



Does disability status modify the association between psychosocial job quality and mental health? A longitudinal fixed-effects analysis



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ABSTRACT

Background: People with disabilities have difficulties in obtaining work. However, evidence suggests that those with disabilities derive substantial mental health benefits from employment. This paper assesses how the relationship between work and mental health is influenced by psychosocial job quality for people working with a disability.

Methods: The study design was a longitudinal cohort with 13 annual waves of data collection, yielding a sample of 122,883 observations from 21,848 people. Fixed-effects within-person regression was used to control for time invariant confounding. The Mental Component Summary (MCS) of the Short Form 36 (SF-36) measure was used as the primary outcome measure. The main exposure was a six-category measure of psychosocial job quality and employment status (including ‘not in the labour force’ [NILF] and unemployment). Disability status (‘no waves of disability reported’ and ‘all contributed waves with reported disability’) was assessed as an effect modifier. We also conducted a secondary analysis on respondents contributing both disability and non-disability waves.

Results: For those with no disability, the greatest difference in mental health (compared to optimal employment) occurs when people have the poorest quality jobs (−2.12, 95% CI −2.48, −1.75, $p < 0.001$). The relative difference in mental health was less in relation to NILF and unemployment (−0.39 and −0.66 respectively). For those with consistent disability, the difference in mental health when employed in an optimal job was similar between the poorest quality jobs (−2.25, 95% CI −3.84, −0.65, $p = 0.006$), NILF (−2.84, 95% CI −4.49, −1.20, $p = 0.001$) or unemployment (−2.56, 95% CI −4.32, −0.80, $p = 0.004$). These results were confirmed by the secondary analysis.

Conclusions: Efforts to improve psychosocial job quality may have significant mental health benefits for people with disabilities. This will contribute to the economic viability of disability employment insurance schemes in Australia and other high-income countries.

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1. Background

In Australia, approximately 2.2 million (14.4%) of working-age people (14–64 years) have a disability (defined as long-term health conditions, impairments or disabilities that restricts everyday activities), with just over 50% of these people being women. Nearly half (47.3%) of people with disabilities were not in the labour force in 2015, meaning they were neither employed nor

actively looking for work, compared to 17.5% of people without a disability (ABS, 2015; OECD, 2009). The low labour force participation of people with a disability is problematic at an individual and societal level. At an individual level, previous research has shown persons with physical, psychological, intellectual and sensory disabilities have better mental health when they are employed compared to when they are unemployed or “not in the labour force” (NILF) (Milner et al., 2014). Further, that the mental health and wellbeing benefits of employment are greater among those people with disabilities than those without (Hall et al., 2013; Milner et al., 2014; Okoro et al., 2007). At a societal level, non-participation in the labour market means a persisting disability employment gap, and greater reliance on welfare and social services.

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One possible explanation for their lower labour force participation is that people with disabilities face numerous barriers in finding work and have lower overall financial capital than those without disabilities (Milner et al., 2014). It is also possible that people with disabilities find a greater source of meaning from employment than those without disabilities, and this both protects and promotes mental health (LaMontagne et al., 2014). This premise is supported by qualitative research, which has shown work to be a meaningful and important source of identity and self-efficacy for persons with disabilities (Saunders and Nedelec, 2014; Vrkljan and Miller-Polgar, 2001). Another explanation is that workers with disabilities are generally more satisfied with the psychosocial quality of their work than those without disabilities. If so, this would align with the emerging evidence that the overall health benefits of employment are dependent on the psychosocial quality of a job (Butterworth et al., 2011b; Broom et al., 2006).

Increasing the labour force participation of people with disabilities is an area of active policy development in high-income countries such as Australia. A National Disability Insurance Scheme (NDIS) was legislated in Australia in 2012; the NDIS aims to enhance the individualised focus of support and services accessed by those with disabilities in order to better meet their personal goals and aspirations, which can include paid work or other community participation (Australian Productivity Commission, 2011). The financial viability of the scheme is premised on narrowing the disability employment gap by increasing employment opportunities and the sustainability of employment for persons with disabilities. Improved understanding of the employment experiences of people with disability could yield valuable insights for such policy initiatives. However, to date, there has been no research on the effects of psychosocial job quality on the mental health of those persons working a disability.

Our study used a fixed effect regression approach over 13 annual waves of available data from an Australian working population panel survey to ask the broader question: Does disability status modify the association between psychosocial job quality and mental health? Because disability is a dynamic state for some people, we identified three distinct disability status groups: 1) disability reported in all 12 waves, i.e., “consistent disability”; 2) reported disability in some waves and not others i.e., “intermittent disability”; and 3) disability not reported in any waves “non-disability”.

2. Methods

2.1. Data source

The Household, Income and Labour Dynamics in Australia (HILDA) survey is a longitudinal, nationally representative study of Australian households established in 2001. It collects detailed information annually from over 13,000 individuals within over 7000 households (Wilkins, 2013). The response rate to wave 1 was 66% (Wilkins, 2013). The survey covers a range of dimensions including social, demographic, health and economic conditions using a combination of face-to-face interviews with trained interviewers and a self-completion questionnaire. Although data are collected on each member of the household, interviews are only conducted with those older than 15 years of age.

The initial wave of the survey began with a large national probability sample of Australian households occupying private dwellings (Wilkins, 2013). Interviews were sought in later waves with all persons in sample households who had attained 15 years of age. Additional persons have been added to the sample as a result of changes in household composition with a top-up sample of 2000 people added to the cohort in 2011 to allow better representation of

the Australian population using the same methodology as the original sample (i.e., a three-stage area-based design) (Watson, 2011). The response rates for new respondents who join the HILDA survey are above 70% and the (wave-to-wave) retention rate for respondents who continue in the survey is above 90% (Wilkins, 2013).

2.2. Outcome variable

The Mental Component Summary (MCS) of the Short Form 36 (SF-36) measure was used as the primary outcome measure. The Mental Component Summary (MCS) score represents a summary measure of mental health and wellbeing constructed from the 8 sub-scales, but with strongest factor loadings on the mental health, role emotional, vitality, and social functioning scales (Butterworth and Crosier, 2004). The SF-36 is a widely used self-completion measure of health status, and has been validated for use in the Australian population, and to detect within-person change over time (Butterworth and Crosier, 2004). The SF-36 in the HILDA survey has been shown to be psychometrically sound, with good internal consistency, discriminant validity and high reliability (Butterworth and Crosier, 2004). The mean score on the MCS in HILDA was approximately 49.8, with a standard deviation of 10.3. Higher scores represent better mental health. The range of the MCS is from 1 to 100, with 100 representing optimal functioning. All of the SF-36 scales demonstrated acceptable internal consistency, with Cronbach's alpha ranging from 0.82 (Mental Health and General Health) to 0.93 (Physical Functioning). These reliability scores are similar to those reported in previous Australian research (Butterworth and Crosier, 2004).

2.3. Definition of disability

The measure of disability used in the HILDA survey was based on the International Classification of Functioning, Disability and Health (WHO, 2011). Disability was determined from the following survey question “... do you have any long-term health condition, impairment or disability that restricts you in your everyday activities, and has lasted or is likely to last, for six months or more?” with a binary response of ‘yes’ or ‘no’. Specific examples of long-term conditions were shown, such as limited use of fingers or arms, or problems with eyesight that could not be corrected with glasses or contact lenses. These questions were asked at every wave. Data was available from 2001 to 2013. About one quarter of those in HILDA report a disability across all waves, as compared to about 18.5% in the general population (ABS, 2012). The majority of disabilities reported in HILDA are for physical (14.3% of observations), unspecified (13.5% of all observations), and sensory (sight, hearing, speech) (5.82% of all observations) disabilities. Psychological (3.56% of all observations) and intellectual disabilities (1.07%) comprise the smallest proportion of cases.

We constructed a time invariant measure of disability that identified if a person reported disability in all contributed waves (consistent disability), in no contributed waves (non-disability), or reported 1 or more waves of each (contributing both disability and non-disability waves, henceforth referred to as intermittent disability).

2.4. Exposure variable

A multidimensional measure of psychosocial job quality was constructed using the measures of psychosocial job characteristics available in the HILDA survey (control, demands and complexity, job insecurity, and unfair pay). Full details of the construction and validation of the job quality measure are presented elsewhere

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