



Return to work outcomes for workers with mental health conditions: A retrospective cohort study



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ABSTRACT

Objectives: The aims of this study were to describe predictors of sustained return to work (RTW) among a cohort of workers with compensated work-related mental health conditions (MHCs); and to examine predictors of subsequent absences due to the same condition.

Methods: This study was a retrospective analysis of compensation claims data in Victoria, Australia. We selected workers with an accepted wage replacement claim due to a work-related MHC from 1 January 2002 to 31 December 2009, with two years of follow-up data.

Results: We identified 8358 workers meeting our inclusion criteria. The median age of workers was 44 years (Interquartile range (IQR): 36–51) and 56% were female. In a multivariable Cox regression analysis, older age, being from a small organisation, working in some specific industry segments, consulting a psychiatrist or psychologist, using medications, and having a previous claim were all associated with a delayed RTW. Workers experiencing work pressure, assault/workplace violence or other mental stress factors, working in the public administration and safety industry and having a medical incapacity certification between 3–4 days and 5–7 days had a higher rate of multiple RTW attempts.

Conclusion: This study identified a number of risk factors associated with a delayed RTW and multiple attempts at RTW. Predictors may help identify high-risk groups and facilitate the RTW process of workers with MHCs.

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Introduction

Mental health conditions (MHCs), including depression and anxiety, are a major burden of disease in developed countries. It is estimated that between 8 and 12% of the population suffer from a major depressive episode at some point during their lifetime [1] and 25% of people experience some type of mental health issue in any given year [2]. The number of people with a MHC is expected to increase over time with depression projected to be one of the leading causes of disability-adjusted life years by 2020 [3].

MHCs are known to contribute to time away from work and decreased productivity among employed people [4]. Further, time

off work for increased periods may exacerbate mental health issues and associated comorbidities and increase the risk of mortality due to cardiovascular disease and smoking-related cancers [5]. Previous research examining sickness absence related to MHCs have identified older age [6–8], severity of MHCs [6,7,9–12], prior mental health absences [10], addiction [8], anxiety [9], occupation in certain industries, including education, public service, commercial services, healthcare, municipal and private sectors [7,11], and lower socio-economic status [6,8,12,13] to be predictors of extended time away from work.

MHCs are also known to be associated with recurrent sickness absence or multiple attempts at return to work (RTW) following the first RTW attempt [14–17]. The literature suggests that MHCs such as depression are chronic in nature and have a high recurrence rate [18]. Subsequent attempts at RTW can also often indicate more serious and long-lasting MHC [15]. Age [14,15], married women [15], women with a duration of employment shorter than 5 years [15], low salary [15], the number of previous sick-leave episode [14],

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organisation size (greater than 100 employees) [16], conflicts with supervisors [16], and high organisational job demand [17] have been found to predict a recurrence of sickness absence after recovery from a MHC. In contrast, having one or more chronic diseases decreased the risk of recurrent sickness absence [16].

The literature on factors associated with RTW and multiple attempts at RTW following a MHC has several limitations. Many of these previous studies have been restricted to small sample sizes [9,10,16] within single occupational groups [13] or they have been based on large social insurance databases, which lack detailed information on employment factors [8,10,12] and subsequent treatments [6–8,11–13]. It is also unclear whether the risk factors that are specific to multiple attempts at RTW, may be the same or different from risk factors for sustained RTW. Most of the research has been conducted in European social insurance systems that compensate workers with MHCs irrespective of the cause of the condition [6–13]. In workers' compensation jurisdictions in nations such as Australia, Canada and the United States of America there must be a demonstrable link between work and the MHC for a compensation claim to be accepted. These system level differences mean that the findings of many previous studies may not be applicable to other contexts, such as Australia, as returning to the environment where the condition was sustained may present different challenges than returning to work in general. A recent systematic review exploring work outcomes of sickness absence and sickness absence recurrences related to MHCs acknowledged an absence of Australian studies [19].

Given the burden of MHCs and lack of generalisability of European studies to the Australian context, there is a need to understand factors associated with RTW outcomes for Australian workers with MHCs. This information could be used to develop interventions to improve RTW outcomes for groups of workers who might be at risk for longer time off work. The aims of this study were to describe a cohort of compensated workers in the state of Victoria, Australia with a sickness absence due to a MHC and examine factors associated with time until the first sustained RTW. As MHCs are likely to relapse or recur easily, we also examined factors associated with multiple attempts at returning to work.

