

Workplace barriers to reducing the incidence of musculoskeletal and mental health disorders

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Abbreviations

LTI	Lost Time Injury
HSR	Health and Safety Representative
MHD	Mental Health Disorder
MSD	MusculoSkeletal Disorder
OHS	Occupational Health and Safety
WSV	WorkSafe Victoria

Executive summary

Currently, risk management procedures for work-related musculoskeletal injuries and disorders (MSDs) focus on controlling risks arising from physical hazards associated with manual handling tasks. There is anecdotal evidence that management of psychosocial hazards is rarely a consideration for managers aiming to reduce MSD risk, despite the strong body of research evidence demonstrating that work-related psychosocial hazards and the broader psychosocial work environment often have a significant impact on MSD risk and workers' health and well-being more broadly. Such evidence is incorporated into new evidence-based guidance and risk management procedures intended to reduce the incidence of MSDs and MHDs in high-risk workplaces.

The purpose of the present project was to produce evidence to support more effective implementation of these procedures.

Study details

WorkSafe Victoria identified two industry sectors with high claim rates for both MSDs and MHDs: logistics/transport and residential aged care. Organisations from these sectors were recruited through a targeted mailout campaign and snowball sampling.

Nineteen organisations (10 logistics/transport and 9 aged care) were recruited to participate. Semi-structured Interviews were then undertaken with 67 staff across a range of levels within these organisations: 41 in the logistics/transport sector and 26 in the residential aged care sector. The interviews explored a range of issues related to the following research questions:

1. What are workplace stakeholder beliefs and attitudes about factors affecting the incidence of MSDs and of MHDs?
2. What are current workplace risk management practices, and what information resources guide these practices including those promulgated by WSV?
3. What are workplace stakeholder perceptions of new evidence-based risk management practices and what factors are likely to hinder or facilitate the implementation of these practices?

Findings

Results from this study identified a number of key barriers to the implementation of more effective workplace management of MSD risk, including a very widespread belief that MSD

risk arises largely or entirely from physical hazard exposures related to manual handling activities. Importantly, this widespread but erroneous belief is reflected in the content of regulatory and guidance documents targeting MSDs, and in the MSD risk management policies and procedures currently used by organisations.

The risk management policies and procedures currently used by organisations to manage risk from psychosocial hazards, particularly MHD risk, mainly target the problems arising from behavior of individual workers, with little attention to risk from the work-related organisational and psychosocial hazards known to affect risk for all workers.

These findings support the need for a broader, evidence-based risk management framework to improve workplace management of both MSD and MHD risk. Much more holistic assessment and control procedures are needed to address risk from all relevant types of hazards in a more integrated way. In addition, line managers and supervisors – who often play key roles in generating both physical and psychosocial hazards – need to be educated on their key roles in managing these risks.

Some other significant barriers to changing current risk management practices are identified, and recommendations for translation of findings into policy and practice are provided, separately for the regulator, organisations and researchers.

Recommendations for translation of findings into policy and practice

Regulator

- Develop web-based and other MSD risk management guidance and associated resources that integrate the management of MSD risk from both physical and psychosocial hazards. These resources would be most effective if customised to particular types of job in high-risk industry sectors.
- Further develop website and other resources to facilitate prevention of work-related MHDs by appropriate management of risk from work-related organisational and psychosocial hazards, highlighting the need for employers to focus more on these hazards rather than on the behaviour of individuals. That is, the present focus on secondary and tertiary prevention should be changed to focus on primary prevention, since this is likely to be much more cost-effective.
- Promote educational programs to improve understanding of the important effects of psychosocial hazards on workers' mental and physical health, and on evidence-

based workplace strategies for managing them. Education programs should particularly target managers and supervisors, since they often play key roles in generating or exacerbating such hazards and therefore need to be actively involved in prevention.

- Develop and promulgate best practice case studies to assist workplaces to manage psychosocial hazards, focusing particularly on case studies from industry sectors where MSD risk is high. Ensure that these case studies include evidence of how risk management costs, including time needed for workers to participate, are outweighed by benefits such as a reduction in LTIs and/or higher quality work performance.
- Promote the use of more holistic risk management tools, such as the MSD risk management toolkit, to facilitate more effective workplace management of MSDs and MHDs which are affected by a diverse range of hazards that can interact with each other in their effects on risk.
- Promote the need for consultation and participation in MSD and MHD risk assessment and control procedures by employees who are at risk. Emphasise the need for employee participation to occur during paid working hours, highlighting the value of such participation in reducing risk and associated costs.
- Promote the need for senior managers to develop and maintain a detailed understanding of both operational and OHS issues, to communicate openly with staff at all levels, and to ensure that all staff perceive OHS issues as important. Often this can be achieved by managers frequently being present where staff are performing their normal work and if possible participating in this work while actively listening to any staff concerns.
- Review and amend the structure and design of information on the WSV website to make it easier for users to locate relevant information, since navigation difficulties currently limit the website's usefulness.

Organisations

- Ensure that site managers and coordinators receive evidence-based education and training about how their decisions and actions can influence OHS risks, and practical ways to manage these risks. This might include topics such as leadership skills, communication strategies, helping employees to feel supported in their work, and conflict management.
- Reduce current management 'silos' (e.g. divisions between HR, OHS and line management) to achieve more effective management of OHS risks. In particular, ensure that risks arising from psychosocial hazards and from manual handling hazards are managed in a coordinated way rather than separately by different

departments. This is essential to achieve maximum value from available risk management resources.

- Ensure that employees who are at risk of MSDs and/or MHDs are active participants in MSD and MHD risk assessment and control procedures, in accordance with research evidence on the value of high levels of participation in reducing MSD and MHD risk.
- Ensure that senior managers frequently engage with floor staff to facilitate open communication and gain greater understanding of both operational and OHS issues, and to reinforce staff perception of OHS as a high priority. Where possible, these goals could be pursued by managers participating in routine work alongside floor staff.

Researchers

- Refine the language and procedures of the MSD risk management toolkit to accommodate a range of literacy levels. (This work is in progress, as part of a separate project).
- Conduct further research to develop broad-based formulae suitable for workplace use to calculate expected financial and other benefits of implementing procedures such as those in the MSD risk management toolkit. (This work is in progress, as part of a separate project.)
- Implement the MSD risk management toolkit in workplaces in various high-risk industry sectors and evaluate its effectiveness in reducing levels of manual handling and psychosocial hazards, and both MSD and MHD risk levels.
- Develop a website to host the MSD risk management toolkit and associated guidance materials on risk control strategies. Such a website would enable organisations to download simple tools for assessing hazard and risk levels for people in target jobs, and upload hazard and risk data to obtain an automatically produced report identifying the subset of hazards most closely linked to risk for the job assessed, along with guidance on how to reduce risk from each of these hazards. It would also enable the organisation to benchmark against comparable organisations within its industry by comparing its data with *average* values derived from all data uploaded by comparable organisations.

Purpose

This research aimed to identify key workplace factors likely to affect implementation of new evidence-based guidance and risk management procedures designed to reduce the incidence of musculoskeletal disorders (MSDs) and mental health disorders (MHDs) in high-risk workplaces within the residential aged care and logistics/transport industry sectors. Interviews, a policy document analysis and a workshop were undertaken to document the following¹:

1. *What are workplace stakeholder beliefs and attitudes about factors affecting the incidence of MSDs and of MHDs?*
2. *What are current workplace risk management practices, and the information resources being used to guide these practices including those promulgated by WSV?*
3. *What are current workplace stakeholder perceptions of new evidence-based risk management practices and what factors are likely to hinder or facilitate their implementation?*

The purpose of this research was to produce evidence to support more effective implementation of new evidence-based guidance and risk management procedures to reduce the incidence of musculoskeletal disorders (MSDs) and mental health disorders (MHDs) in high-risk workplaces.

Rationale

Currently, risk management procedures for work-related MSDs primarily focus on controlling risks arising from physical hazards. Management of associated psychosocial hazards are rarely a focus in workplace strategies to reduce MSDs. However, a strong body of research evidence supports the significant impact of work-related psychosocial hazards, and the broader psychosocial work environment, on workers' health and well-being.⁽¹⁻³⁾ For example, Canadian researchers concluded from a recent review that, 'The effect on physical and mental health of the psychosocial environment at work has been well documented' and 'A variety of psychosocial risks are associated with poor mental health outcomes'.⁽⁴⁾ Similarly, a large body of research evidence demonstrates specific effects of psychosocial factors on MSD risk; effect sizes are variable but substantial, sometimes exceeding those of manual handling hazards.⁽⁵⁻⁷⁾ These conclusions are supported by evidence from evaluations of workplace interventions targeting MSDs and MHDs, demonstrating the need for

¹ Except for 'slips and trips' hazards, vehicle collisions and other such accidents; risk from those types of hazards are beyond the scope of the current project or the toolkit.

multidisciplinary interventions with workers participating actively in the risk management process.^(8, 9)

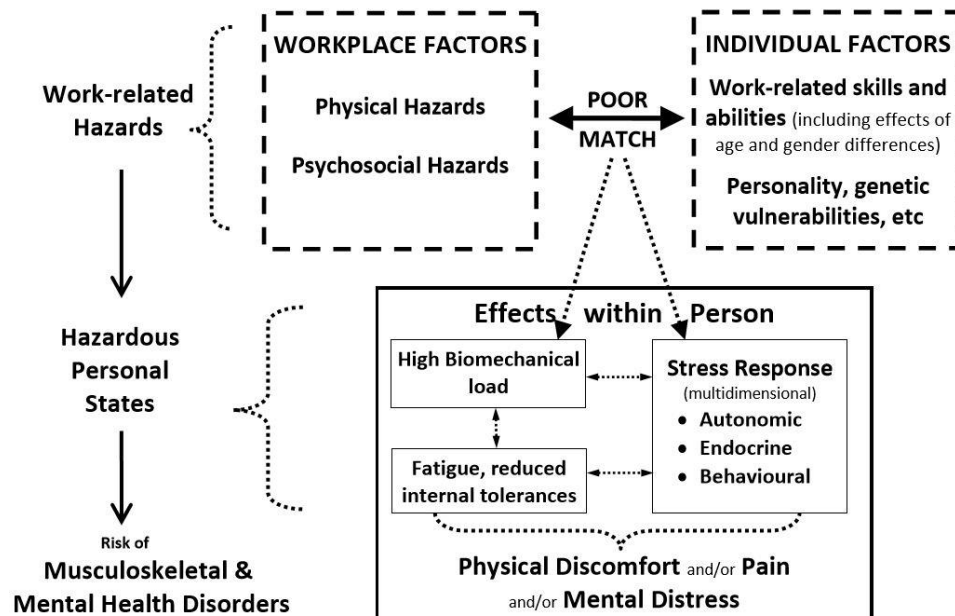


Figure 1: Model of work-related MSD/MHD aetiology

In light of this, more comprehensive and evidence-based risk management procedures and resources have recently been developed, separately, for MSDs and MHDs.⁽¹⁰⁻¹⁶⁾ For example, ISCRF-funded projects have contributed to the development of an MSD risk management ‘toolkit’ for workplace users⁽¹⁰⁾ and to workplace guidelines that target mental health.⁽¹⁵⁾ Researchers in Canada, the UK and Europe have also generated such resources for MHDs.^(13, 16, 17)

Data from surveys and interviews on general psychosocial risk management issues in EU countries has confirmed the key roles played by senior managers, line managers and workers’ representatives.⁽¹⁸⁻²¹⁾ Important influences identified by another European study include managers’ knowledge of and attitudes to psychosocial risk, and any lack of resources (knowledge, tools, expertise, time, money) to support psychosocial risk management.⁽²²⁾

The European research cited above found substantial inter-country differences, which limits its extrapolation elsewhere. Also, evidence is lacking on factors likely to influence implementation (both extent and quality) of any new risk management procedures.

