In this issue of Occupational Medicine

Advising about return to work is a core activity for most occupational physicians. It should be a key component of the rehabilitation process which if performed correctly enhances an employee’s health and well-being through successful return to the workplace following illness or onset of disease. Kivistö et al. [1] examined the practice in Finland through a tri-annual national occupational health survey which included questions about return-to-work practices. They managed to obtain responses from 700 separate occupational health services representing a 95% response rate. Only 41% of those responding offered formal return-to-work services and there was considerable variation in the service offered and not often in line with current evidence. The authors conclude that there is a compelling need to increase and improve return-to-work policies in Finland. They suggest the introduction of an evidence-based guideline to bridge the gap and propose that the effect of this is assessed in the next survey.

Where rehabilitation fails, the risk of long-term unemployment rises considerably and in someone who has been absent for 12 months the likelihood of them working again is low. In the UK, once an individual moves onto incapacity benefit after 26 weeks of sickness, there is a less than 50% chance of them working again in the next 5 years. To be able to predict those at risk of long-term incapacity at an early stage therefore has its attractions and Wilford et al. [2] set out to develop and test a screening tool. They derived predictive questions from a literature search which they then applied to the occupational health records of 741 local authority employees with long-term absence. Five questions emerged as the strongest predictors of job loss, these being the individual’s own assessment of their ability to work, length of sickness absence in the previous 12 months, age, whether the individual was waiting for treatment or consultation and their perception of barriers to return to work. The authors conclude that listening to patients assess their own work ability is the best tool for determining risk of job loss. Using this method, occupational health and human resources practitioners may be able to operate a more focused rehabilitation intervention involving adaptations by the employer and additional health or social support to the employee.

Our other papers consider violence and bullying in the workplace, increasingly recognized as important hazards. Estryn-Behar et al. [3] studied violence in nursing as part of the NEXT study. In a questionnaire study of 40 000 European nurses, 22% reported exposure to frequent violent events from patients or relatives, with higher prevalences of violence in psychiatric, geriatric and emergency units. Factors associated with high reporting of violent events were quality of teamwork, uncertainty regarding patients’ treatments, young age, being a nursing aide, night work and high time pressures. Nurses who reported exposure to violence had higher levels of burn-out and reported more intentions to either leave nursing or change employer.

Brousse et al. [4] carried out an in-depth study of people who had been the targets of workplace bullying. They identified 48 workers referred to an occupational health clinic who met the Leyman Inventory criteria for psychological terror and where on average workplace bullying was reported to have been present for 2 years. Three-quarters were women, 70% worked in the private sector and 90% gave no previous history of mental health problems. When first seen, 80% met criteria for anxiety and more than half for depression using the HAD scale with a quarter of the sample declaring suicidal thoughts. In addition, 88% had high neuroticism scores and for almost half the entire sample this was considered pathological. At the follow-up consultation 12 months later, there remained high levels of mental ill-health on all scores. The only improvement was seen in those who were working (23 out of 48) who reported significant improvements in their anxiety and depression scores. Those who were not working reported a deep fear of returning to or approaching their workplace. While the study was relatively small, the persistence of significant mental health symptoms and consequential ongoing exclusion from work is of concern, particularly when half the sample showed no improvement. However, the study suggests that a return to work can bring about significant improvement and makes this a rewarding goal to be aspired to for occupational health and human resources professionals. It also raises the interesting possibility of pre-existing vulnerability in certain employees.

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References