** solution quickly, but **the** solution always takes time. If you haven't repeated and processed, you probably only have **a** solution.

Sometimes we are better at problem-solving when we detach ourselves from the problem entirely. We can do this with activity - run, cycle, write, make music, socialise. We can even do it when we are sleeping! Hence the old saying '*to sleep on it*'. This 'unconscious processing' can be very effective.

### Really Simple Problem-Solving

Answer these four questions:

- What did you try to do?
- What were the problems you had?
- Why were these problems for you?
- What can you do about these problems?

### Checklist for Effective Problem-Solving

Long-term orientation - Am I looking for a long-term solution to this problem - one that would prevent similar problems happening in the future, or that would help us solve similar problems more quickly?

Asking advice - Can I make the time and space to find the most appropriate person for advice on how to solve this problem?

Changing activities and schedules - Can I change my activities and schedules to give me enough time and space to try new things out or spend longer searching for solutions?

Taking A Break - If I need a break from this problem, can I change my activities and schedules to go and have a social chat with someone or talk about less pressing problems, so I can come back to this problem fresh?

Getting a solution - Now I've got a solution, who needs to know and can they help me improve the solution?

Review - Was the solution implemented successfully? If not, what could I have done better?

Learning - How and with whom do I share my learning in solving this problem?



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## Promoting Activity and Work

What you **say** can have a major impact - use these practical communication tips

**Line managers** and **workers** have a great opportunity to provide early, positive messages about common health problems. These messages help to set expectations for recovery and staying active and working.

- Be positive, avoid negative comments and catastrophising.
- Focus on returning to usual activities of daily living as soon as possible.
- Set expectations early, and discuss how it can be necessary to push beyond the 'comfort zone' in the return to work process.
- Reassure and inform about common health problems.
- Reinforce positive expectations, and emphasise factual information.
- Use time off work as reluctantly as you would take a powerful drug like morphine. The detrimental effects may be just as severe.

## Useful words and phrases about pain

- Pain is a normal part of life and doesn't necessarily indicate a serious problem: e.g. many people wake up daily with stiff muscles and joints, but this improves with movement.
- Exercise and movement often leads to pain or discomfort in the joints and muscles, especially after unaccustomed activity.
- Pain doesn't mean damage or harm: e.g. athletes who train heavily experience pain, but it builds muscle and endurance, which is healthy.
- The pain will settle – most people make an excellent recovery.

## Useful words and phrases about activity

- Movement and activity won't cause harm – they'll help your recovery.
- Exercise and activity are good for you because they:
  - promote blood flow to the muscles and tissues, bringing oxygen and nutrients needed for healing
  - release endorphins, your body's own pain-killers
  - reduce low moods and improve sleep, which help healing.
- Gradually increase your activity early on. Modify your activities, if necessary, but stay active within tolerable pain limits.
- Expect increased pain with increased activity – carefully push the boundaries of pain and discomfort. A gradual increase in activity is essential for a speedy recovery.

## Useful words and phrases about returning to work

- People who return to work early, even in a limited capacity, have the fastest recovery rates.
- Going to work encourages activity, which helps your recovery.
- Work is an important part of our lives and provides us with a daily routine and self-esteem.
- An early return to the workplace is a very important step in your recovery process.
- In the initial stages of your return to work, it's important to pace yourself and take regular breaks e.g. for rest and stretching.

# Health<-->Work

## the toolbox for managing common health problems at the workplace

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### Reasonable accommodations for mental health problems

Work can be part of the recovery process. It provides all of us with important protective factors for our health, such as: routine, structure to day, social relationships, mental stimulus, self-esteem, activity, and a sense of wellbeing.

#### Changes in communication

Arrange for work requests to be put in writing for a worker who becomes anxious and confused when given verbal instructions

Train a supervisor to provide positive feedback along with criticisms of performance, for an employee reentering the work force who needs to be reassured of their abilities after a long psychiatric hospitalisation

Allow a worker who personalizes negative comments about their work performance to provide a self-appraisal before receiving feedback from a supervisor

Schedule daily planning sessions with a co-worker at the start of each day to develop hourly goals for someone who functions best with a clear time structure

#### Modifications to the physical environment

Provide room dividers for a worker who has difficulty maintaining concentration (and thus accuracy) in an open work area

#### Job modifications

Arrange for someone who cannot drive or use public transport to work at home

Restructure a receptionist job by eliminating lunchtime switchboard duty

Exchange problematic secondary tasks for part of another employee's job description

#### Schedule modification

Allow a worker with poor physical stamina to extend their schedule to allow for additional breaks or rest periods during the day

Allow a worker to shift their schedule to attend psychotherapy appointments

(adapted from Mancuso 1990)

# Health<-->Work

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### Being more resilient

Resilience is like a rubber band that when stretched bounces back to its original shape. If you are resilient, you handle problems better – while others are frozen by stress, you are able to take control. You are proactive and future focussed, because negativity doesn't overwhelm you. Building a resilient attitude means becoming more optimistic.

The 'can do' attitude that comes from optimism is often self-fulfilling. Very little progress would be made if everyone sat around fuelled by negative thoughts, like "I'm hopeless" or "I will never be able to do this". As Thomas Edison said: "I have not failed. I've just found 10,000 ways that don't work."

### Techniques to Increase Tolerance and Resilience

#### **Scheduling Activities**

Useful to maintain activity level when condition is acute  
Schedule activities to ration/conserves energy

#### **Working to Quota**

Useful to increase activity level and build tolerance  
'do no more on a good day, no less on a bad day'. Disrupt learning relationship between symptom (pain/fatigue/stress/worry) and activity

#### **Planning Activity**

Useful for low mood, less motivation  
'rewards' completion of difficult or challenging activities with pleasurable ones

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## Identify Signs of Mental Health Problems at Work

Closely related sections: [Reasonable accommodations for mental health problems](#)

The common mental health problems are anxiety, depression, and feeling stressed. **You cannot and should not try to diagnose someone.** However, you **can** note and discuss changes in things like work performance and listen to a workers or colleagues concerns.