Anecdotal evidence suggests that psychosocial hazards are widely seen as only marginally relevant to MSD risk; this constitutes a significant barrier to implementing the new MSD risk management procedures. Research into Australian managers' beliefs and attitudes concerning MSD causal factors is lacking, as is information about current workplace risk management practices for both MSDs and MHDs.

The need to translate research evidence into workplace practices has been identified in Australia⁽²³⁾ and in Europe. The European Agency for Safety and Health at Work (EASHW). analysis of 2013–2020 research priorities identifies the need to 'develop comprehensive intervention ... strategies where ... health and well-being are integrated into the efforts for increased productivity'.^(24,p.22) The project addresses these needs: it builds on existing ISCRR research in both priority areas by addressing workplace barriers to the implementation of the risk management procedures that have been developed for MHDs and for MSDs.

Interventions for reduction of workplace hazards and reducing MSD risk

Whilst workplace interventions to address MSDs have reported some successes⁽²⁵⁻²⁷⁾ these are modest and the 'MSD problem' remains largely unresolved.⁽²⁸⁾ This suggests that a new approach is required for MSD risk management—the premise for the current project. Identifying the workplace barriers to uptake of MSD interventions is critical, so that strategies can be developed to address the potential issues. Such an approach will enable a more targeted approach to intervention development and implementation.⁽²⁹⁾

Systems approaches take into account the consequences of organisational choices for technical, social and environmental aspects of work. Sociotechnical and macroergonomics systems are two such approaches commonly described in ergonomics literature⁽³⁰⁾. They propose that effective and healthy work systems improve the match between individuals and their work, leading to reductions in injuries, improved job satisfaction and productivity (see Figures 1 and 2).

A systems approach to MSD risk management takes into account a range of different factors (see Figure 2). Research has consistently found that, to improve the effectiveness of MSD risk management, a multifactorial approach⁽³¹⁾ with high levels of participation (in the identification, development and implementation of intervention strategies) from those involved in undertaking the work will maximise the likelihood of successful risk reduction. High levels of participation are more likely to result in appropriately designed interventions

with higher levels of uptake, as a result of employee ownership of any changes required to reduce workplace hazards and subsequent risks⁽³²⁾.

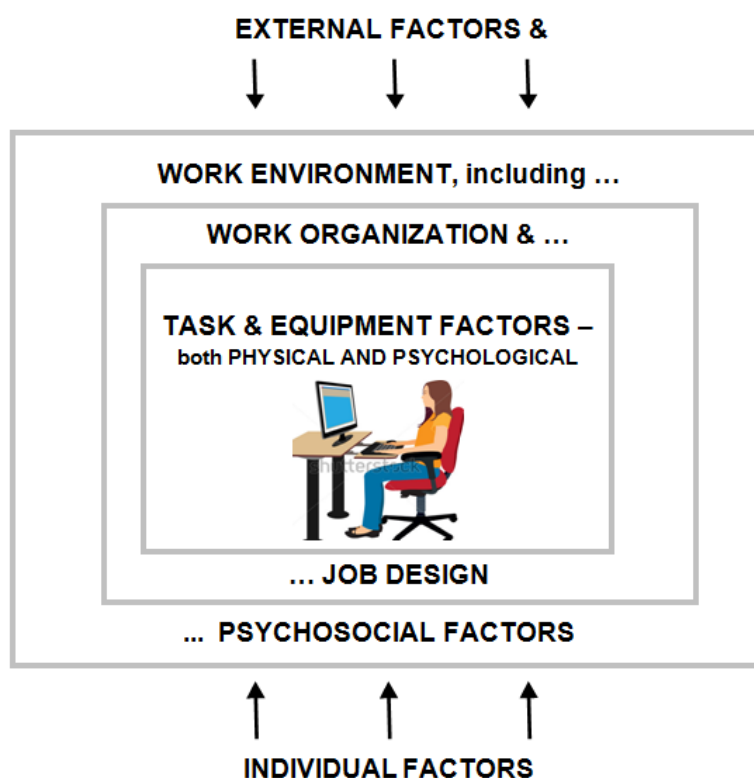


Figure 2: Systems model of factors affecting the effectiveness of workplace health and safety risk management.

Requirements for effective organisational change

A brief review of the human resources management (HRM) and ergonomics/OHS literatures was undertaken to identify general requirements for effective implementation and management of organisational changes or interventions, such as the introduction of new OHS risk management procedures. Workplace interventions to address particular health, safety and well-being issues are often problematic.⁽³³⁾ Nielsen and colleagues (p.219)⁽³³⁾ proposed three key issues in attempts to improve the effectiveness of workplace interventions:

1. examining the processes connecting interventions to the desired outcomes
2. paying attention to the appropriateness of the interventions
3. understanding that using a quasi-experimental design does not guarantee a valid picture of the effectiveness of an intervention.

Identifying an organisation's readiness for change has been proposed as a useful precursor to the development of interventions, enabling a more targeted approach and an increased

likelihood of successful implementation.^(29, 34) Although the mechanisms for identifying readiness for change may differ, the basic premise is that by identifying where the organisation is at, in terms of understanding its workplace and what is needed to improve its particular problems, the most appropriate intervention type can be identified.

Armenakis and Bedelan⁽³⁵⁾ proposed that successful change in organisations needs to address transformational and transactional factors. Transformational factors include leadership, culture, mission and strategy. Transactional factors are organisational structures and systems, tasks requirements, and individuals' skills and capacities. Despite some authors suggesting a lack of validated organisational change frameworks,⁽³⁶⁾ a range of key factors has emerged from the literature as important requirements in the implementation of successful change. These key factors include the need for clear communication, high levels of employee participation, early identification of likely barriers to the new process and commitment from senior leadership.

Communication

Clear communication with strong support from senior leaders in the organisation has been proposed as a fundamental pillar of successful change implementation. A clear communication strategy that ensures that messages are unambiguously endorsed by those in charge is needed to underpin the process.^(37, 38) Francis⁽³⁹⁾ outlined the important role of appropriate conversations at different time-points in the change process, including communication across levels and with different managers, as an important part of workplace learning and organisational change.

Participation

Employee participation has been identified by many to improve the likely success of interventions or adoption of new processes.⁽⁴⁰⁻⁴²⁾ Involving employees in the identification of workplace problems and the development of potential solutions has been proposed for several decades in the ergonomics literature, under the title of participatory ergonomics.^(8, 43) Literature on change management also supports the important role of workers' participation in developing a change process; asking and then responding to feedback so that the implementation of the new process can be modified, taking into account workers' input.⁽³⁸⁾ By nature, participative strategies should be iterative to ensure that feedback is incorporated throughout the process, not just at particular stages. Strategies should be strongly linked and include good communication channels, so that all stakeholders are involved in the process of change and are clear about the intent of change and how feedback is responded to during

the process. However, there are multiple barriers to the successful implementation of participative processes. These include organisational structures, the underlying philosophy of employee involvement, and the nature of how the organisation maintains its competitive strategy in its industry (includes the sector within which the business operates).⁽⁴⁰⁾

Early identification of barriers

The early identification of barriers to change implementation allows time for changes to be made to the change process. In systems where communication is clear and there are high levels of worker participation, barriers are more likely to emerge early which means that they can be appropriately actioned. That is, any transactional factors (organisational structures and systems, task requirements and individuals' skills and capacities) as proposed by Armenakis and Bedelan⁽³⁵⁾ need to be addressed so that they are not barriers to successful implementation.

Commitment from senior leadership

Extensive support from the research literature underpins the importance of senior leadership in guiding successful change and its role in culture-setting for the organisation and any subsequent required changes.^(44, 45)

A systematic approach to change

Fortune and White⁽³⁷⁾ proposed the Formal Systems Model (FSM), a framing device to ensure successful project delivery following an extensive review of the literature on change management. The FSM approach takes into account critical success factors and uses a systems approach to the implementation of effective change. It provides useful considerations for the current project. The authors identified the following barriers to successful change:

- deficiencies in the apparent organisation structure of the system, such as a lack of a performance-measuring subsystem or a control/decision-making subsystem
- no clear statements of purpose supplied in a comprehensible form to the system, from the wider system
- lack of an effective means of communication between the various subsystems
- not enough consideration given to the influence of the environment and insufficient resources to cope with any environmental disturbances that are foreseen
- an imbalance between the resources applied to the basic transformation processes and those allocated to the related monitoring and control process, perhaps leading at one extreme to quality problems and at the other to cost increases or delays.

HRM systems and performance

HRM systems have been linked with organisational outcomes and in some cases OHS performance.⁽⁴⁶⁻⁴⁸⁾ HRM systems are proposed to influence the employees' perceptions of climate.⁽⁴⁶⁾ In organisations with strong systems, variability among employees will be low and a strong collegiality evident with common purposes. It is reasonable to suggest that strong HRM systems are beneficial for the implementation of new approaches and will assist with delivering the clear and unambiguous messages needed for successful change implementation.

Key research aims

This research seeks to determine the barriers and enablers associated with implementation of a new risk management toolkit within the residential aged care and logistics/transport industry sectors. This will be achieved through the documentation of:

1. workplace stakeholder beliefs and attitudes about factors affecting the incidence of MSDs and of MHDs
2. current workplace risk management procedures, and the information resources guiding these practices including those promulgated by WSV
3. workplace stakeholder perceptions of new evidence-based risk management practices,^(10, 11, 13-16) and factors likely to hinder or facilitate their implementation.

Methods

Recruitment strategy

WorkSafe Victoria identified two industry sectors with high claim rates: residential aged care and logistics/transport. Organisations from these sectors were recruited through a targeted mailout campaign. WorkSafe Victoria initially sent a letter to 'The Manager' of 230 organisations, in either the residential aged care or logistics/transport sectors, which had over 150 employees. The letter briefly outlined the study and asked organisations to contact the research team via email or phone if they were interested in participating.

There was a low response rate, which the research team attributed to the fact that the letter was addressed to 'The Manager'. WorkSafe Victoria then re-sent the letter to the same 230 organisations, changing the addressee to 'OHS Manager'.

To participate in the study, organisations needed to:

- have over 150 employees
- be in the residential aged care sector or the logistics/transport sector
- have employees in Victoria.

To participate in the study, individuals needed to:

- be aged over 18 years
- have a role in the OHS management system
- be able to read and speak English
- be an employee of a recruited organisation.

A total of 29 organisations contacted the research team in response to advertising during the period June 2015 to September 2015. Of these organisations 15 did not participate because they were either in an ineligible sector (5 organisations) or did not respond to further communications by the researchers. Fourteen organisations agreed to participate and a further 5 organisations were recruited through snowball sampling. Recruitment was completed by the end of November (10 organisations from logistics/transport sector and 9 organisations from the residential aged care sector). Although an initial target of 90 interviews was proposed, across the organisations, this was not reached for a number of reasons. In many cases there were only a limited number of relevant personnel for interview, as in some cases interviewees were doing a number of roles. In some cases, appointments could not be made within the timelines of the project. However, as analysis was done throughout the project, saturation was deemed to have been reached and thus extra interviewees would not have changed the outcomes presented here.