Methods

This study involved a retrospective analysis of compensation claims data. The Compensation Research Database (CRD) is an administrative database held by the Institute of Safety, Compensation and Recovery Research (ISCR) and includes data for work-related claims covered by the insurer, WorkSafe Victoria (WSV). In Victoria, Australia, WSV provides compensation insurance for the majority of non-federal government employers (representing 85% of the Victorian working population). WSV does not provide insurance for the proportion of the Victorian working population who are sole traders, employed at self-insuring agencies or federal government employees (approximately 15% of the working population). All claims that exceed the financial threshold for health care expenses or require more than ten days off work must be registered with WSV. These cases are then managed by case managers at one of WSV's authorised agents. To receive workers' compensation benefits, workers must have their illness or injury certified by a registered medical practitioner.

Data held by the CRD is collected and coded by case managers and includes demographic information, injury type coded according to the Type of Occurrence Classification System (TOOCS) [20], occupation type coded according to the Australian and New Zealand Standard Classification of Occupations (ANZSCO) [21], workplace industry coded according to the Australian and New Zealand Standard Industrial Classification (ANZSIC) [22], medical and rehabilitation services utilised by workers, medical certificates

of capacity issued by a registered healthcare provider (e.g. medical practitioner, physiotherapist, chiropractor or osteopath) and reimbursement payments made by the insurer. Payment data include WSV reimbursement amounts and the dates of each service. Data are routinely quality checked at Monash University by database staff using internal logic checks.

Participant inclusion criteria

We selected all workers with a wage replacement compensation claim due to a work-related MHC resulting in ten or more days off work where the date of the first incapacity (first lost day from work) related to the MHC was between 1 January 2002 and 31 December 2009 (total sample after exclusion criteria applied $n = 8358$). MHC includes any mental disorders (e.g. adjustment disorder, phobias and psychotic conditions), stress-related illness, post-traumatic stress disorder (PTSD) and anxiety. Cases were excluded if the worker was not of working age (i.e. aged under 15 years ($n = 1$) or aged over 70 years ($n = 10$)), had their claim terminated by the insurer (i.e. fail to provide medical certificates, fail to participate in rehabilitation or assessments, fraudulence activity) ($n = 8065$), or died during the follow-up period ($n = 25$). Subsequent MHC claims made by the same worker which occurred within the specified study period were also excluded ($n = 393$). That is, only the first claim by the worker was included in the sample to avoid double counting of workers.

Outcome measures

The primary outcome of interest was time until a first sustained RTW during the two year follow-up period as measured in days. First sustained RTW was defined as return to pre-injury hours denoted by a gap in wage replacement payments of 30 days or longer following the date of the first incapacity related to the MHC [23]. Workers who were still receiving wage replacement payments 104 weeks after their first payment were considered not to have returned to work and were right-censored. In Victoria, Australia, the weekly wage replacement payments provided by WSV is 95% of the pre-injury average weekly earnings (PIAWE) for the first 13 weeks and 80% of PIAWE from 14 to 130 weeks. At 130 weeks post-injury, weekly wage replacement payments are only paid if the injured worker is still unable to work as a result of the injury. Censoring at 104 weeks avoids the sharp decrease in wage-replacement payments expected at 130 weeks, which can either refer to RTW or to a cease in payments due the compensation scheme policy. A secondary outcome was the number of attempts at returning to work during the follow-up period. As wage replacement payments are typically made on a weekly basis, a RTW attempt was defined as a gap in payments of seven days or more followed by a resumption of payments thereafter. This definition is based on a previous study [24].

Explanatory variables

We examined utilisation of the health services that make up the majority of the mental health workforce in Australia [25]. These included consultations with psychologists, psychiatrists, and the use of any prescribed medications. Health services were limited to the first 30 days from the first day of incapacity as a measure of MHC severity. Initial medical incapacity certificates describing time off work were also examined. Medical incapacity certification duration was categorised into five groups: 1–2 days, 3–4 days, 5–7 days, 8–14 days and 15 days or more. A history of work-related claims including MHC claims was determined by examining previous claims using historical WSV data dating back to 1992. In addition to mental health services, we also examined demographic

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