You should also learn how to identify the signs of mental health problems. Every person is an individual and each day is different from the last so there is no simple formula or checklist. The most important thing is to watch out for changes, especially those that look like they're becoming consistent.

### Behaviours that might indicate mental health problems

- Working more slowly than usual
- Missing deadlines
- Calling in sick frequently
- Increasing absenteeism
- Expressing irritability and anger
- Difficulty concentrating and making decisions
- Appearing numb or emotionless
- Withdrawing from work activity
- Overworking
- Forgetting directives, procedures and requests
- Having difficulty with work transitions or changes in routines

Remember these signs could also result when one of your workers or colleagues has a family member with a mental health problem, or other serious health issue.

Make [reasonable accommodations](#) for workers with mental health problems.

# Health<-->Work

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## Evaluate Work Ability

### Quickly and Easily Evaluate Someone's Work Ability

Work ability is a measure of how people feel they are coping with work and health. The simplest way to evaluate it is to focus on how they feel they are coping with their work and health. Yes, there is a difference between what someone 'can do' and what they 'will do'. But, what we want to do here is get an overall idea of whether the person believes they are able to do their work. Remember, if you believe you can't do something you probably won't do it.

**TIP:** You can help to prioritise your colleagues who are likely to be most in need of help, by asking a simple question about how they rate their work ability. Work ability is a measure of how people feel they are coping with work and health.

*"Assume that your work ability at its best has a value of 10 points. How many points would you give your current work ability?"*  
**completely unable to work - 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - work ability at its best**

If your colleague scores 8 to 10, they will probably be able to stay at work (or return to work) with little help. If they score 3 to 7, you need to look for obstacles, devise a plan and start acting – without delay. If they score 0 to 3, they may need quite a lot of help, and you may need to consider getting professional advice. Repeat the question every week or so: your colleague's score should be improving – if it's not you need to re-evaluate the **obstacles**.

**CHECK:** Do line managers know how and when to use the work ability question?

# Health<-->Work

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## Workplace Accommodations

### Provide Reasonable Adjustments to the Job for a Period of Time (*not for ever*)

Providing workplace accommodations - there are lots of different terms used to describe these including alternative duties, modified work, selected duties and 'light' duties.

The most important thing about workplace accommodations is that they should be **temporary** not permanent.

- Temporary job modifications allow the person to continue working while they recover
- Permanent job modifications mean that the person has a new job description

The key practical issue is to work out what is **reasonable** in the way of temporary job modifications. There is no formula for this!

#### Temporary

Supportive workplaces generally need only provide reasonable job modifications or adjustments for a limited period of time.

Graduated (graded) programmes to return to full-time work are effective, and usually simple to set up and manage. For common health problems and minor injuries they require periods of days, or a few weeks at most.

#### Reasonable

A reasonable accommodation is any modification or adjustment to a job or the work environment that enables a worker to perform essential job functions. The purpose is to enable the employee to stay at work, or return to work, while they are recovering from symptoms of common health problems.

Provision of reasonable job accommodation is the foundation of a supportive workplace. It is no one's interest to make, or agree, to unreasonable requests. This means that co-workers, line managers, and others should not be disadvantaged; and the employer should not experience excessive difficulties. It is all about common sense: *'what will make it possible for this person to stay at work (at least part-time)?'*

There are issues that may arise, such as:

- The sick or injured worker may have to deal with co-workers who resent having to take over some of his or her work and therefore feel that the worker has managed to get an 'easier' job.
- Line managers may be required to fulfil production quotas in spite of accommodating a returning worker, and may not have the work that such accommodation requires fully acknowledged.

These can be dealt with effectively. Workplaces should create individualised plans that anticipate and avoid these pitfalls, and will be much more likely to have better outcomes.

## Temporary Workplace Accommodations

1. Alter the work tasks or environment to reduce physical and psychological demands

Examples: reduce reaching, provide seating, reduce weights, reduce pace of work, reduce task frequency, enable co-worker help, increase task variety

2. Alter the work organisation

Examples: flexible start/finish time, reduced work hours/days, added rest breaks, graded return to work (achievable level, increase on regular quota)

3. Change the job

Examples: allow work at home, selected duties, co-worker as 'buddy'

4. Flexibility

Examples: achievable goals scheduled at start of each day, allow reasonable time to attend therapy appointments

**Supportive Workplaces** do whatever it takes to help someone with a health problem to stay at, return to, and remain in work

## Identify problems Early, and Respond Rapidly

## Identifying Suitable Duties

The goal of suitable duties is to help the worker return to their usual job and hours. This means they:

- Should be useful work that's valuable to the company or organisation
- Are temporary duties that the worker is able to do that assist with recovery
- Can be similar to the worker's usual duties, but don't have to be

**Practical Tip:** it is useful to think of two types of suitable duties:

- Modified duties - the worker's usual duties and/or the equipment they use are adjusted
- Alternative duties - the worker performs completely different tasks from those they usually do

There are lots of different options to consider, and these can be combined in any way:

- Performing modified duties, or alternative duties
- Working in their usual area within your organisation, or a different area
- Working their usual hours, or reduced hours

## Coming Up With Ideas For Suitable Duties

Check to see if the [fit note](#) contains any suggestions.

**Line Managers** can think about all the jobs your organisation has available and the current skills of the worker. Could they train to perform a different role temporarily? Could they supervise, mentor or train others?

Consider work that tends to sit on the back-burner, or good ideas you haven't had time to implement. Could you temporarily re-deploy staff while your worker recovers? Your employee may be able to switch jobs with a workmate during recovery. If your employee will never be able to return to their pre-injury job, consider making the re-deployment permanent.

Could you change the way the worker does tasks they find difficult? For example, consider regular changes in body position. Could get the worker to do lots of different tasks. Could you temporarily incorporate more rest periods into the job?

It's helpful to be aware of the timing of suitable duties for part time or shift workers. These workers may have organised their routine to take into account child care, the care of other relatives or study.

When trying to identify suitable duties ask yourself:

- What are the tasks the worker usually carries out?
- How are these tasks carried out (methods, techniques and processes)?
- What are the skills, knowledge and abilities needed to carry out the usual role?
- Is the task performed for a short period of time or a long period of time?
- Does the task occur frequently during the working day/week?
- Can the task be done independently from other tasks?
- Can the task be safely performed by one person?
- Does the task have a quality standard?
- Is the work environment unusually hot or cold? Is this safe for the worker?
- Is the worker taking medication that might affect their concentration?

**Workers** can help by making suggestions to their line managers about what might be the best option. For example:

- Modified duties with usual hours
- Modified duties with reduced hours
- Alternative duties with usual hours
- Alternative duties with reduced hours

**Practical Tip:** try having a 'brainstorming' session. This could involve the worker, line manager, and other colleagues. It can be a great way of coming up with innovative ideas. Also, it helps to ensure that everyone is supportive of the approach.

## Examples

Administration

- Do you have a list of tasks to be done that never get actioned?
- What needs to be prepared for future projects in the next three to 12 months?

- processing tax receipts
- data entry and checking
- filing and re-organising business files.

#### Sales/promotion

- Does your business have needs for any extra promotion?
- phone sales or calling clients
- developing content for promotions
- conducting market research on competitors
- doing a small scale client satisfaction survey
- analysing business sales information
- updating client contact databases.

#### Labour

- Do any other areas of your business need an extra hand or temporary support?
- cleaning up/organising around the work site
- researching/buying equipment for the business
- re-organising bookshelves to improve access to business documents.

#### Organisation

- Could your worker help organise a certain part of the business?
- organising parts and materials
- finding new suppliers for parts/materials including cheaper or better materials.

#### Training

- Could your worker participate in any training which they can bring back to share in the workplace?
- computer courses
- manual handling courses
- technical skills.

#### Business improvement

- developing new systems to further improve the business
- improve current business processes
- write part content of a training manual
- work on a quality assurance system.

#### Deployment

- Could the worker go to another department?
- Could the worker exchange with another colleague?
- Could the worker train staff in another area to perform certain skills?



## Better At Work Checklist for Line Managers

Much of today's work disability due to common health problems can be foreshortened or averted entirely. This is because work absence is hardly ever medically required for more than a few days after illness and injury. To make a positive difference, emphasise these:

- Being active during convalescence speeds recovery, and extensive work avoidance and "rest" tend to delay it.
- Prolonged absence or permanent withdrawal from work is bad for people's wellbeing -- mental, physical, social and economic.
- Prolonged withdrawal from work is usually being driven by psychosocial factors instead of medical ones.

<b>STAY AT WORK PLANS: Check</b>	<b>Yes/No</b>	<b>Comments</b>
<b>Is there a Stay at Work Policy?</b>		
<b>Did you make contact with your worker as soon as possible to offer a Stay at Work option?</b>		
<i>If it was not appropriate did you move to developing a Return to Work plan?</i>		
<b>Did your worker give you a fit note?</b>		
<b>Have you explained the Stay at Work process to your worker?</b>		
<b>Have you identified suitable temporary modifications?</b>		
<b>Have you discussed and agreed these with your worker?</b>		
<b>Have you identified obstacles to the worker staying at work?</b>		
<b>Have these been adequately addressed?</b>		
<b>Is there a timeframe for the Stay at Work plan?</b>		
<i>Will it be reviewed and/or modified if necessary?</i>		

<b>RETURN TO WORK PLANS: Check</b>	<b>Yes/No</b>	<b>Comments</b>
<b>Is there a Return to Work Policy?</b>		
<b>Did you make contact with your worker at an appropriate time to offer a Return to Work option?</b>		
<i>If it was not appropriate did you move to developing a Return to Work plan?</i>		
<b>Did your worker give you a fit note?</b>		
<b>Have you explained the Return to Work process to your worker?</b>		
<b>Have you identified suitable temporary modifications?</b>		
<b>Have you discussed and agreed these with your worker?</b>		
<b>Have you identified obstacles to the worker returning at work?</b>		
<b>Have these been adequately addressed?</b>		
<b>Is there a timeframe for the Return to Work plan?</b>		
<i>Will it be reviewed and/or modified if necessary?</i>		

## CONFIDENTIALITY WAIVER

I give permission for <health professional> to reveal details of my current work-relevant health problem to the following people at my workplace (<company>) so that we can all discuss how best to help me recover while working – e.g. decide on suitable adjustments to enable me to stay at work or return to work.

\_\_\_\_\_

Print Name

Position

\_\_\_\_\_

Print Name

Position

\_\_\_\_\_

Print Name

Position

I do **not** give permission for details of my health problem to be revealed to the following people:

\_\_\_\_\_

Print Name

Position

\_\_\_\_\_

Print Name

Position

I hereby waive my right to confidentiality as detailed above.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

## WHAT DO YOU THINK ABOUT HEALTH AND WORK?

*Tick the boxes*

	True	False
Coping with health problems whilst working leads to faster recovery		
Medical advice isn't always needed in order to stay at work with a health problem		
Carrying on at work with an injury or illness does not usually make it worse		
Work is good for our health and wellbeing		
Modified work is not always needed for an injury or illness at work		
It's OK to sort out job modifications with your line manager		
The Fit Note can help people stay at work with an injury or illness		

Name:

Date:

Health & Work Questionnaire

# **Health & Work**



**HEALTHCARE**

**WORKPLACE**

**WORKER**

- *How to get better and back to work:*
  - *a flexible approach*
  - *everyone working together to overcome obstacles*

This leaflet is about helping you get back to health and work. You will learn what you need to do, and what you should expect from health care and your workplace. You will get practical advice on overcoming obstacles to recovery and work.

## WORK AND HEALTH

Work is an important part of life. And research shows that work is good for physical and mental health.

We now have good evidence that returning to work as soon as possible actually helps recovery. It is the best way to avoid long-term sickness.

## COMMON HEALTH PROBLEMS

Most sickness absence is due to:

- Mental health conditions such as 'stress' or depression
- Muscle and joint conditions such as back pain or whiplash
- Heart and chest conditions such as blood pressure or asthma

All of us suffer these kinds of problem at some time in our lives. They can certainly be distressing and may make life difficult, but there is usually no serious disease or lasting damage. Most episodes settle quickly, even if some symptoms may continue or come back from time to time. Most people remain at work, or return quite quickly.

Why do some people with common health problems end up with long-term sickness? There is usually no good medical explanation. Rather, it's because something has gone wrong with the way things have been handled. We need to look at what can go wrong.

## MYTHS AND REALITIES

There are many unhelpful myths, which cause unnecessary fear and uncertainty. Fortunately, we now have the knowledge to dispel them:

Myth: Common health problems are caused by work.

Usually, they're not! Everyone gets these kinds of problems.

Work may make symptoms feel worse at times, but that does not mean work caused the problem.

Myth: Working will make my health condition worse.

False!

- most people with common health problems stay at work most of the time, and come to no harm
- in fact, working will often help you feel better.

Myth: You should not return to work until you are 100% OK.

Actually, you should – and the earlier, the better!

- work is often part of treatment, and getting back to work is part of the recovery process
- simple changes to your job may be the key to getting back quickly.

Myth: a sick certificate means that you **MUST NOT** work

Wrong! A sick note is not a medical order to stay off work

- it just says that you met the criteria for sick pay or benefits
- you can arrange to get back to work at any time

## OBSTACLES TO RECOVERY

Various things can get in the way of recovery, and getting back to work.

- Personal issues, such as how people think and feel
- Work issues, which can block return to work

**Personal obstacles** • Unhelpful attitudes and beliefs about health and work • Uncertainty • Anxiety and depression

- Loss of routine and work habits

**Work-related obstacles** • Loss of contact with work

- Negative attitudes by people at work • Lack of modified duties • Legal claims

## SAM'S STORY



Last year I just wasn't feeling too good. The doc gave me tablets and told me to stay off work - but that didn't make any difference. Then I had to sit around for six weeks waiting for treatment - and then it didn't help all that much. They said it was probably my job that caused it, so I shouldn't go back till I was fully fit. By that stage I was getting really worried - and depressed. Then out

of the blue I got a letter from work saying they were paying me off. So now I'm on Benefits. The union's helped me put in a claim, but that could take 2-3 years to go to court! This whole saga has just taken over my life, yet to begin with I thought I'd soon get over it. Looking back, I never thought it would end like this. All I wanted was a bit of help.

### What went wrong?

Sam's story shows how easy it can be to drift into long-term sickness. As time passes, obstacles multiply. Beliefs and actions - or lack of action - can block your recovery. The people who were supposed to help actually created obstacles.

## THE RISK OF LONG-TERM SICKNESS

The longer you are off, the harder it is to get back. Most of the warning signs are then about what you feel and do, rather than your medical condition:

- Believing there is something seriously wrong.
- Unable to accept reassurance and help.
- Avoiding activity in case it makes things worse.
- Getting withdrawn and depressed.
- Fears and uncertainty about going back to work

The faster you get back to normal activities and back to work, the sooner you will feel better.

## GETTING BACK TO WORK

### Recovery

Recovery depends on working with the health professionals who are helping you - and on your own motivation and effort.

Treatment can help to reduce your symptoms, but **you** are the one who has to get active. No one can do it for you.

Look at it this way; you can be an 'avoider' or a 'coper': if you want to recover, you need to be a copier.

Those who are helping you should also take this can-do approach. Make it clear to them that what you really want is help to get on with your life.

### RETURN TO WORK

Getting back to work depends on you and your employer working together, and that needs communication. The key thing is to stay in touch with the people at work – if you don't you lose the chance for them to help you. Talk about any obstacles you see, and how you can sort them out together.





## **YOUR RETURN-TO-WORK PLAN**

Getting back to work needs planning.

### **Take control:**

You have to take responsibility for making sure that you recover – making the best use of whatever help you need.

### **Set realistic goals:**

Set a clear time-line to get back to full activity and your usual work – aim for weeks rather than months.

### **List what you can do:**

Don't dwell on what you can't do. Think positive. What are you still able to do? You will probably find it is more than you think. List the obstacles to getting back to work. Now list what you, your doctor, and your work can do to overcome these obstacles.

### **Talking with your doctor:**

Talk about how and when you can get back to work. You know your job best, and will need to explain what it involves. Discuss which work tasks you feel you could do and that they are OK with your health problem. You could even ask for a letter that tells your employer what you can do rather than what you can't – a 'fit note' rather than a sick note.

### **Increasing activity:**

Start with those activities you find easiest. Do a little more, a little longer, every day. You will have good days and bad days. Pace yourself - keep up your activities on the bad days. Most people get set-backs, so don't give up!

### **Talking with your therapist:**

Ask for treatment designed to get you ready for work. And then go back as soon as you are ready – you can complete the treatment once you are back.

### **Changing your mind-set:**

Illness and injury often lead to anxiety and depression. Many people feel uncertain about getting active, about return to work,

and about whether they will be able to cope. Loss of confidence is often a real issue.

These can all be obstacles to recovery. So, an important part of your return to work plan is to re-think your mental approach. Getting active will help you feel more positive and is the best treatment to dispel many of these worries. As you get fitter things will improve.

### **Talking with your employer:**

If your employer has not been in touch, you can make the first move. Look in to see your boss or line manager – at a time you know they'll be free.

Make it clear that you want to get back to work as soon as possible. Temporary changes to your work are one of the best ways to help you return quickly. If you think some adjustments to your job would make getting back easier, ask. Adjustments are almost always possible, so talk about your ideas to overcome obstacles.