Following the recruitment of an organisation, the primary contact person was interviewed. During this interview the primary contact was asked to contact other relevant staff members to invite them to participate in the research. Relevant staff members were defined as staff who had one of the following roles: executive, manager, supervisor, OHS consultant/coordinator/advisor, health and safety representative (HSR). Staff from a range of levels in the organisation were interviewed, as it was considered important to gain a wide perspective and varied insights. The primary contact person acted as a liaison to recruit

further staff for phone interviews. A total of 67 participants were recruited. The recruitment process is described in Figure 3.

Data collection

Qualitative data was obtained through semi-structured phone interviews between July and November 2015. Organisations were also asked to provide copies of their OHS policies and procedures, and their WorkCover employer performance rate.

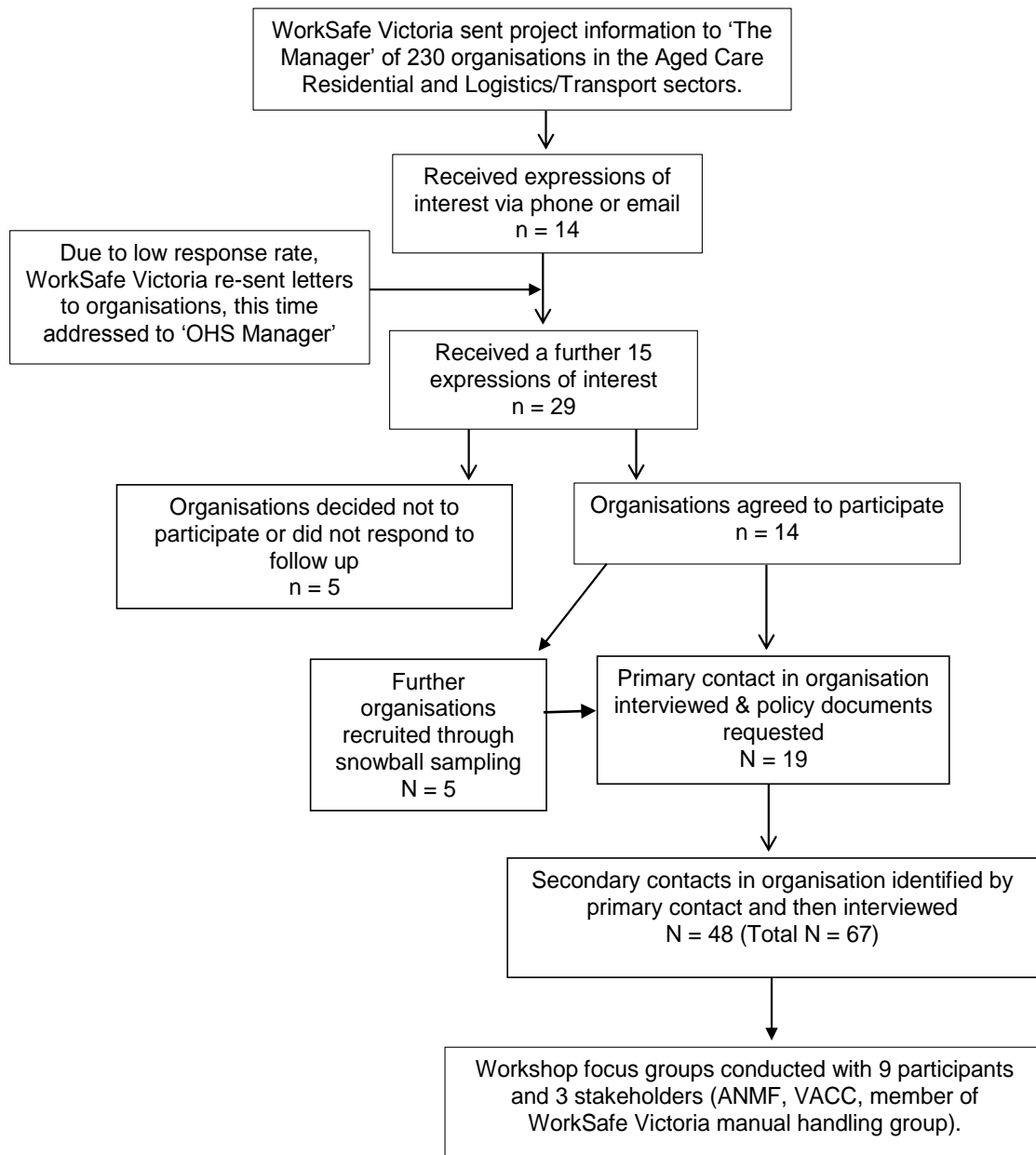
Semi-structured interviews

An interview schedule (Appendix 1) was developed by the researchers. The interview comprised two sections: existing OHS system/issues and feedback on a new MSD/MHD risk management toolkit. The first section covered the following areas: current MSD/MHD incidents and risks, current risk management procedures, and demographics. The second section of the interview commenced with a 10 minute PowerPoint presentation about the new risk management toolkit developed by the authors (<https://www.youtube.com/watch?v=9aJHonxtZic&feature=youtu.be>). Participants were then asked a range of questions related to their perceptions of the new risk management resource, and whether they had previously heard of the link between MSD and psychosocial hazards.

Of the total number of interviews, six were conducted at the workplace and the remainder via telephone. Interviews were conducted individually; they ranged from 45 to 90 minutes duration and were audio-recorded (with the participant's consent). Audio-recordings were later transcribed and analysed thematically using NVivo software to assist with data management.

The first four interviews were conducted jointly by two researchers (JO and NK) who conferred and revised the interview schedule. Interviews did not necessarily follow the order of the schedule (other than to ensure section 1 preceded section 2); however, all topics were covered during the interview. Fifteen interviews were conducted by one of the researchers, and the remaining 52 were conducted by another researcher.

Figure 3: Recruitment strategy



Workshops

Workshops were conducted in March 2016; they included industry stakeholders and some interview participants. Due to the low number of attendees (N = 9), one workshop was convened during which two focus groups were conducted; one for the residential aged care sector and the other for the logistics/transport sector. The project results were presented and participants had the opportunity to provide further feedback to enhance the usability of the risk management toolkit.

Data analysis

NVivo software was used to assist with data management and the categorisation process. Interviews were analysed using grounded theory approaches to define categories, and researchers used memo writing to assist with analysis of emerging categories. Categories were then inductively developed into themes; sub-themes were developed to strengthen analysis of the data. To establish consistency in coding, 10 interview transcripts were randomly selected and read independently by five researchers to develop codes and identify themes. The researchers then conferred and a consensus was reached on codes and emerging themes within the data. These codes were used as a basis for subsequent coding of the remaining transcripts. If new codes were required due to emerging themes, these were added during the process.

Ethics approval was obtained through the La Trobe University Faculty of Human Ethics Committee, approval number S15/176. Study participants were provided with written and verbal information regarding the study; all those who participated provided informed consent.

Research findings

Participant information

Ten organisations were recruited from the logistics/transport sector, with a diverse focus ranging from large-scale shipping to public transport. Nine residential aged care organisations were recruited, the majority being Victorian-based organisations and the remainder operating across several states.

A total of 67 interviews were completed; 41 in the logistics/transport sector and 26 in the residential aged care sector. Characteristics of organisations and interviewees are described in Table 1.

Table 1: Summary characteristics of organisations and interview participants

	N =
Type of organisation	
Logistic/transport organisations	10
Residential aged care	9
Size of organisation (no. employees)	
150–250	4
400–600	4
750–800	3
1100–2200	5
7000–15 000	3
Age group	
18–24	1
25–34	7
35–44	14
45–54	30
55–64	15
Gender	
Male	35
Female	32
Role	
Executive	13
Senior manager	12
Site coordinator/manager	12
OHS advisor/coordinator	17
HR officer	1
HSR	12
Completed formal OHS training	
Yes	54
No	13
Type of OHS training	
Short course	4
5-day HSR course	24
Certificate IV	7
Diploma	7
Graduate certificate	2
Graduate diploma	6
Bachelor degree	2
Masters degree	2
OHS Training by job role (Total Number)	
HSR (12)	10
Consultants/advisors (17)	14
Site managers (12)	9
Senior managers (12)	10
Executive (13)	11
Sources of OHS information	
WorkSafe/other regulator	38
Internal experts	24
Courses/seminars	13
Professional organisations	13
External experts	10
Google	9
Insurer	8
Industry leader organisations	7
Research	6
Legislation	2

Of the 67 interviewees, 25 were in a job role with a specific responsibility for OHS management. The majority (92%) of those with specific OHS management roles had formal OHS training. All participants in senior manager/executive roles with specific OHS responsibilities (N = 14) had formal OHS training: 5-day HSR course (N = 4), Certificate IV (1), diploma (3), graduate diploma (4), Bachelor degree (1), and Masters degree (1). Eleven senior managers/executives did not have specific OHS responsibilities, and of these six had very limited (short course) or no formal OHS training.

None of the site managers (facility managers in the aged care sector and warehouse/distribution managers in the logistics/transport sector) reported having specific responsibilities for OHS management. All had very limited OHS training: nine out of 12 had either a short course or 5-day HSR training, and three had no training. The overall education level of site managers was also relatively low, with only four out of 11 having a tertiary level qualification.

Seventeen interviewees were classified as OHS consultants/advisors and three of these had no formal OHS training. The majority of OHS consultants/advisors with formal OHS training had completed a diploma level or higher qualification. Education levels of participants are summarised in Table 2.

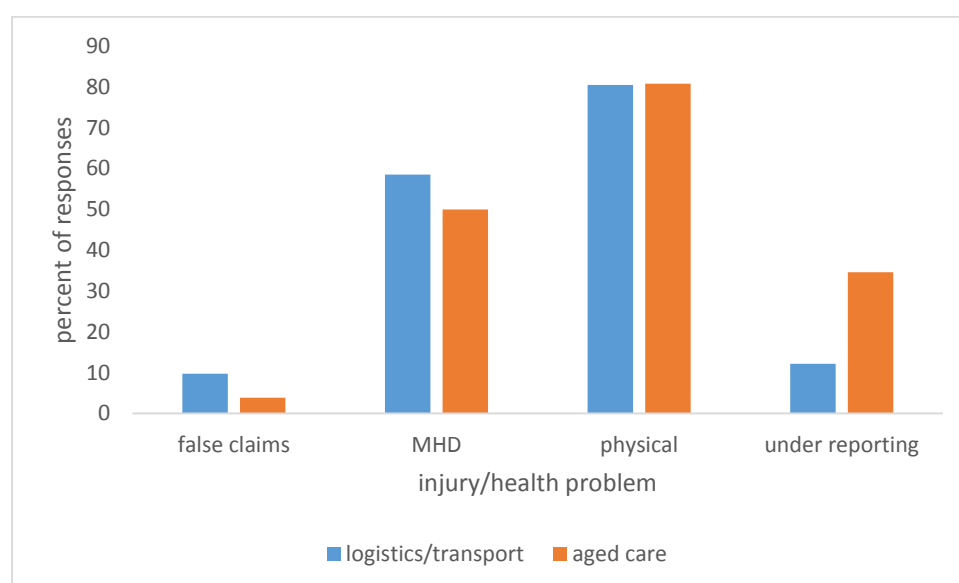
Table 2: Education levels of participants by job role

Job role	Highest level of education	N
HSR	Year 11 or below	5
	Year 12	2
	Certificate/diploma	5
OHS consultant/advisor/HR officer	Year 12	3
	Certificate/diploma	4
	Graduate diploma	2
	Bachelor degree	4
	Masters degree	5
Site coordinator/manager	Year 10	3
	Certificate/diploma	5
	Graduate certificate	1
	Graduate diploma	1
	Bachelor degree	1
	Masters degree	1
Senior manager	Certificate/diploma	2
	Graduate diploma	9
	Bachelor degree	1
Executive	Year 12	1
	Certificate/diploma	3

	Graduate certificate	1
	Graduate diploma	4
	Bachelor degree	1
	Masters degree	3

All participants were asked ‘What do you see as the major injury or health problem in your workplace?’ Responses included reports of physical and mental health disorders, false reporting and some under-reporting. Participants often provided more than one answer and may have raised additional relevant issues at a further point in the interview (refer to Figure 4).

