Towards Integration:
Psychosocial issues & MSDs

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OUTLINE
• What do we need to know about psychosocial issues?
• Why do we need to know this?
• How do psychosocial issues relate to MSDs?
• Case examples to move us forward to integration
Psycho-what?
Psycho-what?

• Widespread lack of confidence with terms related to “psychosocial” (eg. Leka et al., 2015; Leka Jain & Lerouge, 2017; Kunyk et al. 2016; Caponecchia & Wyatt, 2009, 2011)
  • Different usages based on subdiscipline
  • Age-old confusion of hazard (source of harm) and risk
  • Different issues included under this term by organisations (Johnstone et al., 2011)
• In organisations, psychosocial is often interpreted as meaning
• STRESS (Leka et al, 2015) or
• MENTAL HEALTH (DISORDER)
“Psychosocial”

• Factors in the environment (including the social environment) that can have an effect on mental processes (eg. thoughts, attitudes, expectations, perceptions, schemas, motivations, emotions) and behaviours.

• These psychological processes have a physiological base (ie. they are “psychobiological”)
Psychosocial hazards

• “aspects of job content, work organisation and management and environmental and organisational conditions that have the potential for psychological and physical harm” (Cox 1993).

• **Examples** (see Leka & Cox, 2008; SWA, 2018; Caponecchia, in press)
  - Job content – variety, use of skills
  - Workload, pace and schedule
  - Control and autonomy
  - Environment and equipment
  - Relationships, supervision
  - Roles – ambiguity, conflict
  - Career development
  - Bullying, violence, harassment, discrimination behaviours (often included; may be a combination or outcome of other hazards eg. see Comcare 2013; Leka et al., 2015)
Wider environment
Job security & casualization
Location, industry & economy

Organisational factors
Culture & values eg. reporting, attitudes to time off due to injury

Psychosocial hazards
Job content variety, use of skills
Workload, pace and schedule
Control and autonomy
Environment & equipment
Relationships, supervision
Roles: ambiguity, conflict
Career development
Bullying violence, discrimination, harassment
Controlling psychosocial hazards

- Control through work design (see Parker, 2015; Tuckey, Zadow, Li & Caponecchia, in press)
- Using a range of principles as needed eg consultation; effective training, assessment & skill development; task and workflow analysis…)

<table>
<thead>
<tr>
<th>Psychosocial hazard</th>
<th>Examples of controls</th>
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<tbody>
<tr>
<td>Job content – variety, use of skills</td>
<td>Design through consultation new workflows or component tasks to a job, supported with available data</td>
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<tr>
<td>Workload, pace, schedule</td>
<td>Staffing; Consultation on rostering, duty hours, flexibility</td>
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<tr>
<td>Control, autonomy</td>
<td>Increase participation in decision making, especially in re-design process, relevant training to equip workers to have increased decision latitude</td>
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<td>Environment &amp; equipment</td>
<td>All levels of HOC, good physical ergo and related fields</td>
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<tr>
<td>Relationships, supervision</td>
<td>Team building, workflow and reporting lines, competency based training, feedback mechanisms, mentorship programs. Multiple points of contact, reduced hierarchy</td>
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<td>Role conflict &amp; ambiguity</td>
<td>Job descriptions and role statement review, redesign workflows, review role expectations</td>
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<td>Bullying</td>
<td>Range incl reporting systems, policies and procedures, but also the controls for the other contributing psych hazards</td>
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<tr>
<td>Violence</td>
<td>Depends on type (client, internal, external); incl. engineering controls, procedures, training, culture dvt, debriefing &amp; support</td>
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Outcomes to prevent

- Psychosocial hazards can lead to a range of possible outcomes which vary in intensity and duration
- Can lead to a clinically diagnosed mental disorder
- But other sub-clinical outcomes still represent negative effects on health
- Eg. Anxiety, stress, depression, nausea, sleeplessness, headaches, muscle tension, fear (of going to work)
Patterns of experience that lead to outcomes

