The Royal Australasian College of Physicians

**The Australasian Faculty of Occupational & Environmental Medicine**

# HELPING PEOPLE RETURN TO WORK

## *Using evidence for better outcomes*

### A POSITION STATEMENT

## CONTENTS

## FOREWORD

Loss of work has devastating effects on the individual, the family, and the community. While the economic consequences are well recognized, the adverse health effects of being out of work for extended periods are less well recognised and addressed.

Research shows that being out of work for extended periods of time is bad for a person's health. The longer someone spends away from work, the less likely they will ever return. We have the knowledge and skills necessary to transform work disability into work ability. Why, then, do many Australian and New Zealand workers continue to suffer from work disability?

Work disability exists when an employee is not able to perform his/her usual work as a result of a health problem. There are health problems that preclude individuals from being at work, including severe pain, debilitating injury or illness and recovery from surgery. *However, there are also many health conditions with which employees could be at work if the right systems were in place*. In these instances, work absence is not 'medically necessary'.

In March 2009 the Australian Safety and Compensation Council (now Safe Work Australia) estimated the total economic cost of work-related injury and illness for Australia for the 2005–06 financial year to be $57.5 billion, 5.6% of Australian Gross Domestic Product.[2]
Paralleling the financial costs, the human and social costs of work disability are enormous.

Despite the vast sums of money spent on work-related health problems, the health outcomes for compensable conditions are worse than for similar non-work-related conditions. The considerable resources of the workers' compensation systems are not being put to their best use for employees, employers and the community.

Meeting the aspirations of governments, compensation authorities, employers and health practitioners with respect to the wellbeing of employees requires a coordinated approach, partnership with all stakeholders and political will. This document offers a starting point for the process by reviewing the key issues and making a number of recommendations for change. The College seeks to partners with policy makers and stakeholders to ensure that the hard work and considerable resources expended on Australia's return to work and workers' compensation systems achieve the best results for those it serves: injured and ill workers, their employers and the broader community. There have been many endeavours to improve return to work outcomes over the last decade, and the positive intentions of those involved are acknowledged. The aim of this document is to support and future initiatives to improve outcomes.

John Kolbe
Chair, College Policy and Advocacy Committee, RACP

## CONTEXT

This position statement is the first of a series of position statements exploring work and health, developed by the Faculty of Occupational and Environmental Medicine. The second position statement explores the health benefits of work, and conversely, the health consequences of being out of the workforce in the long term. Further position statements are planned on workplace approaches that improve employee wellbeing and workplace productivity.

## RECOMMENDATIONS

The working group recommends the a series of strategies and actions, and these are summarised below.

### I. Policy and legislation

The systems and legislation pertaining to the management of workplace disability require substantial overhaul to facilitate a partnership approach between employer and employee as a fundamental component of return to work management.

1. Early coordinated care, with the employee's wellbeing the prime focus, should be embedded within the policy decisions and processes to improve medical care, reduce delays and improve return to work outcomes.
2. The use of evidence-based medicine and evidence-based policy making should become standard practice and form the basis of return to work approaches.
3. Policy makers should take the lead in ensuring employees have access to evidence-based information and evidence-based medical care.
4. Seemingly minor abuses of the system should be taken seriously and addressed appropriately to improve respect for the system.
5. Policy makers should report on health outcomes of employees.

### II. Use of evidence and "knowledge transfer"

'Retailing' the substantial amount of evidence on return to work through partnerships between research institutes, policy makers and groups with expertise in getting research information into practice to improve transfer of research information to the medical, employer and general community.

1. The College of Physicians plays an active role in disseminating evidence-based information to physicians and other treating health practitioners,
2. The College of Physicians works with the Australian Medical Association and other medical colleges to develop a consensus statement on the medical practitioner's role in return to work.

## III. Training

The Faculty of Occupational and Environmental Medicine, through specific education programs such as basic and advanced training curricula and Continuing Professional Development (CPD), encourage health professionals to take an active role in prevention and management of long term disability and work loss by:

1. Developing a training module for medical practitioners about the negative consequences of keeping patients away from work
2. Routinely training doctors at the undergraduate and college level in management of return to work
3. Provide ongoing training / information to practitioners about evidence-based medicine relevant to return to work.
4. Plays an active role in educating other physicians about the importance of reducing work disability

## IV. Enhanced clinical practice

The College should work with governments and medical professionals and other interested parties to:

1. Discourage the use of the certification of work absence due to medically discretionary injuries and illnesses
2. Finds way for the patient(s) to remain at work during the recovery period
3. Develop systems support for improved practitioner–workplace communication.
4. Promulgate the concept that management of a work injury requires management of the injury AND management of the work
5. Ensure prompt referrals to appropriate specialists, including specialist care in management of medical and occupational rehabilitation
6. Assess and manage common psychosocial factors such as fear or distress
7. Enlist support in avoiding delays in medical treatments.

## V. Promote patients understanding of their condition

Medical practitioners:

1. Communicate return to work options to the patient, including the health consequences of remaining off work
2. Provide sufficient consultation time to address patient issues and concerns
3. Advise patients about the natural history of their condition
4. Be aware that a patient's attitude to their injury or illness has a huge impact on their recovery. Care should be taken to provide clear and non-threatening information about the condition.

## VI. Community education and engagement

The College, along with other medical professionals and community and consumer organisations, advocates increasing the level of awareness of the serious negative health effects of long term long term disability and work loss by developing policy and a public health campaign. This should be conducted in conjunction with the provision of more detailed information to the medical community.

## VII. Employee and employer responsibilities to prevent disability

Misunderstandings about work contribution to health conditions should be corrected through promotion and better accessibility of the evidence base on work causation and occupational epidemiology.

Both employer and employee have roles and responsibilities that need to be assumed in this process.

## EXECUTIVE SUMMARY

Employers, workers, governments, families and communities benefit when work disability is transformed into work ability.

Long term work absence has many negative consequences. It has an adverse impact on mental and physical health, high social and economic costs, and can result in permanent work disability.

Unfortunately, the return to work and workers' compensation systems developed to meet the challenge of work disability sometimes contribute to rather than ameliorate the difficulties faced by workers, families and employers.

Despite the considerable costs associated with compensable conditions, outcomes for work-related health problems are consistently worse than for similar but non-work related conditions. Many factors contribute to the negative results. Change requires recognition of the problem, coordinated interventions and a robust commitment to improve outcomes.

This paper:

- Identifies the costs of work disability, in terms of economic losses and poorer health outcomes;
- Proposes policy and legislative reforms that would reduce long term work disability and promote return to work, including public education programs and more stress on the field at the tertiary level;
- Highlights the impact of patient attitudes on return to work outcomes;
- Outlines how medical professionals can promote best practice return to work; and
- Describes the role of the employer in best practice return to work management.

# INTRODUCTION

> *"...long term worklessness is one of the greatest risks to health in our society. It is more dangerous than the most dangerous jobs in the construction industry, or the North Sea, and too often we not only fail to protect our patients from worklessness, we sometimes actually push them into it, inadvertently…"*
>
> Professor Gordon Waddell, commenting on the health effects of being off work, from the report "Is work good for your health and well being?"[1]

Over the last ten years, important reforms have been made to Australia's workers' compensation systems. These reforms have sought to balance the interests of workers, employers and policy makers and ensure that our compensation systems remain financially viable in the long term.

Financial viability is certainly important, but it is also important to consider how successfully our systems prevent work disability and promote return to work. In this respect, the news is not all good.

Each year, more than a hundred thousand Australians develop health conditions that affect their performance at work. Most people return to work quickly after sick leave, but a significant minority are absent for a long time and a small minority remain off work permanently.

In about ten percent of cases the ill or injured person will:

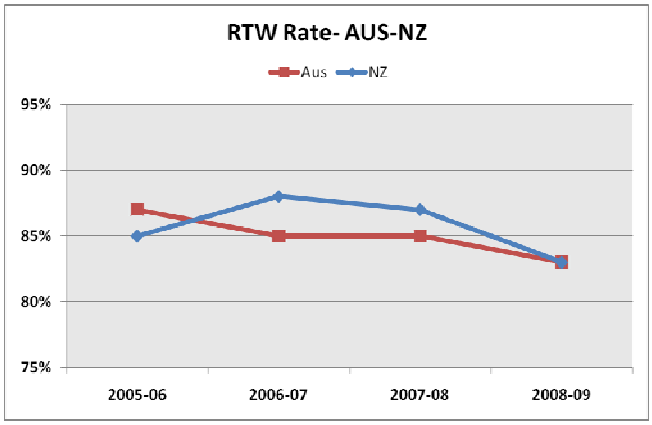
- Withdraw from the workforce for long periods or permanently; and
- Receive at least one disability benefit and remain on that benefit long term. This may be sick leave, workers' compensation, a disability pension, private disability insurance or salary continuance employment insurance.

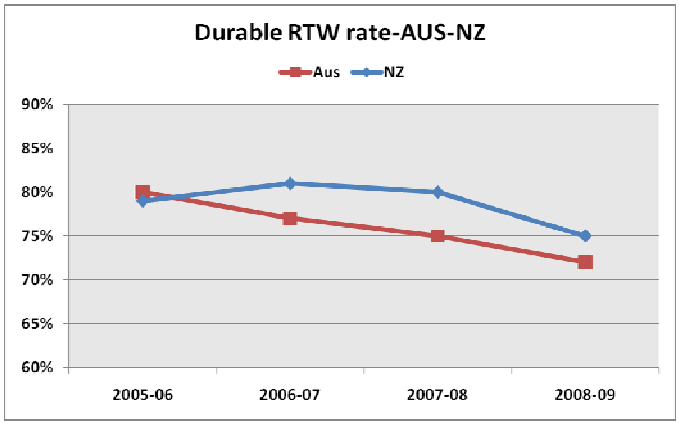
These workers are sometimes referred to as "disabled." In this document, "disability" is taken to mean an inability to work that is caused by a health condition.

The Return to Work Monitor,[2] an annual survey of employees with a work related compensation claim, shows that return to work rates in Australia and New Zealand are declining. The percentage of people returning to work after a work-related injury has fallen over the last four years. There is a need to review and tackle this is issue in a coordinated fashion.

The *RTW rate* measures the percentage of employees who had returned to work at any stage between their claim being lodged and the time the interview was conducted six months later. In Australia the rate has fallen from 87% to 83%, with a lesser fall in New Zealand.

*The Durable RTW rate* measures the percentage of employees who have returned to work and have remained at work. It is a measure of sustainable return to work. This steadily declined in Australia over the last four years, from 80% to 72%. In New Zealand the return to work rate has




declined only over the last two years, and the fall in the rate has been less significant.

In addition to the health condition that removed them from the workplace to begin with, an individual off work for significant periods may:

- Become isolated and depressed;[3]
- Suffer adverse socioeconomic consequences;
- Become unemployable in the long term;
- Experience family disruption, loss of self-esteem and quality of life;[4-7] and
- Have increased morbidity and mortality, with increased rates of many health conditions.[8]

**In many cases, many of the consequences described above could be prevented through a coordinated approach that helped the person return to work.** In this document, the term "return to work" is used broadly, to describe both situations where an individual is off work and returns to work and where, thanks to effective disability management, the person is maintained in the workplace for the duration of their health problem.

The need for better management is urgent. Unfortunately, the available evidence suggests that, despite good intentions, Australian return to work outcomes are showing little improvement, or even moving backwards.

Intentions are good and many jurisdictions are committed to addressing these worrying trends, but a major coordinated approach is needed to alter the status quo.

This AFOEM policy on preventing work disability has been produced to encourage all players to examine their role in assisting workers to return to work safely, swiftly and durably.

The Faculty believes that medical practitioners should play a key role in assisting people to remain at work, and encourages occupational physicians and other medical practitioners to take the lead in educating the community about this important issue.

If the return to work process fails, injured workers become temporarily or permanently disabled workers. The social, personal, emotional and financial costs of this transition are often very severe.

This document is concerned with the return to work process and the ways in which its management can be improved. Good return to work management prevents disability.

### How was the policy document developed?

This policy document was developed by integrating substantial amounts of research on work disability with a practical understanding of the issues faced by employees, employers and practitioners in the area. Extensive feedback from employer, employee, medical, insurance and government bodies was also sought.

In 2000 the Committee of Presidents of Medical Colleges, through the participation of The Australasian Faculty of Occupational Medicine of The Royal Australasian College of Physicians, itself undertook a research project aimed at identifying whether people with compensable injuries have poorer health outcomes than those with similar but non-compensable injuries. The results of this publication, Compensable Injuries and Health Outcomes,[9] as well as subsequent research in the field, inform this policy.

The Faculty is also grateful to the American College of Occupational and Environmental Medicine, whose guide *Preventing Needless Work Disability by Helping People Stay Employed* [10] served as an important base for this document.

## THE INTERNATIONAL CLASSIFICATION OF FUNCTION, DISABILITY AND HEALTH

In addition, the policy draws on the International Classification of Function, Disability and Health (ICF), which was developed and promoted by the World Health Organisation (WHO) to encourage practitioners and policy makers to focus on a person's abilities rather than their disease or health condition.

The ICF provides a model for assessing what a person with a health condition can do in a standard environment (their level of capacity), as well as what they actually do in their usual environment (their level of performance). While AFOEM's work disability policy does not use the ICF terminology, its principles are directly in line with the WHO's intent to embrace a focus on function rather than disease.

The ICF model is useful because it encourages consideration not only of body functions and structure, but also areas of activity and participation. Table 1 below outlines how this model applies at the individual, institutional, and social level.

Table 1 – Use of the ICF model of functioning, at the individual, institutional and societal levels*

**ICF Applications Service Provision:**

**At the individual level**

For the assessment of individuals: *What is the person's level of functioning?*
For individual treatment planning: *What treatments or interventions can maximise functioning*?
For the evaluation of treatment and other interventions: *What are the outcomes of the treatment? How useful were the interventions?*
For communication among physicians, nurses, physiotherapists, occupational therapists and other health workers, social service workers and community agencies (should a question follow this sentence?)
For self-evaluation by consumers*: How would I rate my capacity in mobility or communication?*

**At the institutional level**

For educational and training purposes
For resource planning and development: *What health care and other services will be needed?*
For quality improvement: *How well do we serve our clients? What basic indicators for quality assurance are valid and reliable?*
For management and outcome evaluation: *How useful are the services we are providing?*
For managed care models of health care delivery: *How cost-effective are the services we provide? How can the service be improved for better outcomes at a lower cost?*

**At the social level**

For eligibility criteria for state entitlements such as social security benefits, disability pensions, workers' compensation and insurance: *Are the criteria for eligibility for disability benefits evidence based, appropriate to social goals and justifiable*?
For social policy development, including legislative reviews, model legislation, regulations and guidelines, and definitions for anti-discrimination legislation: *Will guaranteeing rights improve functioning at the societal level? Can we measure this improvement, and adjust our policy and law accordingly?*
For needs assessments: *What are the needs of persons with various levels of disability impairments, activity limitations and participation restrictions?*
For environmental assessment for universal design, implementation of mandated accessibility, identification of environmental facilitators and barriers, and changes to social policy: *How can we make the social and built environment more accessible for all persons, those with and those without disabilities*? *Can we assess and measure improvement?*

*From Towards a Common Language for Functioning, Disability and Health (ICF), WHO
www.who.int/classification/icf

## THE 'FLAGS' MODEL

The 'flags' model, developed and refined over a decade, identifies the common barriers to return to work and assists in identifying ways to overcome those barriers.[11]

Flags are warning signals that psychosocial factors in or around the individual are acting as obstacles to full recovery and return to work.

The Three Flags are:

- Yellow flags are about the **Person** (thoughts, feelings, behaviours)
- Blue flags are about the **Workplace** (work and health concerns)
- Black flags are about the **Context** (relevant people, systems and policies).

Identification is about looking for unhelpful behaviours and circumstances. All players have a role in spotting flags related to: the **Person** with the problem; their **Workplace**; and the wider **Context** of their lives. In this document we have not used the terms within the flag model, but these concepts underpin the approach taken in this document. Further reference material is available at www.tsoshop.co.uk/bookstore.asp?FO=1299153

## CONSEQUENCES OF BEING OFF WORK

Work absence is sometimes medically necessary, for a range of illnesses and injuries. However, many stakeholders – including treating practitioners, the person with the injury or illness and their friends and family – may not know how to avoid, or may not even recognise the potential for, negative consequences of missed work. After all, people take annual leave and sick leave for short term illnesses: how can time off work for a work-related health condition be problematic?

The weight of the evidence over the last 20 years[1, 7, 8, 12, 13] shows that people who are out of work in the medium- to long-term are at greater risk of negative health outcomes.[1, 7, 8, 12, 13] Furthermore, the more time spent away from work, the less likely a person is to ever return.

**Whatever the reason for sick leave, it is important to realise that missing work influences recovery.**

**Figure 1 Likelihood of return to work after various length of time off work**

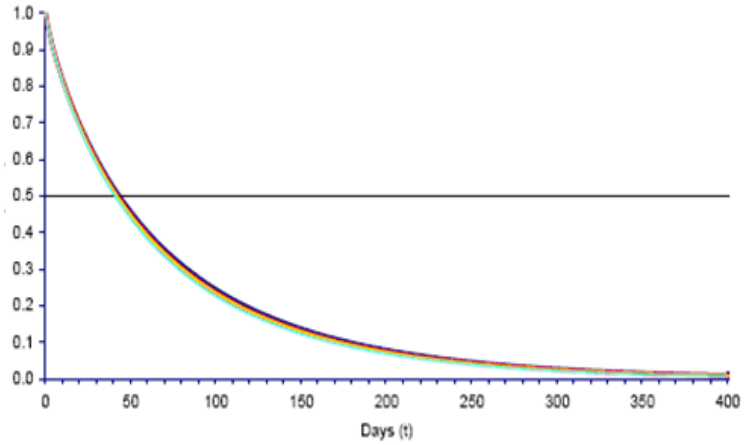



Figure 1 shows how the number of days spent away from work impacts on a person's chance of return. In many systems, the likelihood of return to work is down to 50% after 45 days off work.

Unless work absence is medically necessary (see the section on medically necessary, medically discretionary and medically unnecessary work absence below), remaining away from work is likely to hamper rather than promote recovery from injury and illness.

### HEALTH IMPACTS ON THE WORKER

A major review of work and health [8] summarises the evidence as follows:

> *Worklessness carries more risk to health than many "killer diseases," and more risk than most dangerous jobs (e.g. construction, working on an oil rig).*

The review presents strong evidence that long term disability and work loss has the following consequences:

- Increased risk of dying;

- Increased risk of dying from heart disease, lung cancer and suicide;
- Poorer physical health, including heart disease, high blood pressure and chest infections;
- Poorer general health and poorer self-reports of health and wellbeing;
- Increased long term illness;
- Poorer mental health and wellbeing;
- Increased likelihood of suicide attempts; and
- Higher rates of medical attendance and hospital admission.

The magnitude of the effect was given as:

- 2–3 times the risk of poor health;
- 2–3 times the risk of mental illness;
- A significantly increased risk of depression; and
- 20% excess deaths.

## PSYCHOLOGICAL AND SOCIAL IMPACTS ON THE WORKER

People develop a sense of themselves through social roles and relations.[4] Work — which is often accompanied by a sense of being a provider at home and contributing in the workplace — can form a substantial part of a person's core identity. This may be lost or diminished when a person is absent from the workforce. When people can no longer fulfill what they see as the basic obligations of their relationships they often feel that they are a burden on those around them and describe feelings of uselessness and dependency on others.

An overly restrictive approach to injury or illness can cause people to withdraw from their normal activities (including work) and result in isolation. Co-workers may respond negatively to someone off work on compensation and even express doubt about the legitimacy of the problem. The significance of such experiences depends on how often they occur, the perceived importance of those who discredit the person, and how strong the negative response seems to be. This will not affect all people equally, but for many it will further shake a sense of self already made vulnerable by injury, illness and pain.

The psychological and social (sometimes called psychosocial) impacts of work absence may include:

- Depression;
- Erosion of work skills;
- Decreased income and social status;
- Loss of social support networks;
- Decreased confidence; and
- Decreased sense of self-efficacy.

(from *Journal of Occupational Rehabilitation, Vol. 4, No. 2, 1994, "*Worklessness and Disability: Expansion of the Biopsychosocial Perspective"*,* Brian M. Schulman)

The psychological and social impacts of work absence may, in turn, impact poorly on recovery. The WHO and other health organisations have identified social factors which influence health and which are impacted by medium- to long-term work absence, including:

- Income and social status;
- Social support networks;
- Employment / working conditions; and
- The person's social and physical environment.

It may seem natural to forget about work and "focus on getting better" but, unless time off work is medically necessary, the psychological and social costs of doing so – which often have a flow-on impact on physical health – may outweigh the benefits.

### FAMILY, WORKPLACE AND COMMUNITY IMPACTS

Work absence may put strain on families for a number of reasons.

One or both parents being out of work has been shown to affect the physical and mental health of their children[6]. When both parents are out of work the effect can be explained by the financial strain on the family. However, research has shown that having just one parent out of work, secondary to loss of their job, worsened the children's self-reported health.

The workplace also suffers as a result of work absence, not merely through increased compensation costs, lost time and lowered productivity, but also potentially in terms of intangibles such as corporate image, workplace culture and employee discretionary effort.

In addition to the impacts on a person's social network and loved ones, the broader community also helps bear the financial costs of needless work disability.

## Recommendations

1. Research, policy development and a public health campaign about the serious negative health effects of long term long term disability and work loss is required, as well as the barriers preventing people from returning to work. This should be conducted in conjunction with the provision of more detailed information to the medical community, employers and employees.
2. In particular, medical practitioners should be given clear information about the negative consequences of keeping patients away from work, and be trained to facilitate safe, speedy and durable return to work.

## IMPACT OF 'THE SYSTEM'

Whether an ill or injured person becomes work disabled is not simply a consequence of the severity of their condition: many other factors, including the systems around workers' compensation and return to work in their state or territory and their workplace, also have an impact.

The return to work process does not have to be formal or coordinated. Sometimes it is as simple as a worker waking up in the morning, realising they are sick, and deciding for themselves whether they will go to work that day. On other occasions a simple strain results in a series of events involving a range of people in the workplace and beyond: completion of multiple forms, decision making at distant locations and other actions that result in the employee with the injury losing control of the situation.

The formalisation of the process can have a negative impact on return to work outcomes, removing important decision making responsibilities from those directly involved such as the worker and their supervisor, and causing unnecessary delays in return to work.

When absence is prolonged or the condition is severe the process is usually longer and more complex, and involves other participants. If a person is away from work for a significant amount of time their employer is likely to become more involved. The workplace may consult with the doctor, and may modify the person's job so they can continue working while they recover – or the workplace may be unable to do so, leaving the person inactive and unengaged.

If a workers' compensation claim is made a number of official bodies become involved and the process includes compensation procedures. Sometimes the process leads to and includes litigation.

Even without litigation, the stress placed on workers, employers and families by this process may be considerable.

Workers in particular may struggle to deal with a compensation system that seems daunting and impersonal and that presents them with unnecessary delays in obtaining treatment. These difficulties may be exacerbated by the use of industry jargon or legal and medical terminology, which may be alienating for the uninitiated.

In this context, the fact that compensable injuries tend to have worse outcomes than similar, non-work-related injuries, becomes comprehensible. Although 'The System' is intended to provide a safety net for injured workers, some workers exit the system with poorer mental and physical health than they entered it.

## WORK AS REHABILITATION

Research[8] has identified concrete health benefits associated with a return to employment, including:

- Improvements to general health and wellbeing (e.g. self-esteem, self-reported health, physical health and self-satisfaction); and
- Improvements to minor psychiatric health problems and a lessening of psychiatric distress.

The researchers concluded that most of the improvement was directly caused by re-employment, not that return to work occurred *because* people were healthier.

The security of the new job, as well as the person's motivation and job satisfaction, also influenced a person's health following their return to work.

In many instances, work can play an important role in rehabilitation because *doing* promotes recovery.

An athlete will continue to focus on their training and condition while they recover from an injury or illness. Like athletics, working involves skills, attitudes and habits that are built up over the years. Staying "in-training" – even if this involves shorter hours or different duties than usual – can make the transition back to health and regular employment easier to manage and more successful.

### Recommendations

Medical practitioners, employers and employees should be provided with information about the health benefits of work, particularly its role in rehabilitation and recovery.

## NON-MEDICAL BARRIERS TO RTW

Our methods for assessing the performance of return to work systems are often based on facts and figures, for example LTIs (lost time injury), return to work rates and compensation dollars spent. Although this is important information, it can obscure the fact that return to work is a human drama, in which the psychological and social characteristics of the players influence the unfolding of events.

Non-medical barriers to return to work (sometimes called psychosocial barriers) can play a major role in determining outcomes.

There are many non-medical factors that influence whether a person continues to work, including their attitude to work and their beliefs about the importance of work, and the management of their illness and absence by their employer, insurer, treatment providers and family.

If return to work is delayed beyond what would usually be necessary for the health condition in question, it may be that non-medical barriers are responsible.

Common non-medical barriers include:

- Conflict in the workplace, for example between the worker and a supervisor or co-worker;
- An unhelpful family approach, for example a partner who 'does everything' for a person with a strain or sprain;
- Fear of pain and re-injury;
- Conflicting advice from health professionals;
- A sense that the employer is to blame for the worker's injury or illness;
- Low self-confidence, which can lead to low motivation; and
- Unhappiness with other aspects of working life, such as feeling unsupported in the workplace, being passed over for promotion, or undertaking boring, repetitive duties.

The best way to establish whether non-medical factors are delaying return to work is to *ask* the relevant people – for example the employee, their supervisor or manager and (bearing in mind confidentiality provisions) the treating practitioner – "What, from your point of view, are the barriers to return to work?"

Posing this question is a collective responsibility. There is no one person responsible for dismantling the non-medical barriers to return to work. Rather all players in the "human drama" – treating practitioners, supervisors, claims and case managers and return to work coordinators, as well as the injured worker and their personal support network – must learn to recognise and deal with these barriers as they appear.

Thus, strategies for dealing with non-medical barriers to return to work are outlined in the sections of this policy covering employees, the workplace and capacity for work assessment.

In general, the best approach is to:

- Encourage communication between stakeholders about barriers to RTW;
- Intervene early when non-medical factors are apparent; and
- Provide injured or ill workers with accurate, balanced information about pain, their health condition and the impact of activity on recovery.

It is also vital that professionals working in the return to work field remember that injured or ill workers are NOT "cases," "claims" or "LTI statistics"; they are people, who will respond best to being treated as such. Similarly, injured workers should bear in mind that blaming their employer for their situation is an impediment to recovery. In fact they, the injured worker, are the person who has the most influence over their health condition.

### Recommendations

1. Research should be conducted into the impact of "systems" issues on motivation, recovery, mental health and return to work.
2. All return to work stakeholders should be informed about potential non-medical barriers to return to work and act collaboratively to identify and deal with them.

## MEDICAL FACTORS AND RETURN TO WORK

**Medical treatment and return to work should be managed simultaneously. Management of a work injury requires management of the injury and management of the work itself.**

Managing the medical factors influencing return to work is best undertaken as a collaborative process, requiring cooperation between the worker, medical professionals and the workplace.

Where necessary, a rehabilitation provider can act as an interface between the 'work' and 'health' aspects of return to work, allowing employees and employers to make the most of work's potential to assist with recovery from injury and illness.

### MEDICALLY NECESSARY VS MEDICALLY UNNECESSARY DISABILITY

Some medical conditions necessitate time off work. For example, a person recovering from surgery, an individual with a crush injury, someone experiencing debilitating pain or a person admitted to hospital all require recovery time and may be unable to attend the workplace.

However, with many medical conditions there is a substantial discretionary element to work absence. By 'discretionary element' we mean that, while the person has a health condition, they *are* able to attend work if the right accommodations are made. In these instances, work absence is at the employee's, or their doctor's or employer's discretion; there is no medical *requirement* that the employee stay away from work.

Table 2 expands this concept.

**Table 2 - When is disability medically required, medically discretionary or medically unnecessary?**

| Medically Required | Medically Discretionary | Medically Unnecessary |
|---|---|---|
| Typically, absence is medically required when:<br>• Attendance is required at a place of care (hospital, doctor's office, physical therapy).<br>• Recovery (or quarantine) requires confinement to bed or home.<br>• Being in the workplace or travelling to work is medically contraindicated (poses a specific hazard to the public, coworkers, or to | Medically discretionary disability is time away from work at the discretion of a patient or employer that is:<br>• Associated with a diagnosable medical condition that may have created some functional impairment but have left other functional abilities still intact.<br>• Most commonly due to a patient's or employer's decision not to make the extra effort required to find a way for the | Medically unnecessary disability occurs whenever a person stays away from work because of non-medical issues such as:<br>• The perception that a diagnosis alone (without demonstrable functional impairment) justifies work absence.<br>• Other problems that masquerade as medical issues, e.g. job dissatisfaction, anger, fear or other |

| | | |
|---|---|---|
| the worker personally, i.e. risks damage to tissues or delays healing). | patient to stay at work during illness or recovery. | psychosocial factors.<br>• Poor information flow or inadequate communication.<br>• Administrative or procedural delay. |

*Source: Preventing needless work disability by helping people stay employed [10], reproduced with permission.

### Recommendations

1. The certification of work absences due to medically discretionary injuries and illnesses should be discouraged.

2. Treating physicians, patients and employers should work together to find a way for the patient to remain at work during the recovery period.

## TREATMENT APPROACHES AND RETURN TO WORK

Whilst most treating practitioners do not have specific training in work disability, they frequently evaluate a person's illness or injury in terms of how it might affect their ability to work.

Practitioners are called on to decide how much time off work is needed, identify appropriate rehabilitation or return to work steps and verify this information for various insurance agencies, employers or workers' compensation bodies. However, a recent Canadian study found that treating practitioners often feel that they lack the time and expertise to perform these tasks, nor are they adequately compensated to do so.

Despite the constraints of the system and the difficulties doctors may face in assessing and dealing with medical and non-medical barriers to return to work, a range of studies have indicated that treating practitioners have a significant influence on return to work outcomes. A 2006 study, for example, evaluated healthcare provider communication with patients and the workplace in musculoskeletal injury care.[14] It found that:

- If patients were given guidance on how to prevent recurrence and re-injury, they were then twice as likely to return to work early.

  *However, only 62% of patients indicated that their healthcare provider told them how to prevent re-injury.*

- If the healthcare provider contacted the patient's workplace, it was twice as likely that the injured worker would return to work early.

  *However, only 40% of patients reported that their healthcare provider made contact with their workplace.*

- If the healthcare provider gave the patient a date after which they could return to work, they were more than three times as likely to return to work soon after the injury.

  *However, only 50% of patients reported that their healthcare provider gave them a return to work date.*

- Approximately 50% of employers took no action in response to a worker's report of a repetitive strain injury.

  *However, a recommendation from a doctor doubled the likelihood that the employer would respond.*

The fact that, in the majority of instances, the model of getting better first and then returning to work is demonstrably unsuccessful should be in the forefront of treating practitioners' minds. When return to work is recommended by the treating practitioner, it is significantly more likely that the individual will return to work.

Treatment approaches that take into account potential medical and non-medical barriers to return to work, and seek proactively to dismantle these, have good results. Treating practitioners should:

- Encourage the worker to expect that they will recover and return to work;
- Actively monitor the worker's progress and, bearing in mind confidentiality provisions, communicate about this progress with the worker, the employer and the insurer;
- Promote an 'active management' approach to recovery and discourage passive treatments that don't provide outcomes;
- Work in tandem with other health professionals assisting the rehabilitation process, including physiotherapists, occupational therapists, GPs, medical specialists and psychologists, and refer the worker on where appropriate;
- In exchange for appropriate remuneration, understand the workplace and communicate with the employer or relevant manager / supervisor about restrictions and potential accommodations;
- Provide the worker with information about the role of work in rehabilitation and the importance of remaining active and taking control of recovery; and
- Identify medical and non-medical barriers to return to work and share this information – as well as potential solutions – with the worker and other relevant personnel.

Direct communication with the workplace gives the healthcare provider an understanding of the working conditions under which an injured or ill employee will return to work. This allows for a

better assessment of the level of recovery needed before return to work can occur and of the kind of modifications that are possible in the workplace. Healthcare provider contact with the workplace also gives weight to the worker's injury claim, thus potentially lessening the "system stress" faced by the worker.

The Canadian Medical Association and the American College of Occupational and Environmental Medicine have developed statements on the doctor's role in return to work.[15, 16] The documents have been widely disseminated and practitioners are encouraged to recognise the importance of return to work and their role in return to work outcomes. There is, to date, no Australian equivalent of these documents.

## Recommendations

1. Doctors are routinely trained at the undergraduate and college level in management of return to work.

2. Systems be designed to promote communication –with the consent of the injured worker – between the doctor and the employer concerning work absence. To facilitate this, the faculty recommends that:
    - This be the subject of policy development and a public health campaign;
    - The workplace insurer remunerates doctors for discussion with the employer;
    - All parties respect confidentiality obligations; and
    - Electronic forms of communication be developed that allow all participants, including the patient, to communicate with ease and in real time.

3. Treating practitioners:
    - Recognise that management of a work injury requires management of the injury AND management of the work;
    - Refer to appropriate specialists, including specialist care in management of medical and occupational rehabilitation;
    - Assess and manage common psychosocial factors such as fear or distress;
    - Communicate with the employer if workplace factors seem to be significant influences;
    - Clearly articulate to employers and insurers the negative health consequences and poor return to work consequences resulting from delays in treatment; and
    - Have an understanding of occupational epidemiology if they are going to provide comments on work causation issues.

4. The College of Physicians works with the Australian Medical Association and other colleges to develop a statement on the medical practitioner's role in return to work.

Medical certificates influence patient beliefs, employer and system actions and, therefore, return to work outcomes.

A well-informed treating practitioner has the capacity to educate both patients and employers about best practice return to work. Some patients and employers will have a good approach to return to work; others will not. Rather than passively accepting unhelpful ideas about disability, recovery and rehabilitation, practitioners should proactively seek to promote helpful beliefs and attitudes.

In theory, medical certificates outline a person's capacity for work based on their medical condition. However, in reality, certification is heavily influenced by many factors other than the medical condition, including the patient's approach, the workplace situation, the availability of restricted duties, and the overall way the system in the relevant jurisdiction operates.

Currently in Australia, capacity for work assessment processes are overly complex and do not reflect the findings of the best available evidence. In the current context, the norm is to provide general medical restrictions (such as "no twisting" or "no bending") rather than practical, empowering, work-applicable advice. This results in:

- Simple situations becoming complex and rigid;
- Difficulties in relating medical advice to the work environment and applying it in a way that focuses on function rather than impairment; and
- Decreased control and engagement for the key workplace players, including the injured worker.

Doctors and treating professionals can influence the system by providing clear messages.

Evidence-based medicine allows doctors to state clearly that:

- Activity is an integral part of rehabilitation and should be prescribed;
- Provision of modified duties fosters return to work;
- People are best off when they return to productive work in a supportive environment; and
- Return to work is more likely to be successful when undertaken early.

A number of barriers to return to work can be dismantled by:

- Changing beliefs and attitudes;
- Promoting patients' understanding of the importance of being active; and
- Focusing on functional recovery rather than pain relief only.

Treating practitioners are often aware of the medical and non-medical barriers to return to work. A survey of primary care practitioners evaluated the ways in which they assessed capacity for work.[17] Doctors indicated that the most useful strategies and sources of information used to assess a person's ability to work were:

(Rated 4/5 level of importance)

- Clinical observations;
- Past experience with the patient;
- Objective test results; and
- The patient's description of their work.

(Rated 3.5/5 level of importance)

- Input from the employer and the patient's requests and expectations.

Further:

- Doctors agreed that they should be involved in decisions about a patient's ability to work and most saw their role as supporting the patient and advocating their interests, rather than advocating the interests of the employer;
- About 25% advised that they did not think they could influence a patient's beliefs about whether they had a disability or not;
- Doctors were aware of multiple barriers to return to work, including:
    - Conflict between the patient and their employer;
    - Job dissatisfaction;
    - Psychological problems arising from the patient's physical symptoms; and
    - A lack of clear guidelines for the doctor about when to return the patient to work.

### Recommendations

1. Treating practitioners are encouraged to play an active role in shaping patient and employer attitudes about disability, recovery and rehabilitation.
2. Practitioners receive ongoing training/information about evidence-based medicine relevant to return to work.
3. Practitioners should avoid giving people unnecessary restrictions and encourage early return to activity.

## ADVICE AND EXPLANATION

Research demonstrates that patients given thorough advice and explanation about their condition:

- Are more satisfied with their treatment; and
- Have better outcomes.[18]

Regardless of how much their symptoms improve, injured or ill workers are more satisfied with treatment when doctors:

- Appear to take their condition seriously;
- Explain their condition clearly;
- Give advice on how to avoid getting injured again; and
- Try to understand their job.

When patients have confidence in managing their symptoms, they are more likely to return to normal functioning and have good return to work outcomes. Ways that this can be facilitated include:

- Allowing sufficient consultation time to address patient issues and concerns;
- Where possible, letting people know about the natural history of their condition;
- Recognising that management of a work injury requires management of the injury and management of the work;
- Giving advice about remaining active — this may include specific advice about avoiding activities where appropriate, and not advising patients to restrict their activities in other circumstances;
- Advising people how they can self-manage their condition and minimise the risk of re-injury; and
- Basing any advice on work causation issues on an adequate understanding of occupational epidemiology.

### Recommendations

Treating practitioners:

1. Communicate return to work options to the patient, including the health consequences of remaining off work.
2. Provide sufficient consultation time to address patient issues and concerns.
3. Advise patients about the natural history of their condition.
4. Be aware that a patient's attitude to their injury or illness has a huge impact on their recovery. Care should be taken to provide clear and non-threatening information about the condition.

Misunderstandings about work contribution to health conditions should be corrected through promotion and better accessibility of the evidence about work causation and occupational epidemiology.

## THE WORKPLACE AND RTW

The employer's approach plays a significant role in return to work outcomes. While most employers have good intentions and care about their workers' health and wellbeing, the issues around return to work and workers' compensation are complex, and it can be difficult to know what to do to help.

Micro, small, medium and large businesses have differing needs and capacities when it comes to managing return to work, however the basic principles remain the same: treat workers well, be consistent, show leadership and commitment and foster collaboration.

Businesses of different sizes also have similar reasons to prioritise managing return to work effectively. Failing to do so has substantial direct and indirect costs, borne not only by the business but by the worker, their family and the broader community.

Workplaces can improve return to work outcomes through:

- Good individual case management;
- A positive workplace culture;
- Training their staff, such as supervisors, in how to manage return to work;
- Senior management leadership;
- Auditing their own return to work systems and outcomes, and making improvements where appropriate;
- Actively seeking input and fostering collaboration between injured employees, coworkers;
- Assisting employees to access high quality medical care; and
- Adopting sensible policies and procedures – and visibly sticking to them.

Employees value care, communication and concern. Employees who are valued, treated with respect and have their concerns addressed quickly are significantly more likely to return to work.[19-23]

A smart employer works in partnership with the employee and seeks their input.

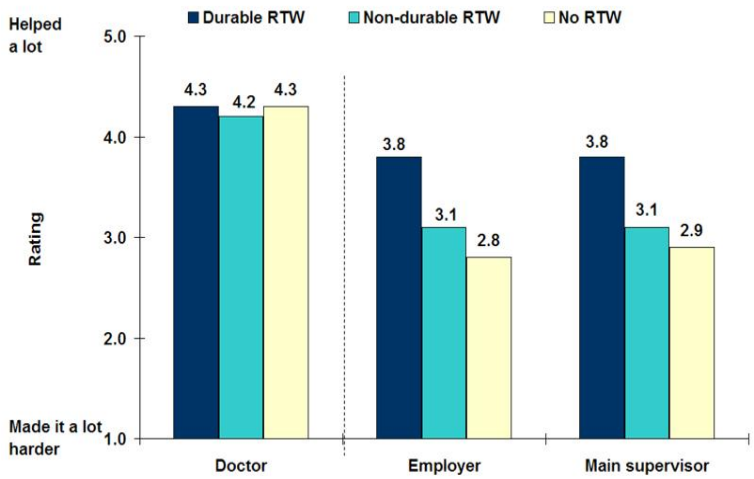
This common sense approach is backed up by solid research.

Research has shown that worker satisfaction with their employer has a significant influence on return to work. A 2007 study titled "It Pays to be Nice"[19] demonstrated that a worker's satisfaction with their employer was the single most important influence on employment stability in return to work after the onset of back problems.

The graph below, from a presentation by Campbell Research and Consulting, demonstrates RTW outcomes correlate with whether the worker considers the employer to be helpful.

Doctors were seen to be helpful by workers whether the outcome was a durable RTW, non durable, or no RTW was achieved.

But the rating of the employer and in particular the main supervisor has a clear impact on the RTW outcome. When the employer was rated as helpful, a durable RTW was more likely. Similar results were noted for the main supervisor's helpfulness rating.




**Extract from "Non-durable RTW: Learnings from the Campbell National RTW Monitor"**

Research on workers' perception of blame has shown that people who fault their employer have a poorer response to treatment.[23] They anticipate greater levels of pain and greater limitation of activity at the end of treatment than those who do not fault their employer. There is a joint responsibility, on the part of workers and employers, to minimise the sense of blame. The employer can assist with this by:

- Where appropriate, acting quickly and visibly to fix the policies, procedures or machinery whereby injury occurred;
- Asking the worker and their family what can be done to assist them; and
- Maintaining regular, supportive contact throughout the recovery period.

Workplace organisational behaviours impact work disability outcomes.[24] Comparing workplace organisational practices demonstrates that improved return to work rates are seen in organisations with:

- Proactive disability management;
- A people-oriented culture;
- Active safety leadership;
- Early workplace intervention;
- An approach that addresses the physical as well as the social and personal needs of the individual.

Supervisors and line managers play a key role and employees perceive that supervisors need to assist workers recover and return to work. Employees expect supervisors to be involved with management of workplace disability[25] through:

- Maintaining contact with absent workers, even when it is unlikely that they will return to work early;
- Involving workers and their workmates in a co-operative approach to planning workplace adjustments; and

- Direct involvement in the return to work planning process.

Skills training for supervisors improves their job satisfaction and reduces the rate of new injuries and work disability following the training program.[25] When senior management is actively involved in an organisation's work disability programs, corporate culture follows and employees receive better care and have improved return to work rates.

Businesses should also be aware that certain kinds of work – particularly work with high productivity demands but a low level of control on the part of the worker – may contribute to injuries and illnesses, and also make it more difficult to return to work. Therefore, work structures that increase employee control over work flow are important.

### Recommendations

1. Research, policy development and a public health campaign to provide employers with information about:
    a. The costs of poor return to work management;
    b. The health and economic benefits of a collaborative approach in the workplace; and
    c. The importance of addressing blame.
2. Employers should:
    a. Demonstrate that they take return to work seriously, by having the appropriate policies, procedures, culture and approach in place;
    b. Provide return to work training for supervisors and line managers; and
    c. Provide safety and return to work leadership.

## PROVIDING MODIFIED DUTIES

It can be difficult to provide modified duties, particularly in smaller workplaces. Nevertheless, modified work programs help people return to work after illness and injury.

Appropriate modified work duties vary from case to case, and are best established consultatively. The input of the injured or ill worker, and their employer, supervisor, treating practitioners and co-workers, will ensure that the modified duties are both medically appropriate and seen as appropriate in the workplace.

There is a substantial body of research on modified duties. Overall, programs of modified duties halve the reduction in time off work.[26] Modified duty programs can significantly reduce the cost of work disability, with studies showing a direct cost reduction of between 8 and 90%. This does not include the indirect costs, generally estimated to be at least four times the direct costs.

Recognised barriers to return to work include a lack of options for modified tasks, lack of knowledge about modified work programs, negative attitudes of employees, and lack of support from co-workers. Supervisors and line managers play a key role in implementing modified duty programs.

Modified duties assist with return to work. However, it remains important to transition the person back to their normal duties. A limited number of people are unable to return to their normal job. An approach that seeks to 'protect' the patient by continuing restrictions beyond a medically necessary period can result in the person losing their job. Employers with an increasing number of staff on restricted duties find it difficult to continue finding modified duties and some individuals may eventually be placed off work if not progressing to normal duties.

### Recommendations:

1. Employers and employees are educated about the contribution that early return to work with modified duties can make to rehabilitation.

2. Return to function should be stressed as a key focus of the medical management of illness and injury.

3. Employers should be encouraged to provide injured or ill employees with modified duties where appropriate, to foster early return to the pre-injury work area and pre-injury work colleagues. This will allow for a supported return to normal duties.

## EMPLOYEES AND RTW

An individual's beliefs and expectations about return to work are major drivers of outcomes.

Employees who are confident about their situation and active participants in the return to work process are more likely to return to work. The single most reliable factor in predicting an individual's return to work is whether or not they believe that they will return to work.

However, confidence can be difficult to maintain in a system which can be de-personalising and alienating for the injured worker and their family. Workers can also struggle to negotiate the "balance of power" between themselves, their employer and the insurer, usually represented by the case manager.

Recognising and addressing these issues supports people back to work. Whilst treating practitioners often believe they have little chance of influencing the situation, evidence suggests they can. Advising the patient to return to work improves outcomes. Motivation can be influenced and an understanding of influencing factors is a sensible starting point.

The following have been shown to influence motivation to return to work:[27]

- Work systems — people are more motivated to work if they feel they can do as much work and as good a job as their workmates;
- Communication in the workplace;
- Work content — people have increased motivation to return to work if their job is meaningful and helps others;
- Relationships with workmates;
- A sense of belonging and being appreciated — a strong reason for wanting to return to work; and
- A bad relationship with a supervisor, and little communication and support are de-motivating factors for return to work.

Many of these issues can be addressed in the workplace.[28]

Employees who are fearful of re-injury and pain are less likely to return to activity, and have worse outcomes. There is consistent evidence that people fearful of their condition are more likely to keep searching for biomedical explanations, and have multiple investigations and treatment from which they do not gain much benefit. This results in frustration for the patient and the treater.[29]

Treating practitioners can increase a patient's fear through the advice given. Terms such as degenerate or ruptured disc can be interpreted as worrying problems. The advice to avoid heavy lifting may lead to the person with back pain avoiding activities, fearful they may do harm by taking on certain tasks. In turn this approach can have far reaching and unintended consequences for the individual.

Programs that reduce pain-related fear and encourage return to activity generally provide positive response. Advice and explanation that encourages the person to return to normal activities have been shown to result in better outcomes for a number of medical conditions.[30, 31]

Distressed patients require more advice and explanation. Spending time on advice and explanation is generally of more benefit than a focus on more investigations and treatment.

### Recommendations:

The development of policy and a public health campaign to address the barriers that prevent employees from returning to work.

Employees should:

1. Be encouraged to be active participants in return to work;
2. Be supported to understand they should not expect to be completely better or pain-free in order to successfully return to work, to either alternative duties or normal duties;
3. Follow up with relevant parties, such as the workplace and claims managers as appropriate;
4. Ensure they have sufficient information and understanding about their condition;
5. Write down relevant questions and/or request longer consultations to have time for discussion about relevant issues; and
6. Be provided with sufficient advice and explanation about their health condition to leave them confident about self management and what they are able to do.

## POLICY, SYSTEMS, LEGISLATION AND RTW

Traditionally, management of work injuries has been:

- Administrative;
- Adversarial; and
- Process driven.

Progress has been made across Australia in turning this management approach around. However durable return to work rates are falling in almost every Australian jurisdiction, indicating that there is still much to be done.

The key difficulty is, that where it should be fostering collaborative relationships between the key parties, the system tends instead to depersonalise and bureacratise interactions between:

- The worker and claims' staff at the insurer.
- The worker and their employer; and
- Health practitioners and the employer.

Additional difficulties may develop when non-medically trained professionals – for example lawyers and insurer representatives – misunderstand the work-relatedness of particular injuries and illnesses.

Misunderstandings of statutory interpretation and case precedent also create problems, especially when lawyers have a vested interest in advising an employer or worker.

Legislation has a huge impact on the return to work process. Schemes which, through common law or statutory entitlements, require injured workers to prove disability in order to achieve acknowledgement of having suffered a serious injury work against early return to work and good health outcomes.

These problems are all amenable to change. Stakeholders are frustrated and many seek ways of improving the system and contributing to better outcomes. In fact, we already know the way forward. Evidence indicates that a partnership approach to return to work produces better outcomes. Cutting edge systems focus on fostering the employee–employer and other relationships.

Insurer claims staff have a difficult job which requires them to deal with claims administration, people in difficult circumstances and a host of negative issues. Turnover of staff is high, and training and skill development are often neglected or suboptimal.

However, there are encouraging signs: systems that do provide training, foster a sense that claims staff are providing assistance to claimants, and recognise the challenges inherent in the role, have lower turnover and more positive claimant – claims manager relationships.

Treating practitioners can be assisted to promote safe and speedy return to work by:

a. The development of fee and communication structures that support treaters' communication with all parties, to allow adequate time for advice and explanation.

b. The provision of adequate medical training in return to work management at the undergraduate and postgraduate level. Policy makers can undertake this by allocating funds for course development and implementation, ensuring a range of course material is available, and encouraging consistency of training across different professional groups.

c. Increased support and encouragement for education leaders and high performing practitioners.

d. Assisting other stakeholders to understand the medical complexities of "work-relatedness".

Policy makers should be aware of the management approaches that yield the best results, and apply an evidence-based approach when developing legislation and systems. In particular:

- Research has shown that simple approaches can be highly cost effective. For example, interventions that provide high quality advice for people with back pain can substantially reduce work disability. Problem solving training for the person with an injury improves self-efficacy and outcomes. Early piloting of such interventions can be trialed and implemented more broadly where appropriate.

- Enhanced communication of research encourages early adoption of better practices.

Policy makers have the ability to influence treatment approaches. While there has been concern about the use of 'managed care', policy makers are in a position to foster best practice approaches, and encourage and expect quality medical care. The New Zealand system has integrated evidence-based care into their system and leads the world in developing systems that improve health outcomes by use of evidence-based care. Australian systems can learn from the New Zealand approach.

### Recommendations:

The systems and legislation around the management of workplace disability require substantial overhaul.

1. Legislative change should position a partnership approach between employer and employee as a fundamental component of return to work management.

2. Early coordinated care, with the employee's wellbeing as the prime focus, should be embedded within policy decisions and processes to improve medical care, reduce delays and improve return to work outcomes.

3. The use of evidence-based medicine and evidence-based policy making should become standard practice.

Policy makers should take the lead in use of evidence-based practice through their knowledge and use of up-to-date research. Policy makers should take the lead in ensuring employees have access to evidence-based medical care. This means that treatment options that have been demonstrated to return individuals to good levels of functioning should be standard practice.

4. Policy makers should report on health outcomes of employees. The social determinants of health are a major driver of long term health outcomes, and compensation systems are a determinant of health outcomes.

## DEALING WITH ABUSES OF THE SYSTEM

Some abuses of the system may not seem important, but all contribute to cynicism and suspicion. Claims managers and the dispute resolution system need to be fair but firm in ensuring that benefits received are appropriate.

Although good faith is the norm, employers, workers and treating practitioners have all been shown to use the system inappropriately sometimes.

For example:

- A worker might take sick leave to avoid dealing with a dispute with a colleague or an unpleasant job;
- A supervisor might fudge lost time injury (LTI) statistics, in order to meet his or her own key performance indicators (KPIs); and
- A doctor might provide a worker with pressing family responsibilities with a medical certificate that does not disclose the real reason for the required leave.

These small abuses of the system seem innocuous, but taken together can represent a serious problem. If enough minor abuse is observed, all claimants are treated with cynicism and suspicion, making recovery more difficult for genuine claimants. The situation is similar with transitional work programs: if these come to be seen as havens for unproductive workers, employers and workers are both likely to lose enthusiasm for them.

It is important the compensation system be used only for its intended purpose. Doctors and administrators need to be gentle but firm in ensuring that this occurs. A corollary to this requirement is that provision should be made, where possible and reasonable, for non-medical absence.

Some abuse is more serious, and may even constitute fraud. For example, an employee may falsely claim they have been injured in order to gain benefits, or an employer may pressure a worker not to report a work-related injury. When serious abuse occurs, the system needs to respond quickly and

clearly.

### Recommendations:

1. Reasonable non-medical absence should be part of a workplace system.
2. Doctors should not provide medical certification for non-medical absences.
3. The system response to serious abuse — by employers or employees — should be swift, clear and predictable.
4. Minor abuses of the system be taken seriously and addressed appropriately.

## DISPUTES

Disputes generally:

- Harden and polarise positions;
- Prolong needless disability; and
- Increase the likelihood of poor outcomes.

There will be circumstances where investigation and disputation is appropriate. However, in the majority of situations, questioning a previously trusted employee damages the employee–employer relationship. Trust and motivation are reduced.

Return to work often has a substantial discretionary component; this is positively influenced by relationships, trust and partnership, and negatively influence by disputes, delays and an adversarial approach.

Disputes result in a more difficult return to work, often with a more expensive claim.

Employers who consider they are unable to influence the outcome of a claim may resort to disputing the initial acceptance of a claim. This is less likely to occur in a system that deals with minor abuses of the system effectively.

### Recommendations:

Insurers and claims managers should:

1. Recognise that a coordinated approach produces improved return to work outcomes
2. Ensure delays are avoided

3. Pay claimants on time

4. Dispute a minority of claims and only when there is a substantive reason to do so.

Policy makers and those who deal with dispute resolution recognise the importance of their role in employers' and the community's trust of the system. Actions that may seem 'kind' or socially helpful for one individual can be seen as lenient and in turn damage respect for the system.

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Mary Osborn – Policy Unit RACP

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The Australasian Faculty of Occupational and Environmental Medicine, RACP
145 Macquarie Street
Sydney, New South Wales 2000, Australia
Tel +61 2 9256 5444, Fax +61 2 9256 9610
Email: afoem@@racp.edu.au
Website: http://www.racp.edu.au/page/policy-and-advocacy