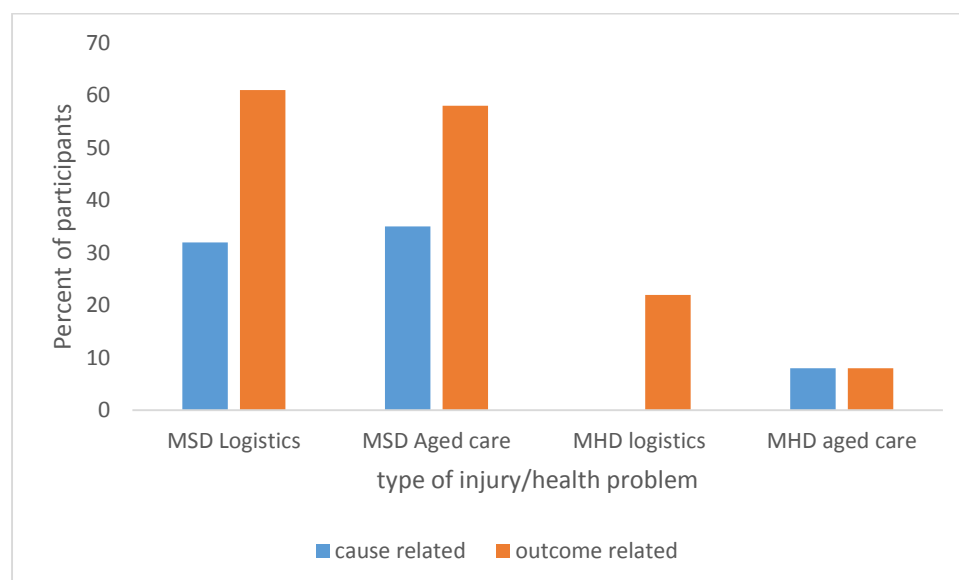
Figure 4: Major injury or health problem reported



Examination of responses to the initial interview question (‘What do you see as the major injury or health problem in your workplace?’) found the majority of injuries related to MSDs (62 participants), with only a small number of participants reporting MHD issues (13 participants). A common issue in MSD risk management is the interchangeable use of causes and outcomes for injury reporting. For example, MSDs are often referred to as manual handling injuries, which implies causation of a physical nature. For MHDs, a similar issue is the use of terms such as bullying or stress. To gain an understanding of people’s perceptions of MSDs and MHDs, analysis was undertaken to identify whether responses to the above question was cause-related or outcome-related. The majority of participants provided cause-related answers for MSDs (see Figure 5). For MHDs, responses were more outcome-focused. Interestingly, a number of participants (representing seven of the 10 logistics/transport organisations and five of the nine aged care organisations) also reported

that MHDs were not included in the incident reporting system, but were reported and dealt with informally, or directly through HR.

Figure 5: Injury or health problems reported by cause or outcome



Participants were asked, 'What are your main sources of information about how to reduce the risk of musculoskeletal and mental health/stress-related problems?' Sixty-one of the interviewees reported having a source of OHS information. Of the six interviewees who did not access OHS resources, three were either a senior manager, an executive member or a site manager. Only 38 participants (57%) reported using WorkSafe/regulator as a source of OHS information. Due to ethical issues associated with anonymity, the sole HR Officer data is not presented in Table 3.

Table 3: Source of OHS information by job role

Job role (n = participants who reported a source of info/total participants in that role)	Main sources of OHS information (N = number participants using that source)
Executive members (12/13)	Internal experts (6) WorkSafe/regulator (5) External experts (5)
Senior manager (11/12)	Worksafe (9) Professional organisation (4)
Site manager (11/12)	Internal expert (8) WorkSafe/regulator (4)

Consultant/advisor (17/17)	WorkSafe/regulator (14) Courses/seminars (5)
HSR (10/13)	WorkSafe/regulator (6) Google (5)

Participants were asked if they had accessed the WorkSafe Victoria website and whether it was useful: 'How often, if ever, do you look at information about this kind of problem on the WorkSafe Victoria website? ... When did you look at it most recently? Was it useful? What did you find most useful? What additions or changes to this information would be useful for you?' Twenty-three participants offered negative comments which mostly centred on navigational difficulties and usability issues, such as these as expressed by managers:

I don't think it's so much what's not there, it's how easy it is to find it and I love prosecutions, enforceable undertakings, anything I can leverage our executive with to get some more money to do what I want to do primarily. I don't think the regulator is necessarily proactive in engagement around whether it be musculoskeletal disorders or anything else (manager, logistics/transport).

I don't particularly find it easy to use. I try to find things using the search function but to be honest you get so many things in that search that are not relevant, I don't particularly find it easy to use at all (manager, residential aged care).

Seventeen participants had positive feedback in relation to the WorkSafe Victoria website:

Definitely, definitely. There's always something there to find and even when you're ... as much as you're looking for something, all of a sudden another topic will catch your eye and you think 'Oh, I must remember that that's there. I can tap into that if I need that' (OHS consultant/advisor, logistics/transport).

WorkSafe Victoria website, I think they do have the resources, they do have a lot of brochures and guidelines, so even if for a drug and alcohol policy you can find something in the website. For bullying it is there (OHS consultant/advisor, residential aged care).

Interview data

Existing OHS system and issues

A coding matrix was developed for data analysis of the first part of the interview, which focused on existing OHS system and issues. During the analysis, data was categorised into three themes: reported causes of MSD/MHDs, existing strategies to address MSDs/MHDs

and existing barriers/challenges to reducing MSDs and MHDs (Table 4). The three themes were then coded into five sub-themes (see Fig. 2): individual, equipment/task, physical environment, psychosocial/organisational and external.

Table 4: Reported causes, strategies and barriers to risk reduction activities

Themes	Sub-theme	Factors
Reported causes	Individual	Worker to blame Underlying condition Non-work related
	Equipment/task	Manual handling/nature of duties Lack of/inadequate equipment
	Physical environment	Physical work environment
	Psychosocial/organisational	Lack of staff/workload pressures Deadlines Management practices Co-worker conflict Violence, aggression and emotional stressors
	External	External factors
Strategies to address existing MSDs/MHDs	Individual	Training/education programs Provision of information Administrative changes Worker exercises Functional testing prior to employment Healthy lifestyle/mental health initiatives Individual-based strategies to reduce MHDs (e.g. employee assistance program) Medical consultation or assessment Performance management Staff supervision
	Equipment/task	Equipment/attire/major structural changes Job redesign – physical
	Physical environment	No strategies reported
	Organisational	Policies Strategies to engage executive support Job safety analysis

		Accommodating non-work injuries Job redesign – organisational
	External	Managing external factors
Barriers and challenges to reducing MSDs/MHDs	Individual	Demographics of staff Lack of OHS skills in management
	Equipment/task	Staff working off-site Inherent difficulties Shiftwork
	Physical environment	Inherent difficulties
	Organisational	Culture of workplace Corporate teamwork structure issues OHS system issues Communication issues Limited staffing/resources Ineffective performance management Shiftwork Inherent psychosocial difficulties Under-recognising the role of stress
	External	Competing commercial imperatives Inherent difficulties/external constraints Legislation or industrial relation issues

Reported causes were separated into those reported in the context of either an MSD or MHD. The majority of participants attributed MSDs to equipment and individual factors (mostly in the context of manual handling), and MHDs to psychosocial/organisational factors (see Table 5).

Table 5: Reported causes of MHDs and MSDs

	Logistics/transport		Aged care	
Category of cause	MSD	MHD	MSD	MHD
Individual	29	8	18	9
Equipment/task	38	1	26	0
Physical environment	10	0	5	0
Psychosocial/organisational	12	29	15	21
External	3	5	0	0

Table 6 shows examples of the reported causes of MSDs and MHDs.

Table 6: Reported causes of workplace injuries/health issues

MHDs: reported cause	Examples/quotes Aged care Logistics/transport
Individual	<p>I find nine times out of ten, people will go ‘Look, this is going on at home and this and this, and I just find my coping skills at work are not quite what they normally would be’ (manager).</p> <p>Not really, no one's pushed to do what they've got to be done. If there is any stress, they probably bring it on themselves I suppose (HSR).</p>
Equipment/task	<p>I’m actually referring to the yard staff, their job is very physical, they handle a lot of freight and work with a lot of equipment. So at the end of the day it’s draining physically and probably mentally I suppose (HSR, Logistics/transport).</p>
Physical	None reported.
Psychosocial/organisational	<p>... so mental health disorders in the elderly obviously is an emerging and growing issue. And I think that that creates real stresses for staff having to deal with aggressive or unexpected behaviour (manager).</p> <p>Q: And if you don’t meet deadlines what happens?</p> <p>A: Well, you know, you can be verbally abused or you know, become someone's worst enemy ... (HSR)</p>

External	... those in transport in particular are still treated like a middle man, so we took a lot of grief from clients. We are, and then from both ends, so those that consign and then those that are receiving from us as well. So the pressures the clients put on us is exceptional and that flows through the business (manager, logistics/transport).
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MSDs: reported cause	Examples (quotes) Aged care Logistics/transport
Individual	<p>And I go 'But you didn't adhere to this policy which you've signed, you've read.' So, I don't know. You can't ... I don't know how you protect yourself against human stupidity or ... And actually, I'm probably guilty of that too, taking shortcuts myself. I'll stand on a ladder to move a box rather than wait for my maintenance guy to come (manager).</p> <p>... generally I find that most incidents that I'm investigating is through people taking a short cut. That's why the incident was actually reported (manager).</p>
Equipment/task	<p>... manual handling patients, manual handling pieces of equipment. So the full range of manual handling issues (manager).</p> <p>As the vehicles are older, they tend to not operate as well. Although they're being maintained they're from another period in time (manager).</p>
Physical	<p>We do have also trips and falls, you know some residents they just spill some fluids on the floor, employees don't see then they trip and fell (OHS consultant/coordinator).</p> <p>Client sites, on-road where potholes, gutters, uneven surfaces that lead to a lot of our troubles (manager).</p>
Psychosocial/organisational	<p>But I think workload is just—it's a constancy, like physical demand that never stops all day. We have people literally working their entire day without a break time (OHS consultant/coordinator).</p> <p>You can see it out on the floor you know, people—because there's people have a deadline to meet as well so that plays an effect. People need to work quicker and it can open up the door for an injury if</p>

	you're doing it the wrong way or if you're rushing (HSR).
External	They've got more traffic devices, roundabouts, chicanes, speed humps, all those sort of things. They're something that we're aware of and something that we look at (manager, logistics/transport).