### **Putting it all together:**

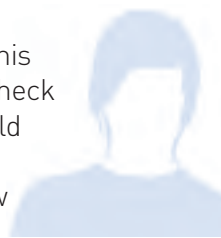
You need to prepare your own return to work plan. Make sure that you, your GP, therapist, and employer all know what is going on. Make sure they are all working together to get you back to work. Make sure they are all in contact.

Write out your return to work plan. This can be a simple list or table of all that needs to happen and when. It is important that everyone agrees on a date for getting back to your usual job.

All that remains is to check off the stages and make it all happen - on time!

## **BANJI'S STORY**

My shoulder problem cropped up again, but this time it seemed worse, so I asked the doc to check it out. Probably muscular he said, and it should settle OK - no need to stop doing anything. That made sense – my dad had a dodgy elbow that flared up now and then, but it



never laid him up. Anyway, after a week the shoulder wasn't any better and I couldn't manage at work. So back to the doc. He said I needed some therapy. As it happens the firm has this arrangement with a local physio, so we agreed I'd try that. One of my friends tried to tell me it must have been caused at work. That just had to be rubbish – I know I've got a physical job but I've been doing it for years and nothing's changed. I reckoned that all I really needed was some treatment to get my shoulder working again. The physio agreed, and when I told her that my job could be made easier for a while, she said going back could actually help. The doc wrote to my boss about what I could manage, and when I went in to see the people at work they were really helpful. A few weeks later I was back at my usual work!

### Remember:

- Most common health problems can be accommodated at work
- Work is an important part of recovery
- The longer you are off work, the harder it will be!
- Share responsibility for your own recovery
- Beware the myths!
- Identify the obstacles and plan how to overcome them
- Everyone working together, doing what's needed when it's needed
- Make a return to work plan

You know what needs to be done. There is a lot you can do. There is a lot that your doctor and therapist, and your employer, can do to help. It is up to you to encourage everyone to work together to help you get on with your life.



A longer version of *Health & Work* in booklet form is available from The Stationery Office: [www.tso.co.uk/bookshop](http://www.tso.co.uk/bookshop)

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## Myths about common health problems need to be challenged and dispelled

Beliefs are central to our responses to a health problem, and influence what we do about it. Myths and legends abound, and are major obstacles to stay-at-work, and return-to-work. Many obstacles are related to these common myths. They are exceedingly pervasive, having negative effects on the behaviour of all involved, and the interactions between them.

Myth	Reality	Why it Matters
<b>Symptoms (e.g. pain, fatigue, worry, stress) means serious illness, damage, or injury</b>	<p>This is not always the case: symptoms such can occur without disease or injury.</p> <p>Even when specific tissues are affected, activity and work are not precluded.</p> <p>Temporary discomfort or distress is often part of recovery.</p>	<p>Believing symptoms means harm results in activity-avoidance behaviour, which are obstacles for stay-at-work and return-to-work initiatives.</p> <p>Worrying about 'damage' and 'injury' is an obstacle to active interventions that see work as a therapeutic intervention.</p>
<b>Work/activity is the cause: something is damaged</b>	<p>Symptoms are common across the whole population, regardless of type of work.</p> <p>Work or activity can trigger symptoms, but most work is unlikely to cause substantial damage.</p>	<p>Erroneously blaming work leads to an undue concentration on simplistic explanations for the causes of symptoms, which gets in the way of effective interventions tailored to specific circumstances.</p>
<b>Work/activity will make matter worse</b>	<p>The actual condition is usually not made worse by continuing work (assuming control of significant risks).</p> <p>Work may become difficult or uncomfortable, but that doesn't mean it is doing harm.</p>	<p>Work is generally good for health and wellbeing, so the belief that work is inherently dangerous is unhelpful, and poses a major obstacle to helping people get back to work or stay at work.</p>
<b>Medical treatment is necessary</b>	<p>Most people, for most episodes of a common health problem, do not seek healthcare.</p> <p>Reliance on healthcare alone is not enough to help with return to work.</p>	<p>Over-cautious behaviours can be powerful obstacles to recovery and return to work.</p> <p>Reliance on medical treatment alone negates the possibility of involving the workplace in helping people back to work.</p>
<b>Injuries and health problems must be rested</b>	<p>Quite the contrary – activity leads to faster and more sustained recovery and return to work.</p> <p>Temporary reduction of activity may be required, but long-term rest is detrimental.</p>	<p>Using rest as a treatment is a major obstacle to modern management strategies that encourage and support return to activity/work.</p> <p>Advising patients to take unnecessary rest can give the disadvantageous impression that the problem is serious.</p>
<b>Sick leave is needed as part of the treatment</b>	<p>Often sick leave is not needed – staying at work is desirable, perhaps with some temporary modifications.</p> <p>The use of 'fit notes' is preferable to sick notes: emphasise what the person <b>can</b> do, not <b>can't</b>!</p>	<p>Helping people stay at work can contribute to their recovery.</p> <p>Injudicious use of medical certificates reinforces fears and uncertainty, and encourages reliance on rest, whilst fostering fears of activity.</p>
<b>Contacting an absent worker is intrusive</b>	<p>Continued contact with the workplace is crucial to the return to work process.</p> <p>If the approach is positive and unpressured, workers are appreciative.</p>	<p>Failure to make early contact with people who are off work leaves them isolated and unvalued, thus fostering distress or depression.</p> <p>Lack of contact means there is no chance to make a return to work plan, and no chance to discuss transitional working arrangements.</p>
<b>No return to work till 100% fit and symptom free</b>	<p>This is clearly unrealistic and unhelpful - many workers can and do return with ongoing symptoms, and they do come to no harm.</p>	<p>Employers' policies that restrict work-return to those who are symptom free or fully fit for their usual work are counterproductive, and are a major obstacle.</p>

## USING THE HEALTH AND WORK QUESTIONNAIRE

Find out if you, your workers, line managers, and senior managers have got the health & work message

There are two uses for the Health & Work Questionnaire

- Find out whether workers and line managers understand the fundamental relationship between health and work. If the level is low, then you should ensure everyone gets 'the knowledge'. This measure may provide justification for the resources needed.
- Measure improvement in understanding the relationship between health and work. For example, use it before and after. This can demonstrate cost-benefit from helping workers and managers getting 'the knowledge'.

The Questionnaire has 7 questions that are answered True or False

- Coping with health problems whilst working leads to faster recovery
- Medical advice isn't always needed in order to stay at work with a health problem
- Carrying on at work with an injury or illness does not usually make it worse
- Work is good for our health and wellbeing
- Modified work is not always needed for an injury or illness at work
- It's OK to sort out job modifications with your line manager
- The Fit Note can help people stay at work with an injury or illness

## SCORING

Each 'True' response is given a score of one, and each 'False' is zero. The total score ranges from zero to 7.

## INTERPRETATION

A score of zero indicates little or no understanding

A score of seven indicates a good understanding

# Template Stay at Work Plan or Return to Work Plan

*Use this type of template to monitor and review progress*

## Worker details

Name

Job title

Location of work

Stay at Work/Return to Work Date

Usual hours worked: per day per week

Line Manager

Other workplace support person

## Goals of Stay at Work/Return to Work plan

Starting number of:	work days	work hours
Target:	work days	work hours

## Return to Work Outline

### Week 1

Days work (circle) M Tu W Th F Sa Su

Hours per days

Breaks to be taken (no. & frequency)

Duties

### Week 2

Days work (circle) M Tu W Th F Sa Su

Hours per days

Breaks to be taken (no. & frequency)

Duties

## Review

Comments and actions during weeks 1 and 2:

Week 3

Days work (circle) M Tu W Th F Sa Su

Hours per days

Breaks to be taken (no. & frequency)

Duties

Week 4

Days work (circle) M Tu W Th F Sa Su

Hours per days

Breaks to be taken (no. & frequency)

Duties

Review

Comments and actions during weeks 1 and 2:

Review date 1

Review date 2

Signed by:

Worker

Line Manager/supervisor

Healthcare Provider (GP, Physio, etc)

Case Manager (if applicable)



# **Work & Health**

## **CHANGING HOW WE THINK ABOUT COMMON HEALTH PROBLEMS**

- in health care
- in the workplace
- and in society

**HEALTHCARE**

**SOCIETY**

**WORKPLACE**

- *Work is generally good for health and well-being*
- *Most common health problems can be accommodated at work if:*
  - *a flexible approach is adopted, and*
  - *all players work together to overcome obstacles*



## WHO AND WHY?

This leaflet challenges how you think about health at work, and offers ideas on what you should and should not do - based on new scientific [evidence](#) about what is good for workers themselves.


It is for those who have to deal with health issues at work • senior management • line managers • human resources • small employers • unions • health & safety advisers • occupational health professionals • rehabilitation providers • employment advisers • claims handlers • lawyers.

Achieving health at work depends on **everyone** working together. What you do makes a difference – for good or ill.

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## THE PROBLEM

Overall sickness rates have not decreased over the last 50 years despite improvements in healthcare and working conditions. What we have been doing clearly isn't the whole answer, but we now know what needs to be done. And it makes financial sense.

 So, this leaflet explores how we've gone wrong, dispels some harmful myths, and shows how things can be improved. It is about changing the culture of work and health.

*Work is generally good for health and well-being – including people with common health problems*

*Worklessness is generally bad for health and well-being*

*Work should accommodate people with health problems*



## COMMON HEALTH PROBLEMS

Most sickness absence is due to 'common health problems' • mental health (e.g. 'stress'; depression) • musculoskeletal (e.g. back pain; arthritis) • cardio-respiratory (e.g. hypertension; asthma)

These problems can be distressing and may make life difficult, but they are not 'severe' in a medical sense:

- most of us experience them at times
- usually there is no serious underlying disease or lasting harm
- most episodes settle quickly, even if symptoms may recur
- many people remain at work, or return quite quickly

Common health problems should be manageable: the paradox is that so many end up with long-term disability. There is usually no good medical explanation, but we must not jump to the conclusion that it's malingering. Rather, something has gone badly wrong with the way things have been handled. And the longer people are off work, the less likely they are to get back - ever. So it's crucial to step in and help without delay.

---

## OBSTACLES TO RECOVERY

People with common health problems face real obstacles to staying in or getting back to work.

*Health-related obstacles* • Ineffective treatments • Waiting for tests or specialist appointments • Unnecessary sick leave • Unhelpful advice • Failure to support and encourage return to work

*Personal/psychological obstacles* • Negative attitudes and beliefs about health and work • Uncertainty about what to do, and what the future holds • Anxiety and depression.

*Occupational/social obstacles* • Poor absence management • Loss of contact with workplace • Lack of modified duties • Poor social support • Litigation

These issues influence what we all think and do about health and work.