• Often dealing with repeated stressors, where effects can be cumulative (Wheaton, 1999)
  • Contributes to lack of hazard ID - they can seem small and insignificant in isolation
  • Chronic versus acute stressors (Beehr et al., 2000)

• Jobs with regular exposure to trauma (“job content”)
  • Consider their selection and training, but
  • Job context stressors are most important (see Wilkins Newman & Rucker-Reed, 2004)
Psycho-why?
Why are we talking about psychosocial

- Psychosocial factors are fundamental to WHS, because they are fundamental to health
- Psychosocial issues can manifest in any industry, regardless of task, equipment, role or complexity
- In some industries, psychosocial issues are actually the largest slice of the “WHS pie”
- Psychosocial issues have been demonstrated to affect hazardous manual tasks and MSDs (National Research Council US; 2001; Macdonald & Evans, 2006; Lang et al., 2012; Gerr et al., 2014; Vignoli et al., 2015; Oakman et al., 2018)
- Most MSD guidance and interventions from around the world does not address psychosocial contributors (see Oakman et al, 2018; Macdonald & Oakman, 2015)
More reasons why...

• Managing psychosocial hazards is part of WHS duties (and has been for a very long time)

• “Health” (now explicitly!) includes psychological health

• Nationally agreed guidance from Safe Work Australia 2018

• New international standard on Safety Management Systems AS/NZS ISO45001 Section 6.1.2.1 specifies the following as part of hazards to identify:
  
  • “how work is organized, social factors (including workload, work hours, victimization, harassment, and bullying), leadership and the culture of the organization”

• Proposed new International Standard 45003: Psychological health in the workplace
Psycho- how?
Organisational factors
Culture & values eg. reporting, attitudes to time off due to injury

Psychosocial hazards
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Wider environment
Job security & casualization
Location, industry & economy

OUTCOMES

STRAIN (proximal outcomes)
eg. stress anxiety
Sleeplessness
Fatigue
Headache
Nausea

OUTCOMES (distal outcomes)
more serious disorders
approaching or meeting clinical thresholds

Hazazardous manual task(s)

OUTCOME
MSD
Internal processes (causal mechanisms)

- Biomechanical load
- Pain sensitisation
- Cumulative Tissue damage
- Muscle tension
- Stress response
- Hormones

Physical hazards

Psychological hazards

MSD

Adapted from Macdonald and Evans, 2006
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Number of tasks in time period
Duration of tasks
Who does what tasks and when
Expected loads & speed
Number of available staff
Ability to consult, report, fix
Support for safe performance
Support, supervision & feedback on performance

OUTCOMES

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Hazazardous manual task(s)

OUTCOME
MSD
Case studies

• To exemplify the need to think more widely about psychosocial issues in the context of MSD interventions

• Showcasing:

• Controls introducing risks inadvertently, by not considering the psychosocial environment

• Psychosocial risks return to work after MSDs

• MSD controls that can improve psychosocial issues
Case 1: Industrial Athletes

• James (aged 25) works in a medium sized manufacturing business in a small regional town. There are few other sources of employment – most of the town works at the business, or knows someone who does. James’ section is comprised entirely of men aged 22-37.

• Their tasks involve repetitive lifting, moving and delivery of packages, some of which are oddly sized, and usually very heavy.

• An “industrial athletes” program is implemented by James’ manager, a former soldier, which consists of
  • stretching, exercise before work
  • provision of a work gym with boxing ring
  • rewards for exercising in the gym
  • facilitation of competitive sports-based social interaction (boxing, rugby)
Case 1: The intervention

• Stated goals:
  • reduced injuries due to better conditioning;
  • faster return to work following injury (like an injured professional athlete returns to play)
  • community building and self-esteem

• Metaphors used in implementation:
  • workers as athletes; work place as “on-field”; “game day”;

• Framework from Sports Medicine (see Sevier, 2000)
  1. Use protective equipment
  2. Conditioning training strengthens areas of weakness
  3. Early identification of injury
  4. Progressive treatment to increase flexibility, muscle balance and prevent future injury
Case 1: Analysis

- Leaving the intervention and the approach aside…(individual focus etc)
- What are the psychosocial implications of this intervention?
- How might they affect hazardous manual tasks?