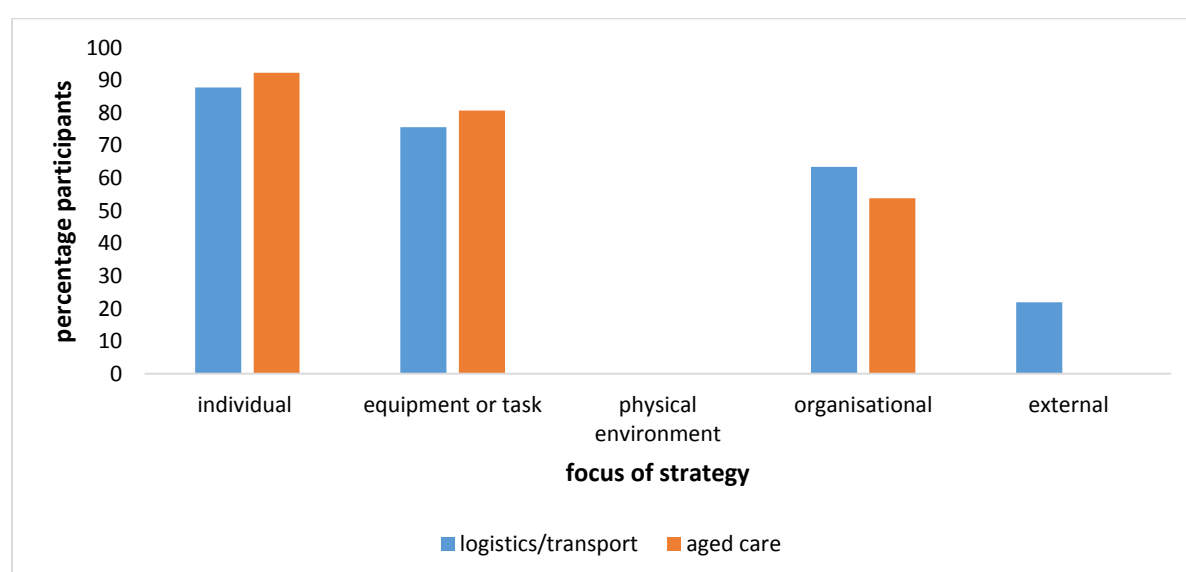
Participants were also asked, 'Were you previously aware of the link between MSDs and psychosocial hazards?' Of the 25 participants who had specific OHS management responsibilities, six were aware of the link between psychosocial factors and MSD (see Table 7).

Table 7: Knowledge of links between psychosocial factors and MSDs

Job role	Aware of link between MSD and psychosocial factors (n)
OHS Consultant/advisor (n= 11)	2
Senior manager (n= 8)	3
Executive (n = 6)	1

When asked what strategies were used to address the reported causes, the majority of participants reported strategies that were individual or equipment/task-focused (Figure 6: Reported strategies to address MSDs/MHDs).

Figure 6: Reported strategies to address MSDs/MHDs



Examples of strategies used to address MSDs are provided in

Table 8. Predominantly, individual strategies were focused on training (mostly manual handling training) and provision of counselling (i.e. Employee Assistance Program). The majority of equipment/task strategies involved provision of mechanical aids, for example lifting machines (aged care), ergonomically suitable vehicles (logistics/transport), and job rotation (logistics/transport). Although the organisational strategies include policies, some of the policies relate to manual handling and are an individually focused strategy (e.g. 'no lift' policy in aged care, and 'correct lifting procedure/safe work methods' in logistics/transport).

Table 8: Examples of most commonly reported strategies to address MSD/MHDs

Theme	Example (quote)
Individual	<p>Every quarter I send out things about bullying and harassment, stress, what the signs may be, who's your contact officer if you need help, all those sorts of things. I try to do that every quarter (manager, logistics/transport).</p> <p>We do have an EAP available to all our staff and we have posters around the place telling them about the EAP (OHS coordinator/consultant/advisor, logistics/transport).</p> <p>So we talk about job rotation and all of those sorts of things to try and reduce the duration of time that we're leaving the guys handling material (site manager/coordinator, logistics/transport).</p> <p>... on orientation and when they first start staff have always had training and there's obviously the annual mandatory training in manual handling (manager, aged care).</p> <p>If someone's fairly stressed, I would always say to them, take some time off. That's what your annual leave is there for, and I think that's adequate, but if they did, they can just take their time off, there's never a real issue with that here (HSR).</p>
Equipment/task	<p>Look, for the most part we've done what we can with controlling from an engineering point of view. We identify trucks that we consider to be ideal for climbing for in and out of, using the stairs, those sort of things (OHS coordinator/consultant/advisor, logistics/transport).</p> <p>Certainly also too with sidings having walkways, so rather than them having to climb up from a ladder sort of thing we have elevated walkways and entries and exits for them (manager, logistics/transport).</p>

	<p>We have lifting equipment and slings and slide sheets and all those things that are current practice, and it is our policy that they use them (site manager/coordinator, aged care).</p> <p>We've got a new you-beaut force meter that does a lot of modelling on the forces on the body, and gives us a lot of feedback on things so that we can recommend that certain tasks aren't done unless they have a certain piece of equipment (OHS coordinator/consultant/advisor, aged care).</p>
Organisational	<p>Well, the company's put in policies that is like an acceptable behaviour of relatives and visitors to make them aware of what's not acceptable. That we have to protect our staff (site manager/coordinator, aged care).</p> <p>Previously we had one line manager drop to 400 staff ... He'd never know who was injured. So now we've broken it up. We've got team managers in there. So it's one to 40 and the team managers know all their staff, their injuries, and so forth, and it's easier then to filter that back too, for a summary for the different groups (site manager/coordinator, logistics/transport).</p> <p>We employed extra staff, so we increased the team back to its normal numbers (manager, logistics/transport).</p>
External	<p>Some things are out of your control and I know that from sitting on the OH&S committee that drivers report potholes and issues with car parking in the way and roundabouts and then that's funnelled back to the council (manager, logistics/transport).</p>

During the interviews, some participants reported on strategies they perceived as particularly effective. These have been categorised as enablers (see Table 9).

Table 9: Enablers for effective MSD/MHD risk management

Enabler	Quote
Corporate structure – OHS reporting directly to managing director, OHS staff attendance at regular Operations Management meetings, OHS part of Operations, OHS coordinator regular meeting with Executive Team	<p>I've kind of got the ability to do what I like. I report directly to the managing director and he just says 'Do whatever you need to do'. I've found doing it this way that if I've got the buy-in from the state manager it works better (OHS coordinator/consultant/advisor).</p>

Consultation/participation – feedback from staff after risk control implemented, staff involved in incident investigation, Executive KPI to consult regularly with floor staff	I'm out there and I'm chatting to them and talking about their job and they know that my door is always open and it can be anyone that comes in and we discuss. If I'm doing a risk assessment, the person that does the job is involved in the risk assessment (OHS coordinator/consultant/advisor).
Communication/relationships – managers with people skills	Right skill set in the managers to identify that and to know their staff well enough to know 'Okay, I'll probably need to go and have a one on one conversation with that person and make sure that they know' (site manager/coordinator).

For existing barriers/challenges, the majority were identified as organisational-based (see Fig. 7).

Figure 7: Types of existing barriers/challenges to reducing MSD/MHDs

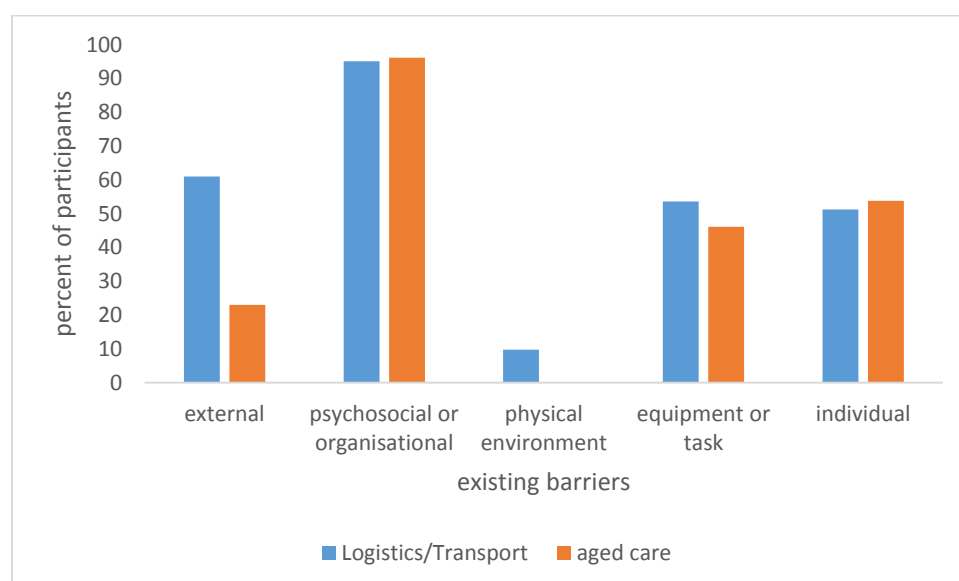


Table 10 provides examples of the main barriers to reducing MSDs/MHDs which were raised by participants. The majority of reported barriers were related to six main organisational factors: culture of the workplace, corporate teamwork structure issues, communication or relationship issues, and lack of staffing or resources.

The culture of the workplace barrier was determined by the attitude of staff, complacency about safety either because of a lack of understanding (aged care) or a 'blokey' attitude

(logistics/transport), as well as the attitude of management (a perceived lack of commitment).

Corporate teamwork structure issues relate to the corporate model of silos and the subsequent issues about the demarcation of OHS responsibilities:

When you talk to operations, like when you go to operations level, they go 'Yes, yes we want that, we need that'. Because they understand, whereas they don't make the decisions, or we don't make the decisions and we rely on HR to make the decision. But then they are neither safety nor ops, so I think they can't see the need or the practicality of things (OHS coordinator/consultant/advisor).

This organisational factor includes issues with reporting lines where staff were unclear about or unhappy with the current reporting line for OHS issues, as evidenced by this apparent HSR:

I don't know how it gets processed from the time it gets submitted over the counter, it just goes through the chain of OH&S and depending on its merit or lack of merit or maybe it's even not a workable thing ...

Communication/relationship issues refer to the staff and management interface where there is mistrust and potential dysfunction. For example, staff may be intimidated by management and reluctant to report OHS incidents for fear of repercussions. This issue has been previously reported by researchers who found that supervisors' 'openness to voice of safety concerns' affected levels of work-related injuries.⁽⁴⁹⁾ Alternatively, management may be frustrated with staff who are not receptive to corporate communications about safety issues. This factor also covers more tangible issues with communication such as difficulties encountered when managing staff who spend the majority of their time working off-site. Limited staffing and resources was cited by many participants as a major barrier to reducing MSDs and MHDs. In the aged care sector, participants most often reported a lack of staff as a barrier to reducing MSDs, whereas participants from the logistics/transport sector most often reported limited financial resources for purchasing updated equipment.