### Most common health problems can be managed at work

- by making accommodations
- and overcoming obstacles



## MYTHS

Before looking at how we can address obstacles, we need to dispel some popular misunderstandings about common health problems:

MYTHS	THE REALITY
They are usually caused by work	<p>Actually, they're not.</p> <ul style="list-style-type: none"> <li>• They are common across the whole population.</li> <li>• Work may bring on symptoms or make them feel worse, but that's quite different from work causing the problem in the first place.</li> </ul>
They are often made worse by work	<p>The actual condition is usually not.</p> <ul style="list-style-type: none"> <li>• Work may be uncomfortable or difficult for a time, but work usually does not cause any lasting damage.</li> </ul>
They mean underlying damage or disease	<p>Mostly this is not the case.</p> <ul style="list-style-type: none"> <li>• There is often little or no underlying damage or disease.</li> <li>• Even when there is, long-term absence is not inevitable.</li> </ul>
They will be cured by medical treatment	<p>Health care is usually not the whole answer.</p> <ul style="list-style-type: none"> <li>• Treatment may help the symptoms, but usually does not 'cure' common health problems.</li> </ul>
They should be treated by rest	<p>Activity is usually best.</p> <ul style="list-style-type: none"> <li>• Much modern treatment encourages and supports continuing or returning to ordinary activities, including work, as soon as possible.</li> </ul>
They require sickness absence	<p>Often they do not.</p> <ul style="list-style-type: none"> <li>• Most workers manage to remain at work or return to work fairly quickly, even though symptoms may persist or recur.</li> <li>• Long-term sickness absence is rarely necessary or helpful.</li> </ul>
They mean people cannot return to work until completely free of symptoms	<p>This is usually unnecessary, unrealistic, and unhelpful.</p> <ul style="list-style-type: none"> <li>• Work is therapeutic and return to work is an essential part of rehabilitation – workers need to be allowed and helped to return as early as possible, even while some symptoms remain.</li> </ul>
They need permanently modified work	<p>This can actually be harmful.</p> <ul style="list-style-type: none"> <li>• Work or workplace adjustments are <i>temporary</i> measures to accommodate reduced capacity.</li> <li>• Modified work facilitates early return to <i>normal</i> duties.</li> </ul>

Other misunderstandings can be obstacles to getting back to work:

### **Myth: A sick certificate is an absolute barrier to work.**

Actually, it simply means the worker has been advised that he or she is temporarily unfit for their full usual job. It is not a medical 'order' to stay off work. The real question it raises is how and when they can get back to some work.

### **Myth: Contacting an absent worker is intrusive.**

Actually, continued contact with the workplace is crucial. If the approach is a positive offer of help without any pressure, most workers are appreciative and feel valued.

### **Myth: Return to work will carry further risk or prejudice a claim.**

Actually, insurers and lawyers now agree that rehabilitation and early return to work is helpful and should be promoted.

---

## **SAM'S STORY**

Last year I got a problem with my health that made my work a bit difficult. So my GP signed me off work and gave me tablets - but that didn't make much difference. Then it took weeks to get some therapy - it helped a bit, but didn't really cure it. They said my work probably caused the problem, so I couldn't go back till I was fully fit. The people at work didn't call, so I couldn't discuss when or how I might be able to get back to work.

By that stage I was getting really worried - and depressed. My union rep said I should make a claim, and sent me to a solicitor. My sick pay came to an end, I lost my job, and I went on to Incapacity Benefit. This whole saga has taken over my life, yet to begin with I thought I'd soon get over it. Some prompt treatment and temporary help with the job could have been enough to let me to stay in work. So why couldn't we all get our act together?

Effective help for Sam is all about communication and accommodation.

The following sections outline how it should have been done.



## MANAGING HEALTH AT WORK

Some people certainly need health care to relieve or control symptoms, but that's only part of the process. Health at work also means accommodating common health problems. The principles are straightforward:

- Provide accurate information and advice
- Maintain contact – assist with timely access to effective health care (if required)
- Avoid unnecessary sick leave – facilitate early return
- Provide temporarily modified duties (if required)
- Establish open communication between everyone involved in the return-to-work process.

The scientific [evidence](#) shows this could cut sickness absence and the number of people going on to long-term incapacity by up to 50%.

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## ALL PLAYERS ONSIDE

Making it happen depends on everyone doing what's needed when it's needed – and avoiding anything that could block the process. It is crucial that everyone thinks the same way, shares common goals and works together. That depends on good communication.

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## TACKLING OBSTACLES

**Workers:** Need good information and advice – e.g. the *Health & Work* booklet promotes self-management • They also need opportunity, support *and* encouragement – from health care and the workplace.

**Health professionals:** Provide symptomatic relief *and* restore function • Ask about the patient's work • Discuss return to work - with the patient *and* the employer.

**Employers:** Be proactive - avoid adversarial approaches • Facilitate early return-to-work • Keep in regular touch; be supportive and helpful - involve the worker

- Communicate with health professionals about the job; tell them you want to help
- Consider modified duties • Ensure line managers and HR personnel are on-board and can arrange workplace accommodations.

**Unions:** Work closely with employers to develop and operate return-to-work policies

- Mediation and facilitation rather than blame and conflict.

**Insurers:** Be proactive • Support employers (including practical help for SMEs)

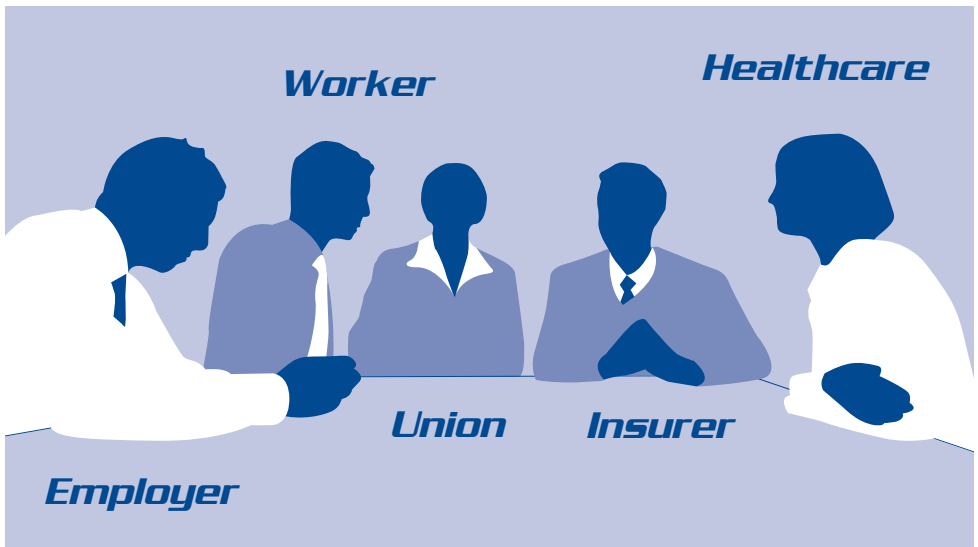
- Support health professionals (promote evidence-based practice, involve case managers).

**Media:** Promote positive messages about work and health • Use the scientific [evidence](#)

– don't sensationalise.

Each will need to develop their own ways to put these ideas into practice, but the key is:

## ***ALL PLAYERS ONSIDE, WORKING TOGETHER***



## **CHANGING THE CULTURE**

We must change the culture of work and health to reflect the new scientific [evidence](#).

Overall, the beneficial effects of work on physical and mental health outweigh the risks of work and the harm of prolonged sickness absence.

Helping workers with common health problems is about more than just health care, it's about accommodating health at work. Making a difference **is** possible – and everyone benefits.

Achieving it demands a fundamental shift in how we think about common health problems – in the workplace, in health care, and in society. This leaflet shows how **you** can play a vital role.

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## ADDITIONAL RESOURCES

*Health & Work* - a booklet for workers (to be published by TSO)  
[Concepts of rehabilitation for the management of common health problems](#) (TSO)  
Managing sickness absence and return to work (published by HSE)  
The rehabilitation code (published by IUA)  
[Is work good for your health and well-being?](#) (published by TSO)  
Fit for work - the complete guide to managing sickness absence and rehabilitation  
(available from EEF)  
[www.health-and-work.gov.uk](http://www.health-and-work.gov.uk) • [www.hse.gov.uk](http://www.hse.gov.uk)

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### 15.1. EVALUATION OPTIONS

Formal evaluation is necessary so that the final prototype is ready for 'market'. There are a number of considerations:

(1) The complexity of CHPs and the range of options for managing CHPs provided by the toolbox make a randomised control trial approach focussing on individual workers inappropriate for evaluating a near market-ready toolbox. For example, the toolbox provides options for return to work and prevention of CHPs, so any randomised control trial would have to factor in measures of CHP improvement in some participants with high incidence of CHPs, improvement in the experience of work for those with work conditions that may increase the chances of experiencing CHPs, but no change in those without CHPs and with good working conditions. The complexity of such an evaluation would make the cost prohibitive.

(2) It may be appropriate to use a range of alternative evaluation strategies in order to triangulate findings from different approaches to form a view of how well the toolbox is performing. One such approach may be to use vignettes or other simulations (e.g., actors) in testing. In a simulation, an end-user sample could use the toolbox to develop appropriate interventions on the basis of their understanding of the toolbox and of the information provided in the vignette or simulation. Estimates of the toolbox's reliability and validity could then be assessed. The extent sample participants provide the same kind of strategies to deal with each case would give an indicator of reliability. If a sample of experts (e.g. occupational health professionals) were also to apply the toolbox to the same cases, the extent to which expert decisions mirror those of end users would provide an estimate of the toolbox's validity.

(3) A complementary approach would be to use qualitative and quantitative analysis of the application of the toolbox in a limited number of organisations, as was used with the HSE Management Standards for Work-Related Stress (Tyers, Broughton, Denvir, Wilson & O'Regan, 2009). Multiple methods could be used to evaluate the cases. For situations in which Good Jobs are developed, simple before- and after-measures of experiences and perceptions of work (e.g., job satisfaction, perceived coping efficacy, perceived job characteristics) could be made (preferably compared to some kind of {non-equivalent} control group). For situations requiring accommodating workplaces, interrupted time series analysis could be used to evaluate daily or weekly perceptions of workability, pain and experiences of work prior to and after the application of the toolbox. Comparisons with historical or concurrent data on other cases of CHP-related problems and sickness absence in the same organisations may help establish if the toolbox is able to help organisations manage work-relevant CHPs complaints. Qualitative analysis would provide essential data on the factors that were perceived to be more/less effective in the toolbox as well as contextual issues that may have help/hindered effective use of the toolbox.

(4) These more detailed approaches could be supplemented by a third approach in which users of the toolbox are surveyed 12 months after being given access to the toolbox and their views elicited on the extent to which they have used the toolbox and the toolbox has led to improvements in Good Jobs and accommodating workplaces. An improvement on such a design would entail obtaining a sample of users of the toolbox and a control group of non-users, surveying both groups before making the toolbox available to the user group, and then surveying both groups after the toolbox was made available to the user group. Post-intervention, users should report in their zone of control: an increase in the extent to which they perceive jobs to fit the characteristics of Good Jobs; an increase in their ability and knowledge to provide accommodating workplaces; and a decrease in the incidence of CHPs and work-relevance of CHPs where they do occur.





# Developing an intervention toolbox for common health problems in the workplace

The Management Standards (MS) approach is a key component of the HSE's 'stress toolbox.' It was developed to reduce the levels of work-related stress reported/experienced by working people in Britain. Although a study by Cox et al, 2009 identified a number of weaknesses and limitations in the current version of the Management Standards, research suggested that there were good prospects for correcting these and building on them to evolve a more generic toolbox.

The aim of the project was to look at the feasibility of developing a toolbox for the management of common health problems in the workplace. Reliable and valid evidence identifies the two most common health problems at work as musculoskeletal disorders and psychological ill-health (stress, anxiety and depression). It was anticipated that the tool could bring together work on work-related stress (ie Management Standards) and musculoskeletal disorders (MSDs) and contribute to HSE's specific aim of developing the applicability of the Management Standards to a wider range of health issues in particular, to extend their scope to cover musculoskeletal disorders.

HSE has concluded that it was not possible to develop the simple health and safety toolbox as envisaged, as the 'model' moved into the 'wellbeing' area and away from HSE's specific remit/responsibilities for workplace health-related issues. HSE acknowledges the work of the researchers and believes that others involved in this area of work are better placed to take forward some of the recommendations.

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