- Connotations of “athlete”
- Perception of demands and capabilities
- Social comparison
- Response to injury/pain
Case 1: Summary

- Work tasks, systems of work and control strategies need to be analysed for all kinds of hazards
- A focus on controlling hazards at source should be maintained
- Interventions need to be analysed (and risk assessed!) in terms of
  - What problem are they solving?
  - Are they consistent with a WHS framework?
  - Are they introducing potential psychosocial hazards?
  - How might these combine with other hazards?
Case 2

Susan was an emergency services worker who sustained a musculoskeletal disorder to her ankle on the job. She had worked in a front-line role for 13 years and was well respected in her industry.

She reluctantly took 8 months off work to recover and seek treatment. Her workplace was supposed to provide a particular piece of exercise equipment as required by her surgeon. She spent 3 months and 47 emails arguing about which model should be supplied.

Subsequently, she was on restricted duties, but not given any meaningful work. She was still in pain, but wanted to work, and asked to be assigned duties. Colleagues notices changes in her mood and outlook.

Monthly meetings with her injury management coordinator essentially involved them asking her when she would return to full duties. No referral to sources of support was made. It was her supervisors role to assign duties.
During this time she was still in pain, depressed and anxious, and relying on pain medication. She was seeing a psychologist. Her relationship started to break down as she was constantly in pain and could not undertake normal activities with her young family.

Eventually she was offered a temporary transfer to a location which was an hours drive from home. Her previous workplace was in walking distance, and enabled her to do some school drop offs. At her new workplace she was still not assigned any tasks. She spent long periods just watching television. The only other female officer at the station had left 3 years before.

Susan has since been diagnosed with a secondary psychological injury.
Case 2: Analysis

- Pain
- Significant absence
- Administrative issues in rehab
- No meaningful tasks assigned
- Transferred, negative impact on home life/flexibility
- Negative impacts not identified nor acted on
- Lack of support; blame
Case 2: Analysis

• Being injured at work is stressful (eg. Anshel, 2000)
• Stress while rehabilitating effects progress of rehabilitation (Shain, 2001)
• Aspects of the work environment have an impact on the success of a return to work program, including
  • support from colleagues and supervisors, not feeling judged, being believed regarding the authenticity of symptoms, and the coordination of administrative strategies for promoting return to work (see Franche & Krause, 2002).
• Not being given tasks potentially increases risks to psychological health
  • perceptions of value, contribution, purpose, role in family and community
• Poor RTW processes, and outcomes for people with psychological injury (see Wyatt & Lane, 2018)

• Negative psychosocial outcomes should be anticipated in RTW processes, and managed as part of a safe system of work

• Roles in this for
  • senior managers/supervisors
  • injury management
  • Co-workers
Case 3: MSD intervention

- Common MSD intervention: localized risk assessment training

- Used in various industries where the hazardous manual task might change a lot in terms of size, shape, weight etc.

- Workers are taught how to apply an informal risk assessment based on the context of the task they may need to perform
Case 3: Analysis

- It is a good MSD control (better than teaching people how to lift)
- But what’s going on at a psychosocial level?

- Developing skill sets
- Empowerment and participation
- Control and autonomy
- Teamwork
BUT…

• The rest of the system has to work, for these benefits (MSD and Psychosocial) to be realised

• For example
  • Decisions have to be supported
  • Equipment needs to be available where necessary
  • Time needs to be available
  • Consequences and motivators need to be aligned with this intervention
Summary

• Psychosocial issues are everywhere and preventing them is part of an organisation’s WHS duties

• They should be identified and managed consistent with a normal WHS framework
  • Risk management, treat at source (see Caponechia, in press)

• Psychosocial issues can affect MSDs both via
  • effects on the internal mechanisms of MSDs
  • effects on exposure to nature, frequency, duration of hazardous manual tasks

• A broad, integrated view of the psychosocial environment is needed, at all stages of WHS to help deliver a safe system of work.
References