OHS system issues were prevalent in approximately half of the organisations, either reported by the participants or identified by researchers. Several organisations had very basic incident reporting and investigation systems, which were limited or lacking detailed processes, and others had no formal risk management system:

There's been a real lack of what to do if there has been a hazard. They've introduced that as an organisational risk management structure but we don't really

have anything similar for dealing with hazards on the floor (site manager/coordinator).

Once you get an injury, no matter how minor it is—we try and encourage—if you get a splinter, report it just in case it gets infected down the track. So we have a reporting system where it goes into a book. It's followed up. Even if no action is needed on it, it is still followed and someone will ring you back within a month's time to find out did you have any problems with that incident (HSR).

A major influence on these organisational factors were the individual factors: these include the demographics of staff (e.g. education, literacy, cultural background) and lack of OHS skills in management. Many participants from the aged care sector reported low levels of education and literacy amongst staff, mostly attributed to the non-English speaking cultural backgrounds. An ageing workforce in the logistics/transport sector was perceived as having a significant impact on the physical injuries. Lack of OHS skills in management was related to middle managers/supervisors not having adequate skills to effectively manage their OHS responsibilities. Seven of the organisations had no participants with OHS training above a certificate IV level, i.e. there were no highly qualified OHS employees within the organisation.

The theme related to equipment/task barriers included manual handling of people (aged care) and manual handling equipment (logistics/transport) as well as the shift work required in the role which affected the level of contact that employees had with management.

Table 10: Main barriers/challenges to reducing MSD/MHDs

Barrier/challenge to reducing MSD/MHDs	Examples (quotes) Aged care Logistics/transport
Individual Demographics of staff; lack of OHS skills in management	<p>We do have a workforce where some of those members of the workforce aren't necessarily literate (OHS coordinator/consultant/advisor).</p> <p>We've got an ageing workforce here and I don't know if enough work or time is put into that aspect of it (OHS coordinator/consultant/advisor).</p> <p>I think what we've done is we've promoted a lot of people into leadership positions in our operations that have not been trained properly in health and safety (OHS coordinator/consultant/advisor).</p> <p>The information can get lost in the communication because,</p>

	<p>you know, like the—we can't pick up the big lingos or like this is why this happens. And sometimes we have these workshops for team managers that just don't make sense ... because we can't understand what exactly the problem is (site manager/coordinator).</p>
Equipment/task Staff working off-site; inherent difficulties; shift work	<p>And when you've got the workforce that is, it's as dynamic as it is, the driving force don't really come to the yard or, if they are, they're in and out ...(manager).</p> <p>We have lifting machines and transfer aids to try and minimise any injury, but you can never fully get away with having to handle people (site manager/coordinator).</p> <p>Not with the type of tooling that we have, no, because if you actually saw what we do, you'd say 'Well, there's no other solution for it, restrain a load another way'. We need to use these tools that we have on hand to actually restrain the loads, you can't engineer this, it cannot be engineered (HSR).</p> <p>98.5% of our staff are part-time or casual, it's hard to get them to attend education sessions (manager).</p>
Physical Inherent difficulties	<p>From ambient outside to chiller, chiller to freezer it doesn't take much to create moisture on the floor plus naturally we do have a lot of, yes, at times ice build-ups, snow build-up. That's one of the inherent sort of problems and hazards that exist in this industry (manager).</p>
Organisational Culture of workplace (attitude and commitment of staff and management); Corporate teamwork/structure issues (disconnect between OHS & HR areas, and reporting line issues); communication/relationship issues; OHS system issues (broad OHS system issues that limit prevention of MSD/MHD); limited staffing/resources (insufficient staff – aged care, inadequate equipment –	<p>But there's been a lot of pressure placed on people I think to say 'Well if you want to work in this industry this is how it works, suck it up and live with it, otherwise move on' (OHS coordinator/consultant/advisor).</p> <p>Yeah, you don't want to be the one to whinge and seem like you look lazy whereas there's other guys out there that are just getting the job done without any sooking but they're getting the job done unsafely I suppose (HSR).</p> <p>Our CEO is quite old school, so they don't see that benefit in those areas yet, they are sort of from that era of 'She'll be right, mate' rather than the new age thinking of looking after employees and how to reduce all those things (manager).</p> <p>From that point of view, that becomes a little bit sticky because HR get involved as well and there's always a bit of a barrier as to how much information you can get (OHS coordinator/consultant/advisor).</p> <p>It's been very hierarchical for many, many years, and so I still</p>

logistics/transport)	<p>run into the fact, 'Oh gee you're an executive director. I shouldn't be talking to you, because I'm not following protocol.' So we still run into that. So there is still this old way of thinking within the organisation that 'I'm the nurse unit manager and everything should be reported to me so I can filter what goes to the next level' (manager).</p> <p>I think the expectations of this company is a little grey (site manager/coordinator)</p> <p>I can see some benefits, just in discussions, but it really has to be a little bit more open I guess from management side. If they want our input and honesty then they need to do the same and I think you'll find that most people think their managers are less than honest (HSR).</p> <p>We report out the incident and somebody says, 'Well I think this is why it happened' and that's as far as it goes. Most of the time it's usually targeted at the person rather than truly understanding what are the systemic or organisational factors that are leading to the incidents occurring (OHS coordinator/consultant/advisor).</p> <p>Well, we do have a safety manual that's probably 250 pages, that no-one reads (manager).</p> <p>There's not funding, really, for putting in extra education sessions which might benefit them (manager).</p> <p>They're not up to current standards. To get them up there it'd cost millions of dollars. So they've managed that by just giving us heights training and harness training but to really fix it they'd have to spend a lot of money which there's a major hurdle there. I'd say cost for most of our risks (HSR).</p>
External Competing commercial imperatives; inherent external constraints	<p>I think there is a general conflict between the commercial model by which aged care operates, which is a very lean resource model, and the requirements for safe handling and the manual movement of residents and equipment (OHS coordinator/consultant/advisor)</p> <p>Every now and then someone gets to choose whether it's growth over safety, whether it's profit over people and sometimes we win and sometimes we wipe our wounds and try and find a safer way to do something that we're not too fussed to be doing (manager).</p> <p>... is the infrastructure ... they put roundabouts in and speed bumps and the roads sometimes aren't maintained as they should be, so it's the environment in which they operate and the road itself, being on the road with all different road users and cut off and jumping on brakes (manager, logistics/transport).</p>

Toolkit feedback

Feedback on the MSD risk management toolkit is presented as it was asked (see Table 11). Participants were largely positive about the toolkit; however, the survey aspect of the toolkit was viewed as problematic by a number of participants. Strengths of the toolkit related to its ease of use and each organisation's ability to adopt it within its existing OHS risk management system (i.e. OHS committee). A focus was on gaining 'insight into issues from a staff perspective'.

Table 11. Feedback on MSD risk management toolkit

Category	Sub-category	Example (quote)
Barriers to implementation	Existing workload pressures	I think it's finding that time for them, so it's not a burden for them. The thing that I kind of worry about is I think I feel bad putting extra jobs on to people (site manager/coordinator).
	Lack of staff commitment	Some people who are dedicated to OH&S wouldn't have a problem but other people would turn around and say, 'Well I don't get paid for doing it so I'm not doing it' (site manager/coordinator).
	Limited management support	The greatest impediment, not necessarily in ours but in an organisation the size of ours, would be ownership of the executive group and finding a tangible meaningful way for them to take ownership and convey that (manager).
	Limited resources	We don't actually get budgeted anything without funding we get from the government, or our budget from head office, for doing injury management prevention. It's kind of all just lumped in on our role (site manager/coordinator).
	Lack of staff OHS skills/general education	Probably with my knowledge of manual handling basic, like a lot of people in my position we're not ergonomists, I can't even say the word, but you know what I mean ... So I think it would be good to have some kind of—either just some assistance on it ...(manager).
Perceived weaknesses of toolkit	Staff not completing survey honestly	Is everyone going to tell the truth in these surveys, though? For me, I've done this job for a long time, I have my doubts (HSR).
	Low survey return rate	One of the hardest things we find in our industry is getting people to fill in them in for a

	<p>Subjective nature of survey ratings</p> <p>Keeping survey anonymous</p> <p>Staff developing unrealistic expectations</p> <p>Will result in increased claims</p>	<p>starter (site manager/coordinator).</p> <p>I think that there needs to be some direction about it so that they're informed scores not just emotive (manager).</p> <p>How anonymous is a survey when you say what district do you work in? What part of operations do you work in? What's your age group? I'm too sceptical about that (site manager/coordinator).</p> <p>Largely uneducated, blue-collar workforce, unionised workforce, and they often have unrealistic expectations. So 'We've had a conversation, we've given you some feedback, this is what we believe the change needs to be', and they don't ever have to balance the commercial aspects of it (manager).</p> <p>I think for the type of questioning and some of the issues there, that some people may well think 'Here's a free kick. I'm going to be putting down that I'm under stress or I'm under, I think there was one thing there about the volume of work or the pressure of work and this sort of thing' (manager).</p>
Strengths of toolkit	<p>Complements existing OHS management system</p> <p>Insight from staff perspective</p> <p>Format/content</p> <p>Covers MSD and</p>	<p>They have a continuous improvement part of their systems that we have to do to meet our accreditation terms each year, so that would fit in under that, no worries ... so it would fit in nicely on that (site manager/coordinator).</p> <p>Up there, a scale of one to 10; most definitely a 10 because I think that's where your information is going to come from. That's something that I'd heavily stress with everything because they're the ones that are actually doing the job (OHS coordinator/consultant/advisor).</p> <p>Look, I think it was good, it seems pretty straightforward and not too complicated and I think one of the strengths was that each stage of the toolkit had resources with it like templates and things which is really important and will make it so much easier than having to develop our own (manager).</p> <p>The strengths are the psychosocial side of it</p>

	<p>MHD</p> <p>Involves whole workplace/staff ownership</p> <p>Can be used to gain executive support</p>	<p>that it gets overlooked and we'd like to really look at that side of it and how we can implement that in our business (manager).</p> <p>Other benefits were that, you know, it involved the whole workplace and management right down, you know, to the lowest level (manager).</p> <p>Yeah I think by having tools that make it easier to sell to senior management, that this is the way to go, and it will actually reduce costs in the long run (manager).</p>
Survey feedback		<p>You've got a lot of people who are new Australians who don't speak English well, who—and the wording of it is quite complex (OHS coordinator/consultant/advisor).</p>

Workshops

The stakeholder workshop was attended by two logistic/transport sector participants, four aged care sector participants and three stakeholders representatives. During the workshop two focus groups conducted; one focus group for the residential aged care sector and one for the logistics/transport sector. The intent of the workshop was to gain more in-depth feedback about the MSD risk management toolkit and barriers to its implementation. A summary of the discussions are presented in Table 12. The feedback at the workshop was consistent with that gained in the interviews, namely that the barriers to the implementation of the toolkit were organisational-based (limited support by management, limited OHS skills, lack of time), or individual-based (staff reluctant to complete survey, or to complete honestly). In addition, the focus groups raised the issues of the role of the regulator in assisting organisations to address psychosocial hazards, and the perceived limitations of the current resources provided by the regulator.

Table 12: Workshop feedback: barriers to MSD toolkit implementation

Theme	Enablers	Quotes
<p>Organisational issues</p> <p>Lack of risk management process: accidents 'just happen – bad luck'</p> <p>Regulator viewed as an enforcer rather than a</p>	<p>Introducing toolkit</p> <p>Root cause identification (use safety alerts, WorkSafe,</p>	<p>You tend to work with WorkSafe when you are already in trouble, it is not going to stop you getting in trouble.</p> <p>I don't think it is the only solution but the regulator is so lacking power it</p>

<p>helper for more proactive management of MSD/MHDs</p> <p>Poor safety culture: safety not integrated into everyday work</p> <p>No ownership at operational level</p>	<p>case studies)</p> <p>Nurture relationships</p> <p>Screen for risk-taking behaviour at recruitment</p> <p>Drive the toolkit from the top and ownership from the bottom</p> <p>Show benefits to management, e.g.</p> <ul style="list-style-type: none"> • reduce WorkCover claims • absenteeism • turnover • morale • attracting staff • reputation 	<p>doesn't have the number of inspectors to go out to each facility.</p> <p>The challenge we have is that management agree that there is an issue with WorkCover claims and lost time but the issue is when we tell them what we believe the issues are, the buy-in isn't there.</p> <p>The problem is that they have this notion that 'We have got a safety team, they will sort it all out'. I turn around to them and say 'Would you trust me to change the brake fluid?' and they say 'No', so I say 'Why would you trust me to write a safe work method statement to do that?'</p>
<p>Manager issues</p> <p>Managers and supervisors not sure how to manage survey results/lack of understanding</p> <p>Accountability of supervisors/managers</p> <p>Reluctance to allow HSRs to engage in the toolkit forum (low credibility of HSRs)</p> <p>Lack of time</p>	<p>Leadership development and training for managers</p> <p>OHS & MSD education for managers</p>	<p>They might have to do something about the answers they get. Sometimes I think it is a case of 'Well, I don't want to do the survey because it might give me some work to do, it might tell me something that I don't know how to fix'.</p> <p>It is holding them to accountability. When you question them about the position description, you see that they have never set the ... there might be someone who has come from a technician into management—they are not skilled. Management might need leadership development.</p> <p>My biggest issue would be time and I don't know how to overcome that. It is a very time-consuming process and I am sure this is the same for everyone ... we are all fighting for a chunk, HR, health & safety, procurement, property, all fighting for your time. And staff don't have spare time.</p>
<p>Employee issues</p> <p>Staff suspicious of surveys and may not complete (or not complete</p>	<p>Promote and communicate survey</p>	<p>I think that comes down to the manager level, as in if you want the drivers to complete a survey, you need the managers and supervisors of those people to engage with them</p>

<p>honestly)</p> <p>May not understand questions or purpose of survey</p> <p>Literacy issues</p> <p>Not enough time provided to complete survey at work</p>	<p>Communicate results of survey and implement positive actions to foster trust</p> <p>Provide survey through external third party</p> <p>More open ended, free text questions</p> <p>Supply a trusted assistant</p> <p>More EFT hours allocated—supported by management, spread over staff so have representation from night and weekend staff</p>	<p>before the survey comes out—tell them why they want the information, how important it is to get their view, what they will do with the information.</p> <p>I think time is a big issue, getting time for staff to fill it out. And literacy would be another issue.</p>
<p>Toolkit design issues</p> <p>Sample size too big for large organisation with 7000 employees</p> <p>Sample method cumbersome</p> <p>Cost to implement action plan from toolkit</p>	<p>Stage implementation, staggered approach, trial program on smaller scale for starters</p> <p>Not too cumbersome, online rather than paper, survey apps (e.g. survey monkey), provide computer portal at work</p> <p>Seek budget approval from management/directors</p> <p>Seek grants</p> <p>WorkSafe support, claims agent</p> <p>Measure benchmarking</p>	

Policy document analysis

A wide range of OHS-related policy and procedure documents were provided by 14 of the 19 organisations. One organisation was in the process of developing OHS-related policy documents and was unable to provide the draft copies. The remaining four organisations did not respond to numerous requests for OHS-related policy documents.

All 14 organisations submitted documents which included a policy statement or stand-alone policy about their OHS risk management system or procedures. Many included documents dealing with specific aspects of general OHS risk management requirements (e.g. Critical Incident Management, Risk Register, Near Miss or 'OHS Concern' Reporting, Risk Control Report, OHS Issue Resolution) whilst other organisations had only a brief general OHS statement without any detail of procedures.

All of the 14 organisations had documents that outlined manual handling procedures. However, no organisations had specific policies that addressed MSD risk management.

In terms of psychosocial hazards, documents from around half the organisations included policies and procedures in which the source of the risk is seen to be individual workers (e.g. policies and procedures related to drugs/alcohol, discrimination, harassment, bullying, Employee Assistance Programs).

Only a minority of organisations submitted policies and procedures that recognised psychosocial hazards within the organisational context (three of eight logistics/transport; one of six aged care). However, these organisations did not have any procedures or policies for assessing or controlling these hazards (one organisation had a procedure for dealing with driving-related fatigue).

The need for consultation was mentioned by most organisations and two had separate documents relating to this.

Employee performance rate

Due to the difficulties in obtaining the employee performance rate of participating organisations, an analysis of the data based on EPR was not possible.

Discussion, Conclusions and Implications

This research aimed to determine the barriers and enablers associated with implementation of a new risk management toolkit within the residential aged care and logistics/transport industry sectors. Interviews, a policy document analysis and a workshop were undertaken to document the following:

1. What are workplace stakeholder beliefs and attitudes about factors affecting the incidence of MSDs and of MHDs?
2. What are current workplace risk management procedures, and the information resources guiding these practices including those promulgated by WorkSafe Victoria?
3. What are workplace stakeholder perceptions of new evidence-based risk management practices and what factors likely to hinder or facilitate their implementation?

Results from this study identified a number of key barriers to the implementation of more effective workplace management of MSD risk, including the widespread belief that MSD risk arises entirely or largely from physical hazard exposures. Regulatory and guidance documents targeting MSDs mostly reflect this belief: risk assessment tools used by organisations focus mainly on physical hazards and psychosocial hazards are managed separately from physical ones. In general, this study identified that psychosocial hazards are managed by HR departments and physical hazards by OHS.

The findings support the need for a systems-based management framework to improve workplace management of MSD risk, which encompasses holistic risk assessment and control procedures that address risk from psychosocial and physical hazards. In addition, the role of line managers and supervisors, who often play key roles in generating hazards, both physical and psychosocial, need to be educated on their role in the system. This education needs to inform managers and supervisors of their important role in managing OHS, in particular psychosocial hazards, and provide knowledge about how to identify and manage this group of hazards.

Some significant barriers to implementation of new approaches to manage MSDs will require considerable changes from both the regulator and individual organisations. The following sections will address the three key aims of the study.

Workplace stakeholder beliefs and attitudes about factors affecting the incidence of MSDs and of MHDs

In general, MSDs were associated with physical causes, rather than psychosocial. MHDs were mainly viewed as people's personal problems (e.g. problems at home that cause them to come to work stressed or tired) and workplace bullying or harassment. That is, MHDs were considered mainly an individual responsibility arising from the behavior of particular 'problem' individuals.

Most of the strategies used to address MSDs and MHDs, such as training and counselling, were focused on individuals. Few strategies were mentioned that adopted an organisational approach. Strong beliefs existed that injuries were the result of shortcuts or procedures not being followed by workers, not that the workload or time pressure may have been the reason why individuals took such actions to 'get the job done'.

Results from this study suggest that despite strong research evidence supporting the important role of psychosocial hazards in MSD causation, current strategies to identify and control hazards and risks do not include psychosocial hazards. For MHDs, risk management is more ad hoc. Many are managed not through formal systems but are dealt with on an individual level, taking a case-by-case approach.

Current workplace risk management procedures and information resources used to guide these practices

Current workplace policies and procedures do not reflect contemporary evidence about the important role of psychosocial hazards in MSD causation. The review of workplace documentation did not find evidence of systematic approaches to the identification and control of psychosocial hazards for either MSDs or MHDs.

Whilst those with specific OHS duties reported seeking further information from a range of sources, many reported some issue with finding appropriate resources from the regulator. Many suggested a need for guidance on how to effectively manage psychosocial hazards but felt that these resources were not available to them at present. In general, education in OHS across site managers was low, with many having minimal (a 5-day course) or no formal OHS qualifications. Many reported feeling ill-equipped to manage OHS responsibilities.

Workplace stakeholder perceptions of new evidence-based risk management practices

Overall, stakeholders were receptive to the new evidence-based risk management practice—the toolkit. Participants expressed the need for clear communication and

supportive leadership when implementing the toolkit, and considered the significant participative role to be a strength. Some were concerned about the use of self-reported survey data, and this might be problematic, but many saw the survey as an effective way to identify the real issues in their particular workplace. Participants commented on the problems with survey completion and achieving high completion rates, and the need for anonymity. In general, comments suggested that the toolkit filled a gap in currently available resources.

Potential impact, use of the research and recommendations

This study identified some significant barriers to changing the way in which MSD/MHDs are managed. Knowledge of the important role of psychosocial hazards in MSD development was limited. In addition, psychosocial hazards which were seen as important for MHDs were not routinely assessed in the workplace. Managers/supervisors reported that they felt this group of hazards was difficult to manage and that information about what to do was very limited and not easily accessible.

The findings from this study provide some clear directions for regulators, organisations and future research needs, and are outlined below.

Recommendations for translation of findings into policy and practice

The current study has identified some key gaps in current workplace approaches to the management of MSDs and MHDs. The results presented here provide useful evidence to inform the development of successful intervention programs to improve the risk management of MSDs and MHDs. Furthermore, clear recommendations for regulators are provided; there is an urgent need for the development of contemporary guidance material to assist workplaces in how to manage psychosocial hazards in relation to MSDs. A need for better integration of OHS into more general management practices is required, to ensure that OHS risk management is not marginalised and is considered an important aspect of business, which cannot be ignored. Currently, the management of psychosocial hazards is not undertaken in systematic manner; action from the regulator and organisations is required for this to change. To reduce the significant burden of MSDs and MHDs, change in current practices is required: from this study, it appears that organisations are aware that they need to do more to manage psychosocial hazards but are not sure where to go for resources.

Regulator

- Develop web-based and other MSD risk management guidance and associated resources that integrate the management of MSD risk from both physical and psychosocial hazards. These resources would be most effective if customised to particular types of job in high-risk industry sectors.
- Further develop website and other resources to facilitate prevention of work-related MHDs by appropriate management of risk from work-related organisational and psychosocial hazards, highlighting the need for employers to focus more on these hazards rather than on the behaviour of individuals. That is, the present focus on secondary and tertiary prevention should be changed to focus on primary prevention, since this is likely to be much more cost-effective.
- Promote educational programs to improve understanding of the important effects of psychosocial hazards on workers' mental and physical health, and on evidence-based workplace strategies for managing them. Education programs should particularly target managers and supervisors, since they often play key roles in generating or exacerbating such hazards and therefore need to be actively involved in prevention.
- Develop and promulgate best practice case studies to assist workplaces to manage psychosocial hazards, focusing particularly on case studies from industry sectors where MSD risk is high. Ensure that these case studies include evidence of how risk management costs, including time needed for workers to participate, are outweighed by benefits such as a reduction in LTIs and/or higher quality work performance.
- Promote the use of more holistic risk management tools, such as the MSD risk management toolkit, to facilitate more effective workplace management of MSDs and MHDs which are affected by a diverse range of hazards that can interact with each other in their effects on risk.
- Promote the need for consultation and participation in MSD and MHD risk assessment and control procedures by employees who are at risk. Emphasise the need for employee participation to occur during paid working hours, highlighting the value of such participation in reducing risk and associated costs.
- Promote the need for senior managers to develop and maintain a detailed understanding of both operational and OHS issues, to communicate openly with staff at all levels, and to ensure that all staff perceive OHS issues as important. Often this can be achieved by managers frequently being present where staff are performing

their normal work and if possible participating in this work while actively listening to any staff concerns.

- Review and amend the structure and design of information on the WSV website to make it easier for users to locate relevant information, since navigation difficulties currently limit the website's usefulness.

Organisations

- Ensure that site managers and coordinators receive evidence-based education and training about how their decisions and actions can influence OHS risks, and practical ways to manage these risks. This might include topics such as leadership skills, communication strategies, helping employees to feel supported in their work, and conflict management.
- Reduce current management 'silos' (e.g. divisions between HR, OHS and line management) to achieve more effective management of OHS risks. In particular, ensure that risks arising from psychosocial hazards and from manual handling hazards are managed in a coordinated way rather than separately by different departments. This is essential to achieve maximum value from available risk management resources.
- Ensure that employees who are at risk of MSDs and/or MHDs are active participants in MSD and MHD risk assessment and control procedures, in accordance with research evidence on the value of high levels of participation in reducing MSD and MHD risk.
- Ensure that senior managers frequently engage with floor staff to facilitate open communication and gain greater understanding of both operational and OHS issues, and to reinforce staff perception of OHS as a high priority. Where possible, these goals could be pursued by managers participating in routine work alongside floor staff.

Researchers

- Refine the language and procedures of the MSD risk management toolkit to accommodate a range of literacy levels. (This work is in progress, as part of a separate project).
- Conduct further research to develop broad-based formulae suitable for workplace use to calculate expected financial and other benefits of implementing procedures such as those in the MSD risk management toolkit. (This work is in progress, as part of a separate project.)

- Implement the MSD risk management toolkit in workplaces in various high-risk industry sectors and evaluate its effectiveness in reducing levels of manual handling and psychosocial hazards, and both MSD and MHD risk levels.
- Develop a website to host the MSD risk management toolkit and associated guidance materials on risk control strategies. Such a website would enable organisations to download simple tools for assessing hazard and risk levels for people in target jobs, and upload hazard and risk data to obtain an automatically produced report identifying the subset of hazards most closely linked to risk for the job assessed, along with guidance on how to reduce risk from each of these hazards. It would also enable the organisation to benchmark against comparable organisations within its industry by comparing its data with *average* values derived from all data uploaded by comparable organisations.

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Appendix 1



College of Science, Health and Engineering
SCHOOL OF PSYCHOLOGY AND PUBLIC HEALTH
Department of Public Health

'Workplace Barriers' Interview Protocol Form - MANAGERS

Interview Protocol

Interviewee (Title and Name): _____

Interviewer: _____

Introductory Protocol

"Hello, I am xx from La Trobe University "Workplace Barriers" Research Project".. Thank you for agreeing to participate in our project. Your responses will be kept confidential to the La Trobe University research team. I would like to clarify that we are independent from WorkSafe and our report to WorkSafe will be in a form that ensures participants' responses are anonymous.

*I am calling you as we would like to do the phone interview with you today if you have time. We anticipate this interview will take approximately one hour.
[Reschedule call if unavailable]*

Thank you for your time today. We will ask a range of questions relating to your involvement in management of workplace risk factors for musculoskeletal disorders, and also for mental health or stress related disorders.

We'd also appreciate your feedback about some proposed new risk management procedures. In order to obtain your feedback, I am going to email you a You Tube link to a presentation. Can you please ensure that you have access to the Internet, and a device that will enable you to open a presentation.

To assist with our note-taking I would like to record our conversations today. Please be assured that only La Trobe University researchers on this project will have access to the recording, which will be stored in a secure place and treated as highly confidential.

Your participation is voluntary and you may skip a question or stop at any time if you feel uncomfortable. Are you happy to continue?

Great, thanks. To start with, there are some questions about your current job ...

1. What is your job title?:
2. Tell me about what you do in your job...

Probes: *How long have you been in the job? How long have you worked in the industry?*

3. How many employees are there in your workplace?
4. What do you see as the major injury or health problem in your workplace?
5. Thinking of the kinds of jobs in your workplace that you know have the highest incident or claim rates for **musculoskeletal injuries and disorders** ... what do you think are the main factors causing these musculoskeletal problems??

Probe: clarify perceived causes of each identified causal factor

Do you have any strategies to deal with [causal factor #1]?

What might make it easier to tackle this issue?

What are the things that make it difficult to do more than you're currently doing?

Does this factor affect all workers more or less equally, or are some people more affected by this factor than others?

6. And what about mental health or stress-related problems in your workplace? (**as per above question**)
7. In your role as the XXX (**insert role of the interviewee**), how much responsibility do you have for managing each of these causal factors?
And regardless of who is formally responsible ... in actual practice, how much direct involvement do you have?

Probes for each of the factors previously identified:

Clarify both their perceived responsibility *and* their actual involvement in risk management processes for each causal factor

Who else has responsibility and/or actual involvement?

8. Would it be helpful if there were some re-allocation of responsibilities?
If so, how should responsibilities be allocated?
How might this help?
What might hinder or prevent re-allocation in practice?

Thinking about the current situation with musculoskeletal problems overall...

9. What are the main factors limiting your ability to reduce current levels of musculoskeletal injuries and disorders?

Probe: elicit answers re *work-related* factors

10. And what about mental health or stress-related problems (**refer to above question**)

11. If you were the CEO, what changes would you make to reduce musculoskeletal and/or mental health/stress-related problems?

Probe: elicit answers re *workplace* changes

*Thinking again as the CEO ... what factors do you think might **limit** your ability to make changes to reduce risk of musculoskeletal problems or mental health/stress-related problems?*

WORKPLACE RISK MANAGEMENT PROCEDURES AND RESOURCES CURRENTLY USED TO TARGET THESE PROBLEMS

12. When you think about musculoskeletal problems in your workplace ... what measures are you currently using?

Probes: Who uses this information? And if so, how?
(*eg, job design, training & development, performance management*).

Does the organisation use the information to change risk management processes or procedures?

For example: putting new posters up, running training sessions

13. And do you have any measures for mental health/ stress-related problems in the workplace?

14. Thinking about your existing risk management procedures targeting musculoskeletal problems ... how effective do you think these procedures are?

15. And for mental health/stress-related problems?

16. Can you think of any changes to existing procedures that might be helpful?

17. What are your main sources of information about how to reduce the risk of musculoskeletal and mental health/stress-related problems?

18. How often, if ever, do you look at information about this kind of problem on the WorkSafe Victoria website?

Probes: (If they have ever looked at it) ... when did you look at it most recently? Was it useful? What did you find most useful? What additions or changes to this information would be useful for you?

Now thinking more broadly about communication within your workplace...

19. How does the organisation currently communicate policies and practices on preventing *musculoskeletal problems* to its senior managers, middles and line managers and workers?

Is there *much* of this kind of communication? How often?

How do you *know* people get the message?

20. How does the organisation currently communicate policies and practices on preventing *stress-related or mental health problems* to its senior managers, middles and line managers and workers?

Is there *much* of this kind of communication? How often?

How do you *know* people get the message?

Perceptions of a new risk management resource

We are now going to look at the power point presentation which outlines an alternative way of managing both musculoskeletal and stress-related problems

Could you please open the link which I emailed at the start of the interview and read through it in your own time. **PAUSE RECORDER**

(At end of reading time) **START RECORDER**

Just to clarify – we are not going to be implementing this toolkit as part of this study, we are only looking for feedback about the toolkit. There will be future studies where we will trial the toolkit in some organisations.

22. Do you have any questions about the earlier slides? Was the general rationale for the toolkit clear? Had you previously known about the link between MSD and psychosocial hazards?

23. Ok... Let's look now at the actual risk management processes. Thinking about this initial stage of "getting started"... do you think it would be difficult for someone trying to get this process started at xxx[name of organisation]?

24. What do you think the main barriers might be in getting it started?

For each barrier identified:

Can you see any possible ways of dealing with that?

What might make it easier?

25. Would you expect any difficulties in forming a risk management team that included people such as: the OHS manager, a senior management rep, a line manager, one or more reps of high risk jobs, relevant health and safety rep(s) and where relevant, a union rep?

Probe for details, reasons

26. How well do you think such a team would function?

Probe for details, reasons

27. First, what did you think about using staff ratings to assess hazard levels?

And if they haven't already cast doubt on credibility/reliability of such ratings data...

Do you think these ratings would be seen as giving reliable information about actual hazard and risk levels?

28. Would you expect any problems in getting people to complete the survey?

Probe: For each problem ... How might that be dealt with?

29. Bearing in mind that the survey is anonymous...

Do you think people would mind answering the questions in this survey?

30. If everyone completed the survey online, there'd be no need for data entry. But if not, someone would need to enter survey responses into an Microsoft Excel spreadsheet ... and it would be important that this was done accurately – a second person would need to check it for accuracy. Would that present any problems?

If yes ... Can you see any way around that?

31. The stakeholder workshop includes some of the workers who completed the survey. And when psychosocial hazard scores are being discussed, it's important that their supervisors/managers are not present, so that they feel free to discuss any supervision/management issues related to the hazard scores ... so supervisors/managers could not be there for that discussion.

Would that present any problems?

Do you see any other problems that might arise with the Stakeholder Workshops?

If yes ... can you see any possible way of avoiding or overcoming that?

32. Now thinking about the "develop and implement an Action Plan" stage...

How well do you think this would work? Can you see any problems?

If yes ... can you see any possible way of avoiding or overcoming that?

33. Now thinking about the "review and evaluate" stage,

Any issues here?

OK ... Well thinking about the toolkit overall, what do you think its main strengths are?

And its weaknesses?

For each weakness ... How might you tackle that problem?

Lastly we would like to ask a couple of background personal questions:

Demographics

34. What is your age group?

18-24

25-34

35-44

45-54

55 – 65

65+

35. What is the highest level of education completed?

- Completed year 10
- Completed year 12
- Certificate/diploma/TAFE
- Bachelors degree
- Post grad certificate/diploma
- Masters degree
- PhD

36. Have you undertaken any formal training in OHS? If so, what was that training?

37. What is your organisation's claim rate for musculoskeletal problems – high/low/medium compared to industry average?

38. What is your organisation's claim rate for mental health/stress-related problems – high/low/medium compared to industry average?

39. Are you able to tell us your organisation's EPR?

And lastly,

40. We would like to interview 4-5 personnel from each organisation at different levels of management. Who would you suggest we contact?

At the end of the interview:

"We are now reaching the end of our conversation. Do you have any further comments to add before we conclude the session?"

"Finally, we have requested that all workplaces involved in the study supply us with copies of their current policies and procedures for managing MSDs and Stress related disorders, so that we can analyse current risk management procedures. What is the best way to obtain copies of these documents?"

(Write down method of obtaining them)

"I would like to thank you for your participation in this interview. Your experiences and comments will be very helpful. Thank You."

Post Interview Comments and/or Observations:

Other Topics Discussed: _____

Post Interview Comments or Leads:
