

# Return to Work Guide

❖ A REFERENCE TOOL BY PRACTISING PHYSICIANS AND ACC

## HIGHLIGHTS

- PSYCHOSOCIAL ISSUES
- MILD TRAUMATIC BRAIN INJURY
- GRADUAL PROCESS INJURIES
- MANAGING CHRONIC PAIN
- ALCOHOL AND DRUG ISSUES
- MANAGING CHALLENGING BEHAVIOUR



# Contact details

Health professional general queries:

**Provider Helpline:**

**0800 222 070**

Claimant queries:

**Patient/Claimant Helpline:**

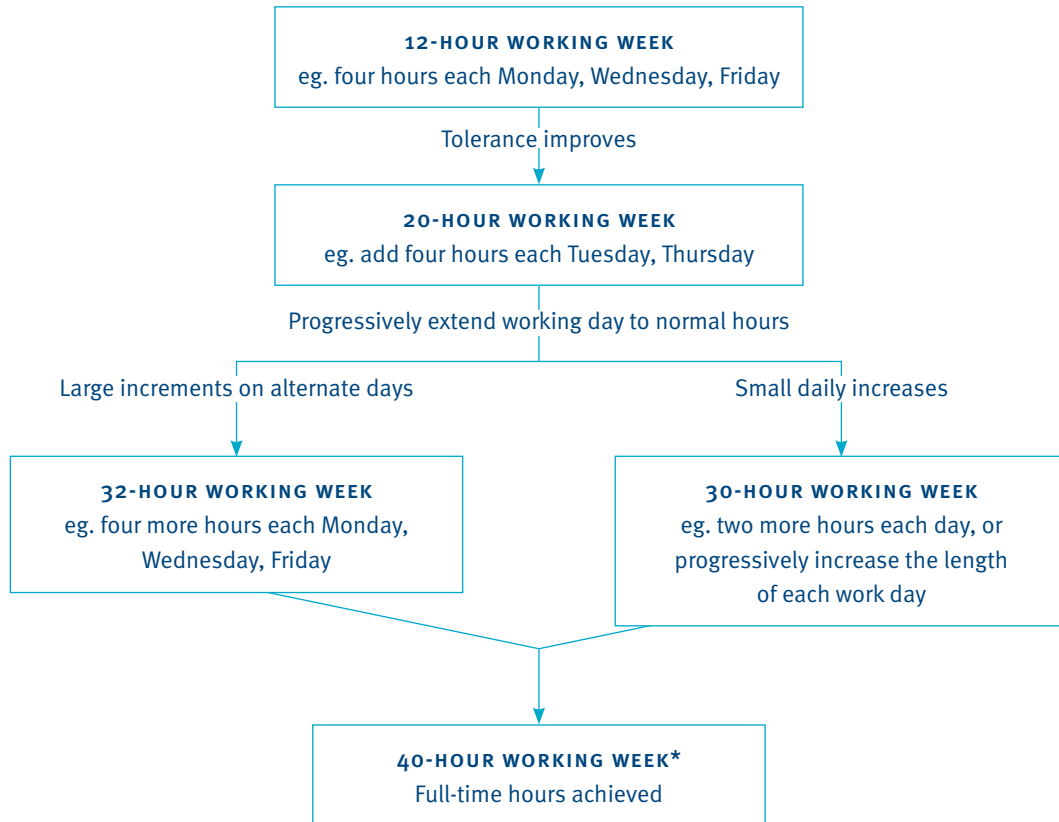
**0800 101 996**

## Useful ACC weblinks

The following information is available on [www.acc.co.nz](http://www.acc.co.nz) under:

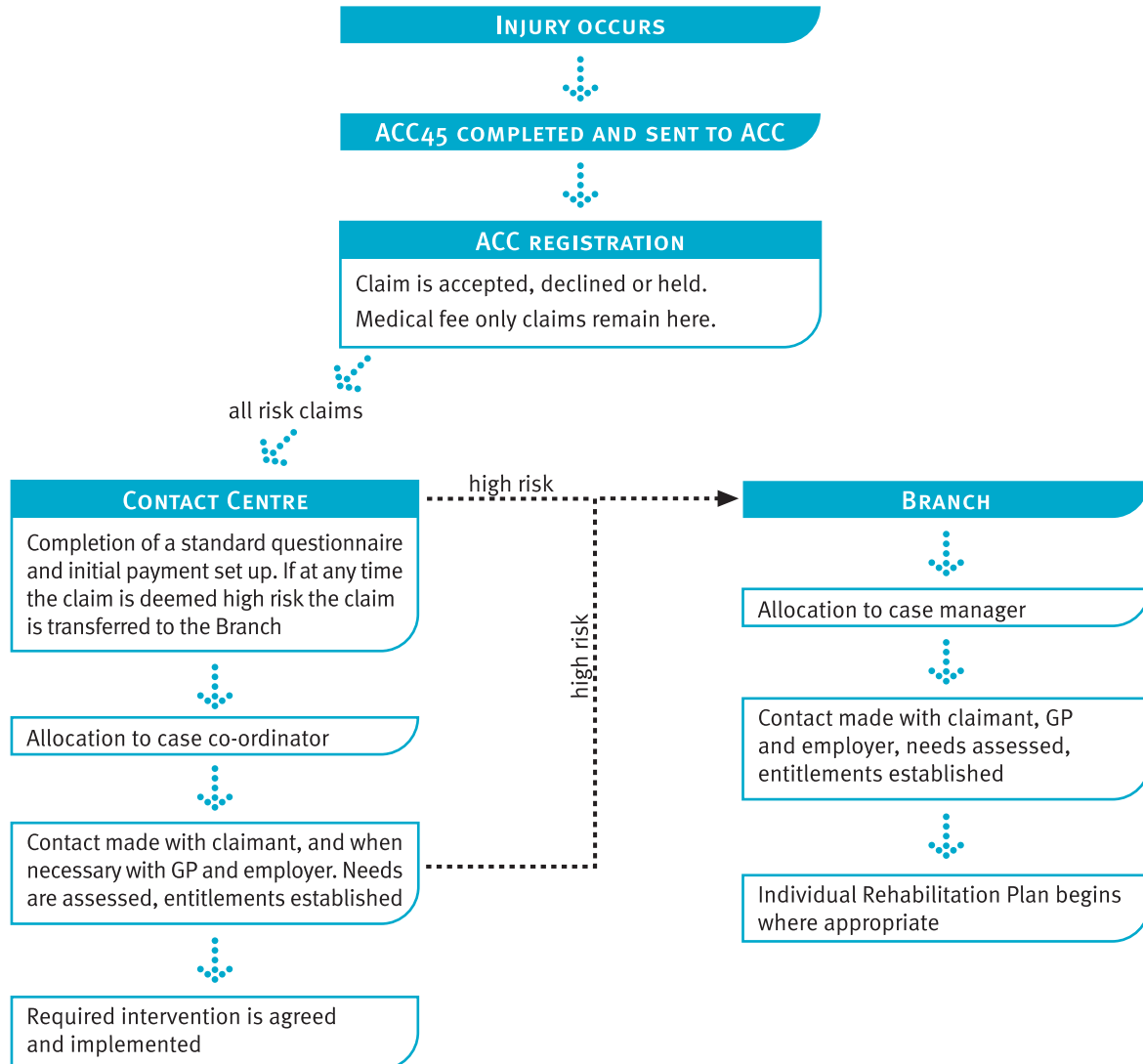
- For-providers/Resources:
  - Accredited employers search
  - Clinical guidelines
  - General practitioner resources
  - Read codes
  - Rehabilitation resources
  - Treatment Provider Handbook 2004/05
  - Work type detail sheets for occupational assessment
- For Providers/Health Services
  - Assessment services
  - Primary care services
  - Rehabilitation services
  - Specialist services

## A graduated return to work example



\*Note: The effects of a person's injury may be so severe that they can't return to full-time hours.

# ACC claims process



# Key factors for an effective return to work

- Early return to work:
  - is an integral part of the injury rehabilitation process
  - reduces the period of incapacity and economic loss, and assists rehabilitation.
- Assessing capacity
  - When first seeing your patient after injury, are they able to:
    - continue normal work hours and duties
    - return to work on suitable selected hours and duties.
- Certification
  - A fully completed ACC Injury Claim form or Medical Certificate (ACC45/18) helps ACC to help your patient.
  - The key elements to note are:
    - restrictions
    - duration
    - capacity ie. can your patient do any work (not necessarily their current job)
    - updated diagnosis/prognosis/capacity at each review.
- Consider a graduated early return to work plan to help your patient to return to work safely as they recover. The activity and psychosocial benefits result in a faster, more durable recovery.
- Psychosocial factors may be a barrier to rehabilitation. These can be unrelated to the present injury.
- ACC has a range of options to help your patient recover more quickly. This includes workplace assessments, vocational equipment, transport assistance, and rehabilitation programmes. A case manager/co-ordinator can discuss suitable options with you.

# Degree of work definitions

## Reference tools for describing work capacity

These are the work definitions used on the ACC Injury Claim Form (ACC45) and the ACC Medical Certificate (ACC18).

### DEGREE OF WORK DEFINITIONS

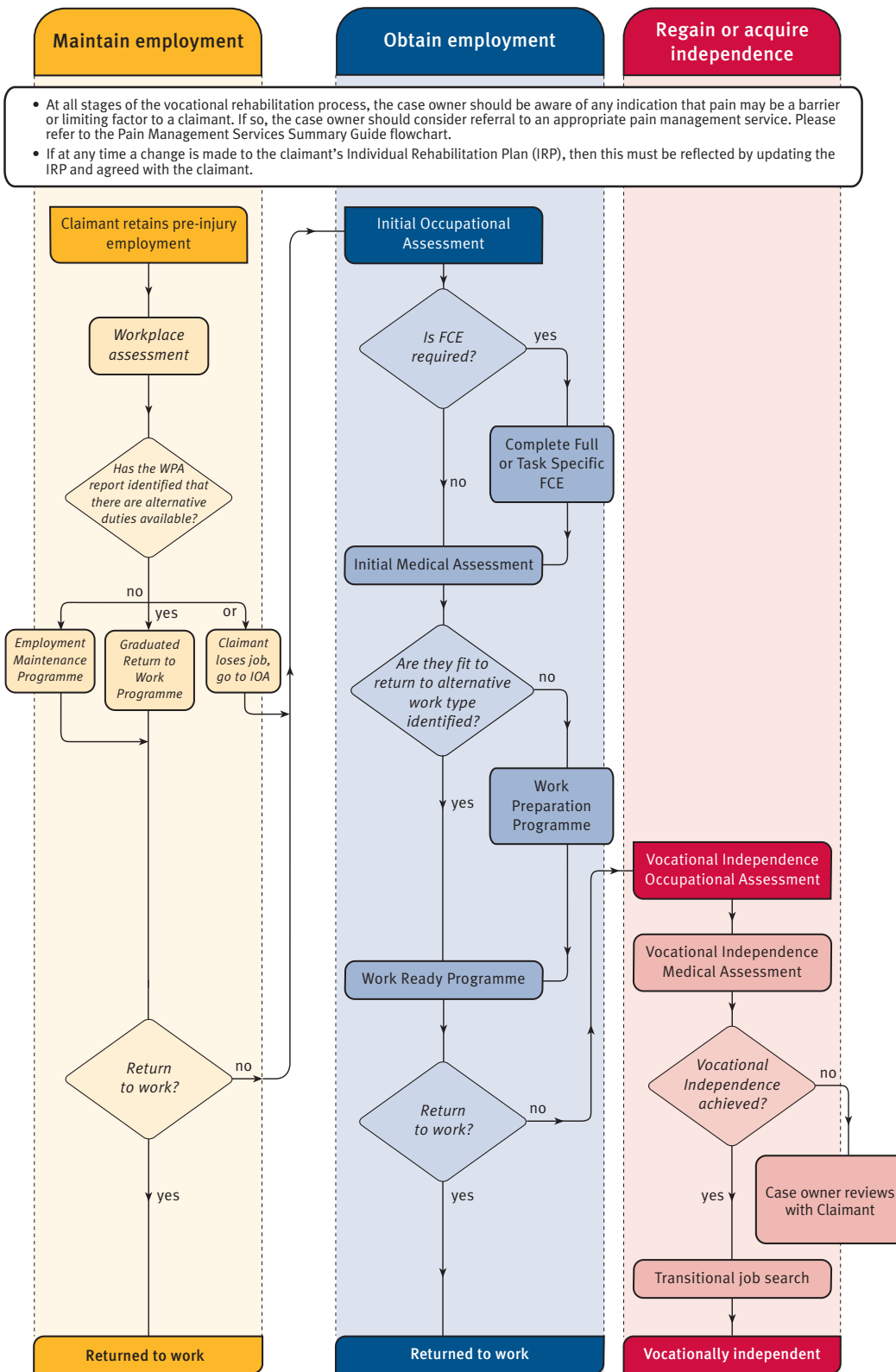
WORK TYPE	DEFINITION
Sedentary	Exerting up to 4.5kg of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull, or otherwise move objects, including the human body.  Involves sitting most of the time, but may involve walking or standing for brief periods of time.
Light	Exerting up to 9kg of force occasionally and/or up to 4.5kg of force frequently, and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for sedentary work.  Usually requires walking or standing to a significant degree. However, if the use of any arm and/or leg controls requires exertion of forces greater than that for sedentary work and the worker sits most of the time, the job is rated light work.
Medium	Exerting up to 22.5kg of force occasionally, and/or up to 9kg of force frequently, and/or up to 4.5kg of force constantly to move objects.
Heavy	Exerting up to 45kg of force occasionally, and/or in excess of 22.5kg of force frequently, and/or up to 9kg of force constantly to move objects.
Very heavy	Exerting in excess of 45kg of force occasionally, and/or in excess of 22.5kg of force frequently, and/or in excess of 9kg of force constantly to move objects.

(US Department of Labor classification)

### FREQUENCY SCALE

FREQUENCY	% OF AN EIGHT-HOUR DAY	EXAMPLE
Occasional	0–33	One lift every 30 minutes
Frequent	34–66	One lift every 2 minutes
Constant	67–100	One lift every 15 seconds

# Claimant Participation in Vocational Rehabilitation



- At all stages of the vocational rehabilitation process, the case owner should be aware of any indication that pain may be a barrier or limiting factor to a claimant. If so, the case owner should consider referral to an appropriate pain management service. Please refer to the Pain Management Services Summary Guide flowchart.
- If at any time a change is made to the claimant's Individual Rehabilitation Plan (IRP), then this must be reflected by updating the IRP and agreed with the claimant.

If at any time during the Maintain Employment phase the claimant loses their job or a 'red flag' appears, refer them to IOA.

This flowchart is a guideline only. To find information on each specific service, please go to: <http://staff/staff/informe/f-entitlements-rehabilitation-treatment/rehabilitation/vocational-rehabilitation/entitlements/>



# Welcome to the Return to Work Guide.

Designed especially for general practitioners (GPs), the Return to Work Guide recognises your unique ability to support your patients by providing early, positive return to work and rehabilitation messages, and assist them to get the best use out of the assistance that ACC can offer them.

Much of the Guide has been written by practising GPs and occupational medicine specialists.

It provides you with best practice information and practical help for managing the effective rehabilitation of injured employees. In particular, it focuses on issues of return to work arrangements and decisions, and reflects the increasing evidence of the benefits of getting injured people back to an active life. If possible and appropriate to then assist them to stay in the workforce on duties during their recovery.

The Guide covers the range of situations arising in everyday general practice, identifying both representative scenarios and less common, but potentially more difficult, cases. It outlines and discusses real situations, options and decision points, and provides information about ways in which ACC can help.

If you have any questions or would like more information (on specific aspects of the Guide or on ACC's services more generally), please contact us. The phone numbers are on the inside of the front cover.

We hope that you find this Guide useful in your daily practice.

Gerard McGreevy  
**Chief Operating Officer**  
**Accident Compensation Corporation**

# Contributors

This Guide is the result of a co-operative effort by a number of medical practitioners who contributed by writing individual chapters (in some cases more than one) and provided valuable feedback on the contributions of their peers. Without their expertise the Guide would not have been possible and we thank them all.

We are especially grateful to Dr Robin Griffiths for his ongoing sound advice and clinical oversight. His wide experience, willingness to respond to our questions at short notice, and unfailing good humour have been invaluable.

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# Benefits of Early Return to Work

## COMPARATIVE CASE STUDIES

### Peter – with return to work support

*Peter, a middle-aged man, works for a tyre company and has been off work for three weeks with acute low back pain and sciatica.*

*Peter's pain makes it difficult for him to work full time, so his employer agrees to a graduated return to work programme, modifying Peter's tasks until he can resume his pre-injury duties. Peter does alternative work for limited periods each day, with his employer paying for his hours at work and ACC contributing 'make up' pay (a proportion of Peter's remaining baseline pay).*

*Four weeks after the injury, Peter returns to his GP for additional pain relief – to help him through the increased pain he's experiencing from prolonged sitting and periods of standing. His GP recommends a regular analgesic regimen and a short-term change from NSAIDs; he also advises care with lifting for a few weeks. At 10 weeks, Peter is fully mobile and his remaining niggles aren't interfering with his work or recreation.*

### Paul – with no return to work support

*Paul, who's the same age as Peter, is a shelf stacker at a supermarket. He has an uncomplicated acute myocardial infarction at the same time that Peter suffers his injury. Paul returns to the surgery at four weeks. He reports some initial exertional chest pain and, while responding well to medication, said he has noticed some slowing down since his heart attack.*

*Paul says he feels "worn out all the time", is anxious that "doing too much" is dangerous for his heart, and has put on quite a lot of weight since being at home. His wife says he isn't sleeping, is "drinking a bit" and is "weepy". Paul's employer doesn't want him to return to work unless he is fully fit and says they "don't do light duties".*

*Although the GP believes Paul should be returning to work soon, he acquiesces to Paul's request for a certificate for another month off work. When he sees Paul one month later, he has been laid off and is applying for a Work and Income benefit.*

*Six months later, Paul comes in for a sickness benefit check-up and the GP finds him to be bloated, miserable and unmotivated. Although applying for lots of jobs, he hasn't had one interview. Paul has lost his self-esteem and self-confidence, and is now clinically depressed. The GP's heart sinks as Paul and his wife leave the room, knowing that he will be seeing a lot more of them over the next few years...*

## Introduction

GPs who assess and treat people with accidental injuries are often asked to provide them with a medical certificate authorising time off work.

Some GPs and patients mistakenly believe that rest and reduced activity (including time off work) will accelerate or help recovery – largely because of an historical and incorrect concept that extended bed rest and/or immobilisation helps to heal injuries, relieve pain, and recover patient function. However, evidence now clearly indicates that prolonged rest may be harmful<sup>1</sup> – that it not only delays recovery and increases the risk of chronic pain, but increases the risk of adverse complications from prolonged inactivity.

Many people also believe that work and workplaces are dangerous for people who are temporarily impaired. But there is evidence that the contrary is true: it is healthier to be at work than at home when recovering from the effects of injury.

Ideally, injured workers should remain in their pre-injury roles or return to them as soon as possible. A prolonged period of incapacity may cause them to lose their jobs, making it more difficult to re-enter the workforce. Some people will need to readjust to work with a permanent impairment, while others may suffer such severe effects from their injuries that they can't return to work at all. However, where injuries are minor and self-limiting, the effects of unemployment are likely to far outweigh the effects of the injuries themselves.

In addition, the longer someone is off work, the less likely they are to return. Research indicates that a person who doesn't return to work for six months has only a 50% chance of ever returning. After a year they have a 10% to 25% likelihood of returning to work.<sup>2,3,4</sup>

Patients (and their employers) are often unfamiliar with the benefits of early rehabilitation and the concepts of graduated return to work. This can make it difficult and time consuming for you to educate your injured patients, especially if they believe the work or workplace was implicated in their initial injury and incapacity.

However, you can make a real and important contribution to improving your patients' lives and sense of personal fulfilment by taking the time during early consultations to provide accurate information about – and actively encourage – early return to work. 'It's healthy to work' is a good message.

Research shows that GPs differ widely in the way they certify work incapacity and apply evidence-based guideline recommendations – yet by aligning your incapacity certification practices with recognised best practice, you can significantly improve injured workers' rehabilitation outcomes. The risk of exacerbating symptoms from a premature return to work is far outweighed by the major benefits of getting patients back into their usual environment, including work, even if the work is modified to meet their specific needs.

This chapter examines the benefits of early return to work for those with mild to moderate injuries – and the adverse consequences of unemployment where a return to work is not managed effectively.

## Benefits of early return to work

An early return to work provides a number of benefits, including:

- reduced periods of incapacity
- minimised economic loss
- treatment and rehabilitation benefits
- improved access to treatment and rehabilitation
- additional support networks
- job retention
- prevention of the adverse consequences of unemployment.

### Reduced periods of incapacity

Most disabilities after accidental injury are temporary, with the patient's condition improving rapidly with time.

- Injured people should remain at work where possible, or return to work as soon as they are able to work in some capacity.
- It's not necessary that they recover fully their functional work capacity before going back to work. Many people with permanent disabilities or changed functions contribute positively to the workplace.
- Safe and suitable duties can usually be found to accommodate injured people's needs.
- Modified hours and/or alternative duties may allow injured people to return to work in a temporary, limited capacity.

It's important to focus on the work the injured person can do (rather than on work they can't do) – detailing what can be done may help their employer to consider opportunities for modified/alternative work and motivate them to make such modifications. The best duration of certificated unfitness for work is the day the injury was sustained, and the best way of avoiding the need for a return to work programme is for your patient to remain at work, with support if necessary.

Reducing an injured worker's period of incapacity can help to maintain their:

- physical conditioning and activity
- motivation
- work habits and daily routines
- self-esteem
- security
- identity ie. social status as a worker
- workplace social relationships
- psychological well-being and mental health.

Prolonged incapacity can place them at risk of psychosocial harm.

- They may become depressed, anxious, and frustrated as much from delays in rehabilitation as from the actual injury.
- Physical activity often declines, which may lead to energy loss and increased time spent in bed and watching TV.
- They may take up (or increase) drinking or drug-taking to relieve stress and monotony.
- Boredom itself may impair their mental health and well-being.
- Relationship issues can also arise if their domestic life is disrupted and they are unhappy.

Injured workers are also at risk of adopting an invalid's role. To prevent their being socialised into disability, it's important to re-establish as quickly as possible the habits associated with working, and workplace social relationships. Injured workers can rapidly develop a lack of motivation to work, resulting in a reluctance to return to work and a disengagement from the social aspects of work.

### **Minimised economic loss**

Injured workers may be entitled to ACC weekly compensation, but this is only a proportion of their baseline weekly pay. There is also a cap on the weekly compensation amount, so those on higher incomes will receive a lower proportion of their baseline weekly income than those below the cap. This may mean considerable economic loss and anxiety.

Injured workers who return to work on reduced hours (and who are entitled to ACC compensation) will get a proportion of their remaining baseline weekly pay as weekly compensation. They are likely to have more money in the hand than if they were only on ACC weekly compensation.

### **Treatment and rehabilitation benefits**

It's important that injured people get appropriate intervention at the right time. This should be based on an accurate early assessment and monitoring to ensure they are progressing as expected.

In most cases, an early return to work (before the person is fully recovered) is an essential part of treatment and rehabilitation. It:

- promotes their physical activity
- improves their functional capacity
- reduces their risk of chronic pain and psychosocial issues
- reduces their recovery time
- improves their long-term rehabilitation outcomes
- helps maintain their normal lifestyle.

A number of studies support the hypothesis that early treatment and rehabilitation will improve long-term outcomes,<sup>5,6,7,8,9,10,11,12,13</sup> especially among young workers.

### **Improved access to treatment and rehabilitation**

Some larger organisations offer injured workers access to workplace-based treatment and rehabilitation services such as:

- doctors
- nurses
- physiotherapists
- gymnasiums and exercise therapists
- occupational therapists.

All employers can help in arranging workplace assessments and modifying their workplaces to enhance their employees' rehabilitation and recovery.<sup>14,15,16</sup>

### **Additional support networks**

Injured people can gain many psychosocial benefits from an early return to work. For example:

- they tend to enjoy enhanced relationships with, and support from, their employers and work colleagues
- their employers are more likely to provide graduated return to work programmes
- their employers are more likely to become involved in modifying work tasks or re-organising work if this is seen as an effective way to accelerate recovery.

### **Job retention**

The loss of a job, either paid or unpaid, has a crucial effect on a person's participation in society.

In most injury cases, any incapacity for work is temporary and partial. However, temporary incapacity can rapidly lead to unemployment, then unemployability, if the injured worker loses their pre-injury job. Any avoidable unemployment – among people with little or no residual disability – is a personal, family and societal loss. You can help avoid this by considering rehabilitation while your patient remains at work or, where this isn't possible, including early return to work in your clinical management programme.

After about three weeks of employees having certificated incapacity for work, their employers become increasingly reluctant to keep their jobs open for them. They are especially likely to lay off injured staff when:

- their injuries are non-work-related
- they are perceived as a 'poor fit' with the business
- their initial certificate is for an extended period
- there is poor communication between the GP and the employer
- the likelihood of a return to the pre-injury job is seen as limited.

The risk of job loss increases when GPs indicate a lengthy period of incapacity – either to the injured worker via a medical certificate or directly to the employer.

Being off work longer than is necessary may not only damage the injured person's relationship with their employer; it could also cause adverse health effects through anxiety about job loss. Studies on job insecurity and downsizing indicate that people whose employment is under threat or review experience significant health problems, such as mental stress, increased cholesterol, and sleep disturbances.

### **Prevention of the adverse consequences of unemployment**

A person's employment status has been linked to their sense of well-being and their view of their own health status.<sup>17</sup>

Scientific studies have highlighted the effects of unemployment on health. However, most specifically exclude people who can't work because of illness or injury. Many people who become unemployed after temporary



incapacity become needlessly, and permanently, unemployable. The effects of unemployment on health far outweigh the effects of health on employment.

The adverse consequences of unemployment include:

- mental health effects:
  - Loss of the psychosocial benefits of working, such as wealth, security, identity, satisfaction, and self-esteem. This causes a 33% increase in symptoms of psychological disorders, such as hopelessness, low self-esteem, anxiety, and depression.
  - Increased suicide and parasuicide rates, at least in males.
  - Crime, violence, abuse, and relationship breakdowns.
- physical health effects:
  - The risk of dying doubles owing to increased chronic stress, compounded by the increased use of tobacco, alcohol, and drugs.
  - The relative risk of developing ischaemic heart disease increases two-fold. The longer workers have been unemployed, the greater the risk.
  - There are similar increases in the risk of stroke, respiratory disease, liver disease, and cancer.
  - Increased use of health services in general.
- economic health effects. Many studies of the long-term unemployed point to:
  - poverty
  - malnutrition
  - restricted access to motor vehicles
  - reduced social participation.

People whose inability to find work is no longer related to their physical incapacity are likely to have their income support transferred from ACC weekly compensation to the (lower-paid) unemployment or sickness benefit. A survey of ACC claimants who worked before their injury, but were out of work at least three months after their weekly compensation stopped, showed that 92% were earning less than at the time of their injury.<sup>18</sup>

#### CASE STUDIES *CONTINUED...*

*So how long should Peter have been off work? Three weeks was probably too long before being offered alternative work. Acute low back pain (ALBP) without red flags can be hard to assess, because the only indicators of its acuity are the reported pain severity and extent (especially sciatica) and the degree of reduced mobility.*

*Guidelines can help – the New Zealand Acute Low Back Pain Guide advises to expect improvement in one to four weeks, reviewing weekly until the patient has recovered. The Medical Disability Adviser (MDA)<sup>19</sup> suggests that patients with sedentary jobs return to work within three days and, if doing very heavy manual work, they return within four weeks. If less demanding alternative work is available, the duration of time off work (if required) may be less than one week.*

*However, while the MDA offers these timeframes, it is important to note that the 85% of people with an episode of ALBP who had no time off work aren't included in its statistics. Advise return to work in the time frames that appear reasonable, at the earliest opportunity.*

## Summary

*Injured workers gain numerous benefits from returning to work early or staying at work while they recover. In addition to reducing the period of incapacity, this can reduce economic loss and stress and provide treatment and rehabilitation benefits.*

*You can play an important role by encouraging your patients to return to work early, before they fully recover. As a treatment and rehabilitation tool, this can lead to reduced recovery times and successful long-term rehabilitation outcomes.*

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# Graduated Return to Work

## CASE STUDY

*Tom, aged 37, was in his car and stopped at a pedestrian crossing when another vehicle hit his car from behind. He suffered a moderate strain of the neck, shoulders and lower back, was treated with physiotherapy twice a week, and started a rehabilitation exercise programme under the supervision of his physiotherapist. His GP prescribed analgesics.*

*Tom is employed as an automotive mechanic. The key physical demands of his job are lifting tools and equipment, bending and reaching to work on motors, and twisting and turning, sometimes in confined spaces.*

*His GP and physiotherapist expect Tom to return to work about four to six weeks after the injury. However, at one month post-accident he still has reduced range of motion and strength in his upper body, and back pain with lifting. Tom's employer is reluctant to allow him to return to work until he's completely recovered and can do all his usual duties.*

*Tom is referred to an occupational therapist, who visits the workplace and meets Tom, his employer and the case manager. She explains the importance of an early return to work and suggests a graduated return to work plan. The employer agrees and, according to the plan:*

- *Tom works half-time for the first two weeks, then progressively more hours over the following six weeks until he is working full time*
- *a colleague does any lifting for the first two weeks, after which Tom gradually resumes the work*
- *for that same first two weeks, the employer avoids allocating Tom work that requires bending or stretching for long periods*
- *Tom takes breaks at regular intervals and, when required, does back exercises. It is explained to him that, although he may feel some discomfort to begin with, it is not harmful and will diminish in time.*

*The programme suits Tom well. By returning gradually to appropriate work, with his employer's support, his workplace re-entry is faster and safer than if he'd stayed home until he could return to normal duties full time.*

## Introduction

A graduated early return to work is a useful rehabilitation therapy tool. It enables injured workers to return safely to work before they have recovered fully. They can do modified or alternative work on a temporary basis and gradually resume their original job. The benefit is not only from the managed activity, but also at a psychosocial level, resulting in a faster and more durable recovery.

Many employers favour a graduated return to work because their injured employees return to work sooner, which reduces absence durations and translates into lower costs.<sup>1</sup> For this reason, most employers are willing to accommodate workers with restrictions.

## Determining work capacity

At your patient's initial presentation it is important to assess their capacity for work. Are they able to:

- *continue normal work hours and duties*
- *return to work on suitable selected duties and/or hours?*

Note that indicating your patient is fit for these duties doesn't mean their weekly compensation will cease.

Or, should they:

- *be certified as fully unfit for all types of duties, or altered hours.* This means that your patient can't do any light or sedentary duties. It is usually appropriate for the immediate post-acute period of musculoskeletal injuries or severe injury cases.

It is best for your patient to continue with their normal job, or return to their workplace on suitable selected duties as soon as possible.

In determining whether a patient is ready to return to work – and whether they are capable of meeting the functional demands of their job<sup>2,3,4,5</sup> – you need to:

- make an accurate diagnosis
- determine their current physical abilities accurately
- understand the tasks and requirements of their job and available modified or alternative duties.

It may be impractical for you to inspect your patient's workplace or obtain a functional job description, so there are several options available:

- contact their employer to discuss temporary suitable selected duties, including those that need doing 'when someone gets around to it'
- contact the ACC case manager for help with things like workplace assessments and return to work planning
- give your patient a 'Work Task Overview' form to take to their employer to complete and return to you (see Appendix 5 for a template of this form). Please let the case manager know you have this information
- review the 'Work Type Detail Sheets' [www.acc.co.nz/for-providers/resources](http://www.acc.co.nz/for-providers/resources). However, note that while these sheets provide basic information about job types, they don't allow for the environments in which the jobs are done
- discuss a referral to our Employer Injury Management team with either the case manager or your provider relationship manager, especially if you have several patients who work for the same employer. The team's role is to build employer capability to manage return to work. This includes helping employers to gather information about the demands of the jobs in their workplaces.

If you need to determine your patient's capacity for work but there's no information available about their job, base your decision around their current function. You could use the work definitions on page 17.

## Temporary suitable selected duties

The temporary suitable or selected duties available for injured workers will depend on factors such as:

- the type of injury
- their medical and functional capacity
- the education or skill levels
- their pre-injury duties
- their access to the workplace and work areas
- work organisational factors and/or task scheduling eg. they may work on a factory line with time-bound tasks
- the support networks available in the workplace
- available training.

There are three types of temporary suitable selected duties:

1. Normal duties – pre-injury duties that the injured worker still has the capacity to perform.
2. Modified duties – duties that have had components removed or included to match the person's capacity.

3. Alternative duties – duties that allow the person to remain at work, or return to work. They are usually different from their pre-injury duties.

In considering temporary suitable selected duties, it's important to remember that:

- the worker must understand and take an active part in their rehabilitation management
- the duties must be safe and supported, with special training provided where required
- where practicable, the duties should be productive and add value to the business.

For example, a trained nurse suffering from low back sprain should be offered work that acknowledges their skills, such as reviewing or revising manuals, postgraduate study, or other non-clinical work.

In many cases, injured experienced workers are employed in providing extra training for other staff.

Wherever possible, the goal is to manage a return to pre-injury work duties and hours. The table below shows the options for temporary suitable selected duties, starting with the best case scenario.

**TEMPORARY SUITABLE SELECTED DUTY OPTIONS (IN RANK ORDER)**

	TYPE OF DUTIES	JOB AREA	JOB HOURS
1.	Modified pre-injury	Usual pre-injury	Usual pre-injury
2.	Alternative		
3.	Modified	Different	
4.	Alternative		
5.	Modified or alternative	Usual pre-injury	Reduced hours
6.	Modified or alternative	Different	

If you know about the employer's available options, you can match the worker's condition and functional limitations to the duties offered.

In deciding on their work options, it's important to remember that hours spent at work tend to be more tiring than at home owing to:

- energy expended on travel
- movement around the workplace
- interaction with other people
- the physical and mental demands of the job.

A useful rule of thumb a person returning to work will be able to manage about 75% of what they think is possible.

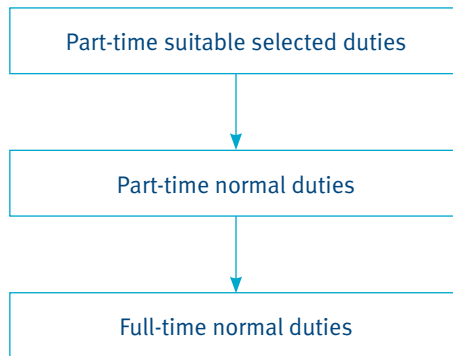
Try to return your patient to a full day of modified or alternative duties as soon as possible. If they need part-time work, it should be time limited to give them a goal.

## A graduated return to work

### Who does it suit?

A graduated return to work programme will suit injured workers who are fit for selected/suitable duties – that is, they have a capacity to complete some type of work, but can't return immediately to their full pre-injury jobs.

If the worker has a long-term or serious injury, they may need to progress in managed stages:



The aim is to build their duties gradually, within a realistic timeframe, without aggravating their condition.

You could also intersperse normal work duties that are within the workers' capacity with the alternative selected duties.

### Excluding some activities

The purpose of temporary suitable selected duties is to exclude activities that are likely to:

- delay the person's recovery
- make their injury worse
- endanger them or other people.

You could advise the injured worker to avoid certain physical and mental activities, such as:

- physical – heavy work (see the degree of work definitions opposite)
  - lifting eg. more than 5kg above shoulder height
  - constant repetitive tasks (see the frequency scale opposite)
  - dynamic bending and twisting.
- mental – unfamiliar tasks
  - dealing with difficult customers
  - high work pressure situations eg. tight deadlines
  - high-productivity outputs.

If your patient needs to avoid certain duties for a period of time, record this information on the medical certificate (ACC18 or ACC45).

This will help to keep ACC and the employer informed, and will provide a useful guide when determining task options for a return to work.

The employer may be able to 'lighten' the job by selecting discretionary tasks, prioritising activities to match variations in work capacity, or providing simple tools such as lifting aids to reduce strain for the injured person.



## Reference tools for describing work capacity

### DEGREE OF WORK DEFINITIONS<sup>6</sup>

WORK TYPE	DEFINITION
Sedentary	Exerting up to 4.5kg of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull, or otherwise move objects, including the human body.  Involves sitting most of the time, but may involve walking or standing for brief periods of time.
Light	Exerting up to 9kg of force occasionally and/or up to 4.5kg of force frequently, and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for sedentary work.  Usually requires walking or standing to a significant degree. However, if the use of any arm and/or leg controls requires exertion of forces greater than that for sedentary work and the worker sits most of the time, the job is rated light work.
Medium	Exerting up to 22.5kg of force occasionally, and/or up to 9kg of force frequently, and/or up to 4.5kg of force constantly to move objects.
Heavy	Exerting up to 45kg of force occasionally, and/or in excess of 22.5kg of force frequently, and/or up to 9kg of force constantly to move objects.
Very heavy	Exerting in excess of 45kg of force occasionally, and/or in excess of 22.5kg of force frequently, and/or in excess of 9kg of force constantly to move objects.

(US Department of Labor classification)

### FREQUENCY SCALE<sup>6</sup>

FREQUENCY	% OF AN EIGHT-HOUR DAY	EXAMPLE
Occasional	0–33	One lift every 30 minutes
Frequent	34–66	One lift every 2 minutes
Constant	67–100	One lift every 15 seconds

## Devising the programme

In devising a graduated return to work programme, it's important to set rehabilitation goals and maintain a schedule. It can be prepared by:

- you
- the ACC case manager
- an occupational rehabilitation provider (eg. occupational therapist through a Graduated Return to Work or Employment Maintenance Programme)
- a suitably qualified employer representative eg. an organisation's medical advisor, occupational health nurse, or occupational rehabilitation expert
- a combination of the above.

It may be appropriate to ask an occupational health nurse or occupational therapist to devise the programme. In other cases, common sense will dictate how much the injured worker does and how often. If several parties are involved, a case conference may be the most efficient way to plan the rehabilitation schedule and get agreement from everyone. An ACC case manager can co-ordinate the work by liaising between you, the employer, the injured worker and other key parties.

Defining the duration of any work-shortening or selected duties (rather than leaving it open ended) will be less stressful on the employer and work colleagues. With this information, they'll be more likely to manage in the worker's absence or help out with duties the worker can't do.

### **Principles of graduated return to work plans/programmes**

All graduated return to work plans or programmes must:

- be time bound
- be goal oriented
- have clear accountabilities
- engage all those involved in the return to work process
- be monitored regularly
- be reviewed regularly
- be based on medical capacity.

If you think your patient would benefit from a plan, contact the ACC case manager to discuss the options.

Here are some examples of approaches to planning. (See Appendix 3 for a return to work plan template.)

#### ***Example A: A set number of hours a day***

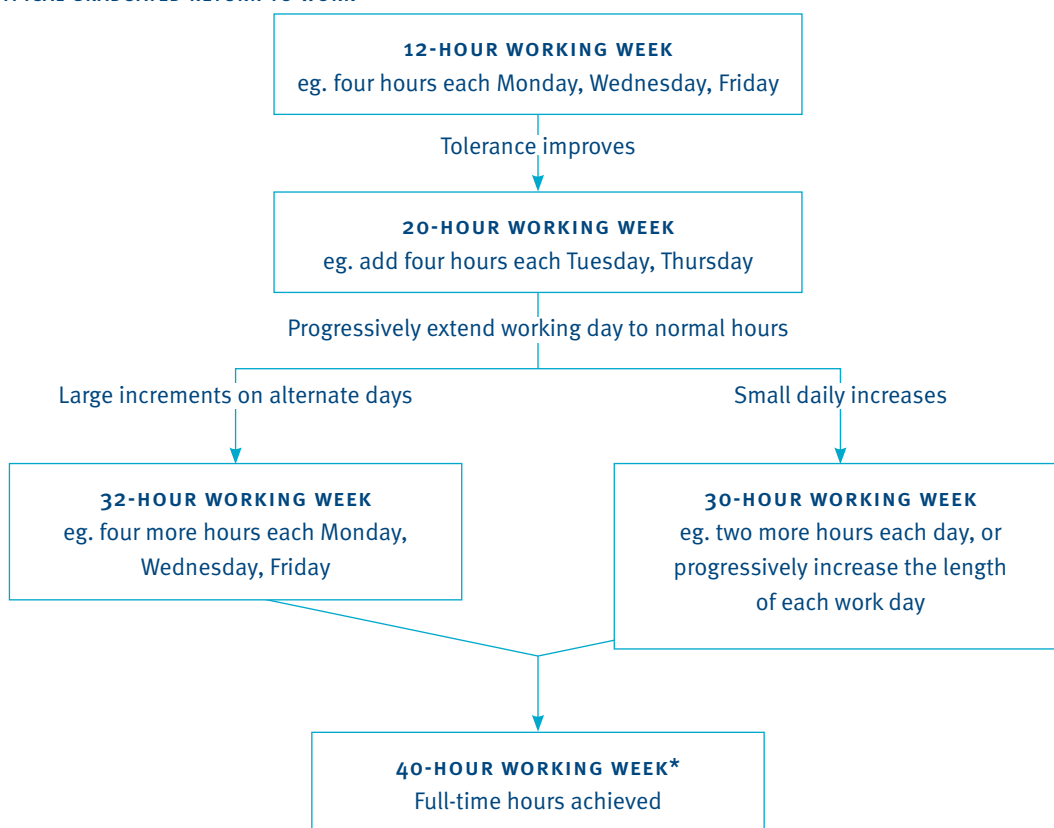
The programme starts with:

- a number of working hours per week in a pattern that allows for resting eg. three mornings only
- as tolerance improves, extra half days
- progressive extension of the working day to normal hours via:
  - larger increments on alternate days
  - a small increase each day.

It's a good idea to build into the plan breaks for rest and fitness activities (such as going to the gym) that can eventually be moved into the worker's own time, or discontinued altogether.

A variety of work duties can be done, including normal duties.

#### A TYPICAL GRADUATED RETURN TO WORK



\*Note: The effects of a person's injury may be so severe that they can't return to full-time hours.

Shorter working hours can help injured workers because they:

- help them to avoid muscle fatigue, rush-hour traffic, and other energy demands
- signal to their organisations that they have not yet fully recovered
- encourage others (in both work- and non-work-related situations) to continue helping out
- ensure the workers have ongoing contact with the workplace.

#### **Example B: A set number of hours a week**

It may not be practicable to establish a rigid timetable for each day, for example, because of:

- variability in the worker's symptoms eg. people recovering from traumatic brain injury may experience fluctuations in energy levels and attentiveness that make it hard to conform to a work routine
- the nature of the work: some jobs don't lend themselves to regular shortened-hours routines, such as those with periods of intensive activity to meet deadlines, interspersed with quiet spells.

In such situations, introduce 'x hours a week' (rather than 'y hours a day') to allow for more work on your patient's better days or when more work is available, within an overall target. Selecting discretionary tasks and prioritising work will help to match variations in work capacity.

If the employer isn't sure if they can accommodate your patient's needs, we may be able to advise them of potential options.

#### **Injury-source activities**

If your patient's injury was caused by normal duties, they should be gradually reintroduced to those duties by work hardening or work conditioning.

For example, a graduated return to work programme for a person with an occupational overuse condition whose job involves almost constant typing could comprise:

WEEK	MINUTES OF TYPING PER HOUR
1	15
2	20
3	30
4	40 etc.

It's a good idea to:

- incorporate work breaks that decrease progressively in length and frequency
- ensure that the duties undertaken between injury-source activities use either different muscles or the same muscle group in different ways.

Note that even when the worker has recovered, it may be unwise to reintroduce the same set of circumstances that caused the injury.

#### ***Non-injury-source activities***

Some activities that are not the source of the injury may cause discomfort and have to be curtailed or managed for a time. For example, back pain caused by heavy lifting may be aggravated by sitting at a desk for prolonged periods.

Recommend simple measures to reduce strain on the injured part, such as providing lifting aids or alternating sitting with standing. Consider also the tasks the worker is undertaking at home, as these may also need managing – in such cases, the worker may qualify for home help.

#### ***Monitoring progress***

Having an appropriately qualified person supervise and monitor key symptoms throughout the rehabilitation period helps to:

- provide an accurate picture of the worker's progress
- alert the supervisor to change
- produce the best possible results.

A person's recovery from an injury can be unpredictable. Some workers try to do too much too soon and hurt themselves through over-activity, while others fearful of pain or re-injury progress too slowly.

If problems arise, the programme may need suspending or adjusting until it's safe to continue. Your focus should be on easing the duties rather than the hours at work, until the person is ready to move on. As long as they feel able to report any deterioration in symptoms, harm is unlikely to result.

## **Summary**

- *A graduated or transitional return to work is a useful rehabilitation therapy tool to enhance an injured worker's recovery.*
- *It is appropriate for those who can return to work gradually, within a realistic timeframe, without aggravating their conditions. Discuss duty options with the person's employer and set a plan for them to start with x hours a day – or, if not practicable, y hours a week.*
- *Gradually build up both the type of duties performed and the hours worked until the person achieves the goal of pre-injury full-time work, where possible.*

- *Keep relevant parties informed to help ease the person's transition back to the workplace.*
- *Monitor progress for symptom changes and, if required, adjust the programme until the worker recovers successfully.*

## How ACC can help

### Graduated Return To Work Programme

A Graduated Return to Work Programme can help an injured worker gradually resume their pre-injury job. It is designed for people with medical certificates (ACC18s) that indicate a need for a workplace assessment and/or fitness for selected duties or reduced hours.

The Programme may include an evaluation of the workplace to ensure the injured worker is safe to work with the duties and in the environment provided. It involves follow-up supervision until they have made a full return to their pre-injury duties.

We engage rehabilitation and vocational practitioners to support workers through the Programme until they achieve a full return to work.

ACC case managers can:

- discuss the Programme with you and your patients
- arrange the Programme for your patients
- approve help with transport
- communicate and liaise with your patients' employers and other relevant parties eg. occupational health nurse, if you require this
- arrange case conferences with relevant parties
- provide ACC information specific to your patients' needs.

In addition, ACC may be able to help if there are employers who have repeated difficulty supporting your patients' return to work. Our team of injury management consultants help employer capability to support return to work. Your patient's case manager or your provider relationship manager will be able to refer the employer to the local injury management consultant.

To talk to the appropriate case manager, phone 0800 222 070.

## References

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5. Institute for Work and Health. *Fact Sheet, Return to Work: Factors that Influence Return to Work* [www.iwh.on.ca/media/images/RTWfactors.pdf](http://www.iwh.on.ca/media/images/RTWfactors.pdf).
6. United States Department of Labor. *Dictionary of Occupational Titles*. 4th edition. Supplement, Appendix D 1986:101-102.



# Working With Employers

## CASE STUDY

*Meredith, aged 18, is a university student working 24 hours a week as a service station forecourt attendant. On her third day at work, she experiences sudden pain in her left shoulder while lifting an LPG container weighing 15kg.*

*When seen at the local accident and emergency clinic, the doctor indicates that there may be an underlying ligamentous sprain, with some limitation in range of movement. He notes 'query rotator cuff injury' on the ACC45 injury claim form and, along with anti-inflammatories and paracetamol, suggests that Meredith will be unfit to do her current job for six weeks.*

*The next morning Meredith's manager tries to contact her. She speaks to Meredith's mother, who indicates that Meredith is still in considerable pain, but feels things have improved a little. The manager suggests a review by the company's appointed practitioner, who is experienced in dealing with forecourt attendants' injuries. The review is later that day, after which the practitioner indicates that, although there is localised tenderness around the shoulder joint, there is now a full range of movement. As Meredith is right handed and the injury is on her left side, the practitioner suggests alternative work within the site store and contacts Meredith's GP to advise her of the review.*

*Meredith's mother expresses concern at the suggestion of an early return to work, given the original advice that Meredith should have six weeks off. ACC is phoned and asked to arrange a case conference, involving Meredith, her mother, the site manager and her ACC case manager. At the conference, the case manager suggests a worksite assessment to identify alternative duties, including in the site store. All agree on Meredith returning to work for four hours a day on alternate days, with a review by the company's appointed doctor in seven days.*

*At this appointment Meredith said things have greatly improved, and the doctor suggests she increase her hours over the next two weeks until she reaches her 24-hour week. At the review two weeks later she indicates that she has no pain at all and has been swimming in the weekend with friends. The company's doctor suggests that Meredith is fit to return to full duties as a forecourt attendant, with a restriction that her co-workers fill LPG bottles for her for a few weeks.*

## Introduction

A number of parties will be involved in an injured worker's rehabilitation - the worker, you and other health professionals, and the worker's:

- employer, manager, and/or other relevant staff members
- support person, union delegate, family member or whanau
- case manager.

Ideally, everyone should be consulted where they can help with a safe, early return to work.

## Why link with employers?

There is some evidence that closely associating clinical care and workplace intervention is important in returning patients to work and preventing chronicity.<sup>1</sup> This can benefit not only your patients, but also you and their employers.

Maintaining contact with your patients' employers is almost always beneficial for the patients and for your understanding of workplaces and any support systems. This is because workers may unintentionally (or intentionally) filter relevant information and are unlikely to provide you with the full information you require. On the other hand, employers can tell you about:

- the tasks and demands of people's jobs
- the workplace environment
- available temporary suitable or selected duties
- other return to work support their workplaces offer.

This information will enable you to make informed decisions on how soon and in what capacity your patients can return to work. It also helps in planning their treatment and rehabilitation to achieve a safe and sustainable recovery. Note that you should get patient consent before discussing their capacity for work with their employer.

If the employer indicates there are no temporary suitable selected duties available and your patient is fit for selected duties, you can:

- ask for ACC to arrange a workplace assessment, which may highlight options unknown to the employer
- contact the case manager to refer the worker to an Employment Maintenance Programme – this provides work options until they can return to their pre-injury job.

Employers may also wish to contact you, for example to clarify information on the medical certificate about an injured worker's current level of capacity and length of temporary incapacity.

Managing their expectations and concerns can help in achieving a successful and early return to work. Once they understand a worker's capacity (or incapacity), an employer may be able (and perhaps more willing) to offer both temporary adjustments to the workplace and suitable selected duties. (See page 15 for more information on temporary suitable selected duties.)

However, the diversity of New Zealand's workplaces, with small, medium, and large organisations, means it can be a challenge to deal with the return to work process.

## Small to medium organisations

New Zealand's workforce comprises a large number of workers engaged in small to medium-sized enterprises. Approximately 80% of the workforce can be found in organisations of ten or fewer people, all operating a wide range of return to work practices. Many employers don't have formal rehabilitation processes for injured workers, perhaps owing to their size or injury infrequency.

If you have the time, it can be useful to contact the employer when treating the injured worker. Alternatively, you can ask a case manager to contact them for you, or provide your patient with a Work Task Overview form for their employer to complete, which will tell you the types of tasks the worker does in their job (See Appendix 5 for a template of this form).

## Large organisations

A large employer may have:

- a unit dedicated to formulating and implementing health and safety policies, particularly since the Health and Safety in Employment Act 1992. The unit may also be responsible for injury prevention and rehabilitation, including developing rehabilitation plans for injured workers. It may include:
  - a health and safety manager
  - a human resources manager
  - an occupational health nurse
  - an in-house medical adviser



- a national network operating 24 hours a day
- a contractual arrangement with a local GP and referred treatment providers. Contracted practitioners benefit from visiting the site to gain an understanding of the work environment and work demands. This enables them to provide the best advice and treatment for injured workers.

In a larger organisation with in-house professional services, injured workers may be treated immediately, and possibly throughout the recovery period, by the organisation's occupational health nurse or medical adviser. Communication between these providers and the employer is essential in developing a coherent rehabilitation programme. However, the worker can consult their own GP (or other health professional) at any stage.

Alternatively, an injured worker may present to you, either on their own or with a company representative. If the representative outlines a rehabilitation plan from the time of treating the injury, it's a good idea for you to review it and make any changes or conditions that will support a sustainable return to work. Formalised plans can be very effective in getting a rehabilitation programme underway immediately.

It's best to start from the position that the worker can work their usual hours, unless there is strong evidence to the contrary. Evidence suggests it's more beneficial to the person's recovery if the temporary (modified or alternative) duties are as close as possible to their usual duties. Some modification may be necessary to maintain safety.

Given all the potential parties in a small, medium- or large-sized organisation, it may be necessary at times to meet to discuss some cases.

## The case conference: An option for complex cases

Effective communication among all the parties is an essential part of any return to work process.

Difficulties often arise when two of the parties reach an agreement about an injured worker's rehabilitation without the knowledge or involvement of other parties. A case conference can be an effective way to manage any potential communication issues. If you ask for one, the case manager can make the arrangements.

### Who should attend?

A case conference could involve:

- the injured worker
- a support person(s) (if required), for example, a member of the worker's family/whanau and/or a fellow worker or union representative
- the employer, management or their representative, for example, a human resources representative or a member of a health and safety team
- the case manager
- medical and nursing staff.

A good result can usually be achieved if the case conference has:

- a clearly outlined agenda
- good record keeping or minutes
- a mutually agreed rehabilitation plan resulting from the discussion.

These meetings should last less than an hour. It's always worth building flexibility into any rehabilitation programme, and the case conference may need to be followed up by briefer meetings, sometimes involving fewer parties, to assess the worker's progress.

## Employers in the ACC Partnership Programme

More than 180 groups of employers, including some of New Zealand's largest public and private sector organisations, participate in the ACC Partnership Programme covering 25% of the workforce between them. Employers who are accredited under ACC's Partnership Programme 'stand in the shoes' of ACC for the claims management and rehabilitation of their employees' work-related injuries.

Accredited employers are responsible for their employees injury management even when they are assisted by a third party such as WorkAon, Wellnz, CRM, Care Advantage or IPMS (Injury Prevention and Management Services). Accredited employers are able to access ACC's rehabilitation programmes and services or they are able to set up their own provider programmes specific to their workplace needs.

The Partnership Programme standards require all participating employers to take responsibility for their own:

- workplace health and safety
- injury management, which includes rehabilitation
- management of employees' work injury claims.

If you regularly treat workers whose employers are part of this Programme, please contact these employers. We also encourage these employers to contact you and other treatment providers in the community. Many have developed networks of preferred service providers to promote injury management for their staff.

Accredited employers replace ACC as the managers of all work-related injuries and illnesses. They are entitled to the same level of work-related injury information as ACC, to enable them to manage their workplace injuries effectively. Please take the usual care with privacy for any personal and non-work injury information.

Please ring 0800 222 776 and ask for the Workplace Incentive Programmes Team, or mention the Partnership Programme if you have any questions or concerns about rehabilitation management under accredited employers.

## Important players in the workplace

### General and business unit managers

The commitment of the company's owner, chief executive, or unit manager to vocational rehabilitation will determine whether the company will accommodate and fund its own graduated return to work programmes.

Good early return to work programmes are usually found in companies that provide good workplace rehabilitation management, and occupational health and safety programmes. Many will belong to the ACC Partnership Programme.

However, while there may be high-level commitment, middle managers can act as a barrier to effective early rehabilitation. And while it may be possible to get rapid results for your patient by going to the top, you need to be careful not to alienate key players who will need to support the return to work plan for a successful result to be achieved.

### Human resources/personnel manager

Human resources/personnel managers usually arrange special work and pay provisions for workers on graduated return to work plans. They also often liaise with case managers.

If your patient's employer is in the ACC Partnership Programme, the human resources manager may be the injury management contact person (see above). Contact them if you don't have the name or contact details of the worker's supervisor or business unit manager.

## Team leaders/supervisors

Team leaders or supervisors play a key role in putting the return to work plan into practice. They identify and manage alternative work, and set up flexible rosters that suit the needs of your patients. Supervisors may also need to restructure teams so that injured workers fit back into the workforce without placing undue strain on other team members.

## Work colleagues

Support from work colleagues is one of the major determinants of a person's successful return to work – and to get their 'buy-in' it's essential to develop a clear communication and implementation strategy for modified work. This is generally management's responsibility, but you need to ensure general acceptance of a graduated return to work plan at a case-by-case level.

## Workplace barriers

Workplace barriers include:

- the organisation of work
- the processes
- the tasks
- managers/supervisors
- colleagues.

A workplace assessment may be required to review the work organisation, working environment, work processes, and individual job characteristics. While these aspects of the workplace may not have caused the injury, they may be barriers to a full and sustainable return to work.

These assessments are likely to be done by health professionals specialising in the occupational setting. To ask for one, contact your patient's case manager on 0800 101 996 and they will liaise with the employer to ensure the assessment can go ahead.

## Building GP workplace expertise

To provide sound advice on early return to work programmes for your patients, you need a clear understanding of the tasks involved in their jobs.

Depending on your vocation, interests, and practice type, you may already work with employers and have a good understanding of the different workplace tasks and environments. Alternatively, a member of your practice may have a special interest in this work, or you could have agreed that one member will specialise in this for the benefit of the practice.

If you'd like to develop your skills further in this challenging field, New Zealand's medical schools offer a number of diploma courses – and occupational physicians will be able to advise you on managing more complex cases.

## Summary

- *Communication between everyone involved enhances an early and successful return to work.*
- *Contact the employer so you can understand the demands of your patient's job and potential suitable duties for them while they recover. Remember to get the patient's consent before talking to their employer.*
- *Find out what suitable duties are available at the workplace.*
- *If you need more information about the job and the workplace, ask for a workplace assessment.*
- *Be aware of what the employer can and cannot support in your patient's return to work.*
- *In more complex cases, ask for a case conference to ease the process.*

## How ACC can help

- ACC case managers/co-ordinators can:
  - contact injured workers' employers on your behalf
  - liaise with employers if difficulties arise
  - arrange workplace assessments
  - support you in co-ordinating the various parties
  - organise and facilitate case conferences
  - if appropriate, contact the ACC Employer Injury Management team, which advises employers on suitable alternative duties in the workplace
  - place injured workers on Employment Maintenance Programmes, where applicable.
- If ACC arranges the case conference, we'll pay for your time in that case conference.
- The Employment Maintenance Programme is available for people who are fit for selected duties and who could return to their pre-injury jobs on alternative duties, but their employers have indicated that no alternative duties are available. It is designed to help maintain workers' ability to stay at work and includes:
  - an initial interview
  - a worksite visit
  - an individual programme plan
  - physical therapy
  - rehabilitation modules
  - vocational modules.

We engage rehabilitation and vocational practitioners to support patients through the Programme until they achieve a full return to work.

- An injured person may work for an accredited employer in the ACC Partnership Programme, who manages work-related injuries in place of ACC (see page 26). Most employees will know if they work for an accredited employer, but there will be times when they don't know or are unsure.

To find out if an employer is in the Partnership Programme either:

- see Search for accredited employers under see [www.acc.co.nz/for-providers/resources](http://www.acc.co.nz/for-providers/resources)
- phone the Business Service Centre 0800 222 776 and ask for the Workplace Incentives team (or mention the Partnership Programme). The team can also answer or assist with other questions or concerns you may have about rehabilitation management under accredited employers.

Contact us on 0800 222 070 if you have any questions.

## Reference

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# Working With Other Health Providers

## CASE STUDY

*Andrew is a 28-year-old foreman on a building site who suffered a twisting weight-bearing knee injury playing with his young nephew. He saw a physiotherapist and took a week off work.*

*After that week, he saw his GP seeking a medical certificate. Retaking the history suggested a meniscus injury, and examination showed an effusion, 5 degrees loss of extension and too much spasm to make a clear diagnosis.*

*Andrew says, "I just wanted the doc to sign the form while I got my knee right with the physio. I was annoyed at the start when he interfered because it was getting better." His GP says, "I was irritated because the physio referred a patient who did not want my professional advice; nor was there a letter from the therapist detailing their expectations."*

*His GP decided that a significant injury had occurred with the potential for prolonged time off work. However, rather than sign Andrew off work as fully unfit, he phoned his employer and found that Andrew could return to office duties. He completed an ACC18 accordingly. He also felt early referral to an orthopaedic surgeon was justified, but had run out of consultation time.*

*The GP arranged to see Andrew the following day and, at this second visit, he copied his consultation note to the physiotherapist with a request to continue quadriceps exercises. He arranged an X-ray and gave Andrew the name of a suitable orthopaedic surgeon and a letter. He talked to Andrew about the diagnosis made the day before, his possible surgery and outlook for a good recovery.*

*Andrew says, "I was pleased my doc took things so seriously and got me sorted out, even though he charged me two part charges. It might have taken ages otherwise." His GP says, "The hardest bit was handling Andrew's expectations, especially when he was so worried about his knee and work."*

*Andrew had a complex meniscal tear at arthroscopy. Recovery was uncomplicated and he gradually resumed full duties.*

## Introduction

GPs are often required to work with a range of health providers in caring for and rehabilitating injured workers.

While one-off referrals to other providers may be enough in some cases, others may indicate the need for a more co-ordinated, multidisciplinary approach involving other GPs or members of the practice, district nurses, physiotherapists, surgeons, radiologists, and other treatment providers.

This chapter offers guidance on the nature and interaction of these relationships and how they can be managed to improve patient care and outcomes.

## Clinical experience

When different health providers are involved in treating the same patient, successful relationships rely on:

- good communication between the providers, the injured person, and ACC. This is key. Providers need to be informed of the history, diagnosis, details of treatment to date, and current treatment plan

- developing a network of known providers and encouraging them to communicate effectively. Ask for and expect short notes from other providers, and give them the same courtesy
- taking time to clinically co-ordinate injury care. It is more effective for ACC and patients to have injuries well managed than to skimp on GP consultations
- reassuring patients about their injury and your expectations for their recovery. Check they have understood the prognosis and treatment they've received from other providers and challenge it if you believe it's incorrect
- creating opportunities for patients to make informed decisions, and respecting their choice in seeking treatment from other providers
- respecting alternative providers' care but being prepared to intervene for your patients when your assessment indicates other management is necessary
- using special interest providers, such as wound care specialists, hand therapists, sports medicine and musculoskeletal medicine services, available in your area to augment your own skills and experience
- ensuring your patients receive appropriate and regular reviews, eg. by using the task or recall systems on your practice management system to ensure appropriate review and follow-up.

## Working as a practice team

Practices work in many different ways, with larger practices often having nurses who become experts in wound care. This can offer considerable benefits to patients, especially when the GPs in the practice don't have special interests in advanced wound care management or when specialist wound care is too time consuming for a GP during the normal practice day. It is still important that you review wounds frequently with your practice nurse(s) and consider broader medical issues such as circulation, neuropathy, and nutritional deficiency when healing is delayed.

Referral between and within practices is also becoming more common for care such as chronic pain management or joint injection. If you receive a referral, make sure you complete the treatment and refer the patient back to their own GP. Provide a detailed report of treatment back to colleagues, even in your own practice, when they refer a patient.

## Working with:

### Other GPs and special interest doctors

ACC has encouraged the role of accident and medical clinics, musculoskeletal medicine GPs and specialists, and sports medicine doctors and specialists. It can be very effective to work closely with these providers – making use of their expertise for the benefit of your patients.

For example, sports medicine specialists can access ACC-funded MRIs for some patients, while doctors with musculoskeletal medicine training can be a good option for a second opinion on back pain that doesn't require surgery.

### District nurses

In many cases, patients with wounds and mobility difficulties are appropriately seen for dressings by district nurses. Since care here occurs outside the practice, good communication between district nurses, practice nurses and GPs is essential in implementing the treatment plan. For the treatment of more complex wounds, you may choose to consult a wound care specialist (if this expertise isn't available in your own practice) and review the patient at agreed intervals. As a general rule, it is good practice for GPs to see most wounds at least once every two weeks, even if chronic, and consider further opinions on any wound that has not healed in six to twelve weeks.

Copies of treatment plans and discharge summaries should be readily available to all health professionals involved in providing the treatment.

When review is required, it's important to have a recall system in place. The recall requirements can be delegated to administrative or nursing staff.

### **Physiotherapists**

Physiotherapists are the most common provider with whom GPs work outside their practice team.

Patients frequently take their injuries straight to endorsed physiotherapists because they don't charge the patient a fee for ACC-related treatment. It's not unusual for GPs to see their patients after some treatment and assessment has been done. The physiotherapist may have assessed and diagnosed the injury and worked with the patient to develop a treatment plan. Physiotherapists may also refer the patient to you when time off work certification, further investigations, or patient management outside their scope is required.

The physiotherapist and patient often have clear expectations of what is needed from the GP. If this is not clear to you, request written confirmation. In turn, you should return the courtesy, informing the physiotherapist of treatment provided. While it can seem expedient to do just as requested, you should fully assess the injury, decide on its management and, if appropriate, modify the diagnosis and management.

### **Surgeons**

When you're referring patients to surgeons, remember to include supporting X-rays with your referral letter.

Also patients don't always understand their discussions with surgeons. You can help avoid any misunderstandings by briefing them on possible treatment options and expected surgery outcomes before the appointment, and seeing them afterwards to discuss the specialist opinion. Take particular care with patients who have different cultural or educational backgrounds.

Surgeons may reasonably take responsibility for work certification after surgery. A useful rule of thumb to use is that whoever has the clinical decision-making about the treatment should assume responsibility for providing the ACC18 certification. Contacting the surgeon when alternative work becomes available or certification seems incorrect may be necessary on occasion. It's also courteous and prudent practice to advise surgeons of complications, such as wound infections, and to discuss referrals to physiotherapists post-surgery. Surgeons often have clear views on the advisability of treatment post-surgery.

### **Radiologists**

The uses and limitations of plain radiology are well known. GPs may also use ultrasound on occasion to aid and/or confirm diagnosis or to compensate for a lack of confidence in clinical diagnosis skills.

If there is uncertainty over the correct radiology to request, consult with a radiologist – they may suggest that an MRI or CT scan is more likely to give the diagnosis required, or confirm that clinical examination should be sufficient. This may indicate the need for a specialist referral.

Make sure you give radiologists adequate clinical details on request forms, clearly noting any specific questions or issues. They also require the ACC claim details. Injury management clinical guidelines that give specific advice on the appropriateness of when to X-ray are available on ACC's website . See clinical guidelines under [www.acc.co.nz/for-providers/resources](http://www.acc.co.nz/for-providers/resources)

### **Occupational health specialists**

Many larger employers have relationships with occupational health nurses, doctors and physiotherapists. These professionals are often familiar with the workplace from regular visits and can help you to establish alternative duties or make changes at the workplace (such as by improving workstations or negotiating with the right people).

If you have a large employer in your area, it may be worthwhile visiting them so that you can understand the conditions and pressures under which your patients work, as well as the range and scope, if any, for light and/or alternative duties. Human resources staff or the occupational health nurse are good contacts to arrange a site visit.

If there are no existing treatment providers at the workplace or specific expertise is needed, occupational therapists may be available to do a site inspection or provide other support.

### **Occupational therapists**

Occupational therapists can undertake holistic assessments of workplaces to identify barriers and recommend changes to help achieve a successful return to work. They can also undertake evaluations and develop recommendations on suitable alternative duties as well as monitor and support injured workers in their return to work programmes. And they can help workers with injury management and training in safe work practices.

Contact ACC (or request an the ACC18 Medical Certificate) if you would like to use the services of an occupational therapist for workplace assessments and/or graduated return to work programmes.

### **Other treatment providers**

Patients present to providers from a wide range of professional disciplines (ACC recognises 14 different groups, including, for example, acupuncturists, chiropractors and osteopaths). It's important that you have a working knowledge of the strengths and weaknesses of the providers in your area.

Patients coming to see you from another provider may have responded poorly to the treatment offered and be seeking a second opinion, or may need work certification. Treatment may have been symptomatic rather than based on a clear diagnosis so careful review of the diagnosis is essential. If necessary, insist on repeat appointments to assess a complex injury adequately. South Island GPs (and eventually all GPs) have access to GP Injury Assessments that help in this process.

### **Public hospital system**

Individual district health boards hold a range of ACC treatment contracts that may provide help with return to work programmes, such as pain, back, and head injury services.

If you believe your patient requires one of these specialist services, it's a good idea to discuss it with, and get a referral from, the case manager. Also if the patient experiences undue delay in accessing public follow-up after their acute injury has been treated in a public hospital, it may be good practice to consider referring them for followup in the private sector.

## **Summary**

- *The key to working well with other providers is maintaining full, timely and accurate communication, and clear boundaries between the patient, ACC, other providers, and you.*
- *You can establish your role as clinical co-ordinator and assist your patient through the complex process of recovery by making sure they inform all parties of any plans for treatment, referral, work and review, and making sure they happen as arranged.*
- *All providers should have the same message regarding the rehabilitation treatment plan for the patient.*
- *ACC case managers can help in this process, but need to be kept in the loop and given clear clinical information.*



## How ACC can help

ACC case managers/co-ordinators can:

- where required, help with co-ordination among health providers. You can charge ACC for time you spend talking with the case manager
- help with patient access to specialist services in the public health system
- advise on ACC's requirements for referrals to health professionals specialising in the occupational setting, such as occupational health nurses, occupational physicians, therapists, and physiotherapists and vocational rehabilitation providers
- advise on, and facilitate, patient access to non-clinical help, such as with the costs of travel to treatment
- advise on the requirements for a GP Injury Assessment.

If your patient works for an accredited employer in the ACC Partnership programme, see pages 26 and 28 (last bullet point) for further information.

If a case manager or co-ordinator has not been assigned or has yet to be assigned, contact your local ACC branch or phone 0800 222 070 with any questions.



# Working With Injured Māori

He aha te mea nui o tēnei ao?

Māku e kī atu

He tāngata, he tāngata, he tāngata

*What is the greatest treasure in the world?*

*I will say to you*

*It is people, it is people, it is people (Te Aupouri)*

## CASE STUDY

*Mr T, a heavy vehicle driver, suffered a fractured right femur in a crash some six months ago. Health professionals involved in his care said he often seemed surly and uncooperative when spoken to on the phone.*

*His GP rang ACC and sought help from his case manager. A meeting was arranged with Mr T, his employer, his GP, ACC staff, the Pae Arahi from the ACC branch and Mr T's whānau.*

*After a formal welcome and refreshments provided by the whānau, everyone was introduced. Mr T did not participate in the formal welcome, but during the discussions that followed expressed his concern that few of the people present had actually met him before, and that he had received conflicting advice from providers. He also expressed the need to agree on a return to work date and rehabilitation plan that would fit his responsibilities at his local marae, in the same way that his pre-injury work had allowed.*

*During discussions with Mr T's whānau, the ACC case manager learned he was acknowledged on the marae as a key orator, and that his preferred method of communication was in person or by phone. Mr T had left school with no formal qualifications, but had worked hard to achieve the certification required for his current job.*

*At the meeting, a plan was developed for further care and a graduated return to work. This included regular face-to-face meetings between Mr T and the various groups present, coordinated by his case manager.*

*Within weeks, Mr T showed significant progress and he was able to begin his gradual return to the paid workforce.*

## Introduction

Compared with other population groups, Māori experience higher rates of serious injury and illness, but lower rates of access to treatment for non-serious injury.

The lower rate of access to treatment can be partially explained by poverty and structural barriers (eg. remoteness and transport issues), but may also be related to interaction difficulties when the providers and patients have differing cultural backgrounds. This can lead to confusion and misunderstanding.

Understanding and supporting Māori cultural needs can improve the return to work process and increase the chances of a successful outcome for the patient. This chapter discusses the factors that can be important in helping Māori patients to achieve a safe and early return to work – and details how ACC can help.

## Cultural components for a successful return to work

### What is cultural competency?

Cultural competence has been described as ‘being about the acquisition of skills to achieve a better understanding of members of other cultures’.<sup>1</sup> The goal of culturally competent care for Māori patients is to improve relationships and thereby achieve better clinical results.

Some of the ways in which culture affects people’s health, injury and return to work include:

- influencing their ‘help-seeking’ behaviours and attitudes towards providers
- shaping their beliefs about the causes of injury, appropriate treatment and rehabilitation, and subsequent activities
- influencing their perceptions of pain and responses to pain
- shaping the behaviours, attitudes and values of providers and their institutions.

By providing culturally competent services to Māori patients, you can reduce delays in their seeking care, improve the collection of clinical information and increase your understanding of, and communication with, them.<sup>1,2</sup> This can lead to improved patient/whānau satisfaction and greater support for and compliance with individual care plans, including return to work plans.<sup>3</sup>

Providing culturally competent services is likely to involve:

- acknowledging the role of the whānau and environmental factors
- greeting and farewelling patients in Māori
- being familiar with Māori terms and concepts relating to health eg. wairua, ora and mauri
- being aware of Māori belief systems and drivers for the individual, such as family reliance, the mana of the individual, communication preferences, and non-work roles and activities
- identifying and involving existing support mechanisms (eg. whānau, kaumātua, mentors, peers and Māori and other specialist service providers) who may be able to work with the employer and help the return to work process.<sup>4</sup>

It is also important to record ethnicity data accurately for ACC claimants. As well as being used to guide patient/provider interactions, this data is used to improve monitoring and service development for different ethnic groups.

### Tikanga (values and beliefs)

While it is important to assess each person individually and be wary of stereotypes, understanding the culturally determined responses of patients to different situations can help with providing effective care.

Key aspects of a Māori world view are:

- a belief that understanding and being connected to the past is important for both the present and the future
- the importance of tūpuna (ancestors) and whakapapa (interconnecting people over many generations)
- a healthy environment.

These traditional values can affect injury – for example, during sport some Māori may bear injuries stoically, putting up with considerable pain to maintain their dignity, independence, or even honour as a ‘warrior’.

Tikanga can be described as a set of rules for living that support Māori social systems and reflect Māori knowledge and traditions.<sup>4</sup> You need to be aware of some important aspects of tikanga, such as:<sup>2</sup>

- tapu – particularly in relation to the sacredness of the head
- mana – the importance of respecting individuals and their right to dignity
- wairua – acknowledging the spiritual force within people
- whānaungatanga – recognising the importance of interpersonal relationships to well-being.

For more information see *ACC Guidelines on Māori Cultural Competencies for Providers 2005*.<sup>2</sup>

Serious injury or illness is a time of heightened concern for many Māori, due to their prior experiences and beliefs. When the injury is serious, it is common for a number of relatives to come and provide support to the injured person's family, even if they have not been in contact for many years. The family may also organise karakia (incantations or prayers) to restore balance within the person.

## Communication and relationships

Successful communication and good relationships between providers, patients and their whānau are very important in the effective treatment and rehabilitation of injured Māori.

Take time to introduce yourself, to explain your role and to understand the patient's roles. You are more likely to see greater adherence to a return to work plan if you build a trusting relationship.

Some of the ways you can help to achieve this are by:

- providing face-to-face (kanohi ki te kanohi) contact – preferred by Māori – which involves not just seeing the face but also hearing the voice and seeing the body language
- allowing enough time at the first meeting for you, the patient and their whānau to introduce yourselves, which will help to build understanding and trust
- encouraging whānau to attend, as they will share responsibility for understanding the injury and supporting the treatment and rehabilitation plan
- correctly pronouncing te reo and following the preferred protocols. Mispronouncing Māori names and other words is seen as showing a lack of respect
- checking that the patient/whānau understands the diagnosis and treatment plans.

**He tao rakau, e taea te karo; he tao ki, e kore e taea te karo**

*A wooden spear shaft can be parried, but a verbal spear cannot be parried*

This whakatauki (proverb) is the opposite of the proverb “Sticks and stones will break my bones but names will never hurt me”, and reflects Māori ideas about the importance of communication.

## Developing return to work and individual rehabilitation plans

As part of the team responsible for developing and reviewing a patient's return to work plan and Individual Rehabilitation Plan, it is important that you are aware of their cultural needs. This may require careful discussion with them and their whānau.

It is important to:

- identify the patient's role in the Māori community (eg. chairman of a trust, kaumātua on a marae) and whether the accident has affected their ability to undertake certain roles
- identify the whānau roles. Is there a lead person who can make sure that the patient and all whānau members receive understandable information from providers and ACC? Can they ensure that all parties reach a common understanding of the issues and the return to work plan? Can they help with devising and implementing the plan? Can they help the patient to achieve the plan's outcomes/objectives? Who can assist with monitoring the plan? Can someone work with the employer and help with the return to work process?
- Check communication preferences. Māori may not challenge medical decisions, even when they are not in the preferred language or communicated in the preferred way. Discreetly using an intermediary, such as a lead person from the whānau, can help with issues of fear or embarrassment and ensure literacy is not a barrier to effective communication.

## Summary

*In working to achieve improved treatment, rehabilitation, and return to work outcomes for Māori patients, you should aim to demonstrate cultural competency. While your patients will have varied backgrounds, you can enhance the effectiveness of your service by being aware of their belief systems, customary practices, communication preferences, and wider support networks.*

### Whiria te kaha tūātinini

*Weave together the strength of the many strands*

## How ACC can help

More detail on the material in this chapter is available in *ACC Guidelines on Māori Cultural Competencies for Providers* – as either a summary document (ACC1625) or full version (ACC1626).<sup>2</sup> Both versions are available on the ACC website and in printed form. ACC also has a number of resources in te reo Māori that you can make available to your patients.

In addition, ACC has established a team of Pae Arahi, or Māori community advisors, to help staff and communities to build relationships with Māori. Pae Arahi have expertise in Māori protocol as well as extensive local and regional networks. They use their skills to support and advise ACC staff and others who work with Māori patients and communities. You can access them through case managers in ACC branches.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

## References

1. Durie M. *Cultural Competence and Medical Practice in New Zealand*. Report to the Australian and New Zealand Boards and Council Conference, November 2001.
2. *ACC Guidelines on Māori Cultural Competencies for Providers* 2005. <http://www.acc.co.nz> (summary ACC1625, full document ACC1626).
3. Agency for Healthcare Research and Quality. *Evidence Report/Technology Assessment No. 90, Strategies for Improving Minority Healthcare Quality*, <http://www.arrq.govt>.
4. Mead H. *Tikanga Māori, Living by Māori Values*. Wellington 2003, Huia Publishers.

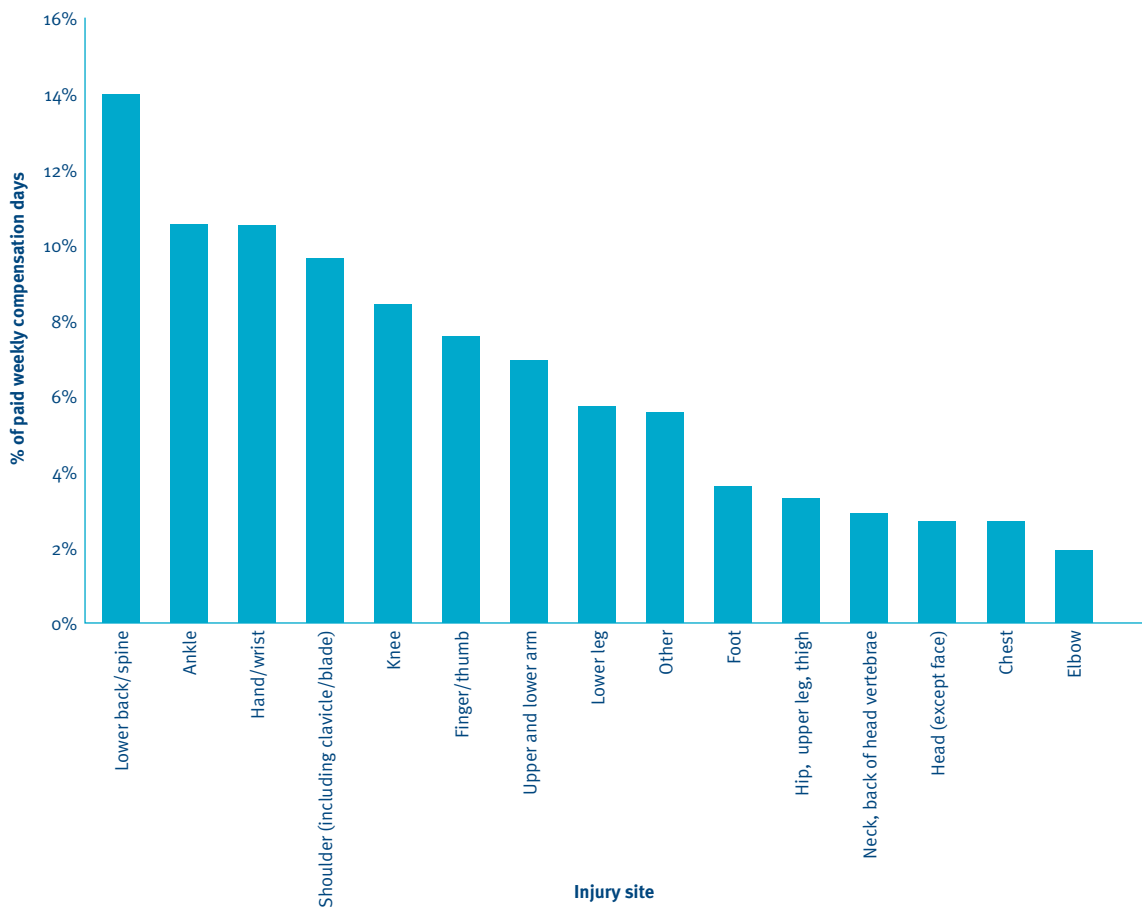


# Time off Work Statistics

ACC processes approximately 1.5 million claims per year for injuries arising from accidents. Of these, around 65,000 claims have more than one week off work. The majority of our injured claimants have little or no time off work, due partly to the low impact nature of the injury, but also due to the work of health practitioners and ACC staff to ensure a speedy recovery.

By far the most common injury requiring time off work each year is the lower back/spine, with approximately 8000 cases. This results in over 250,000 paid absence days per year.

Figure 1 represents the breakdown of total time off work days (paid to claimants) broken down by injury site. The top five injury sites: lower back, ankle, hand/wrist, shoulder and knee amount to more than 50% of the paid weekly compensation days annually.





# Gradual Process Injuries

## CASE STUDY

*Christine, aged 45, works in an electronics factory assembling light switches, a job she has held for 18 years. Throughout her working day she uses pliers in her right hand to cut and twist wiring. Her team is on a productivity incentive bonus, but over the previous month her numbers have dropped because of worsening elbow pain aggravated by gripping the pliers.*

*Christine says “I can’t grip as strongly as before because of the pain, and it’s impossible to keep up with my production targets. My team is getting annoyed with me because we’re not getting such good bonuses.”*

## Introduction

Gradual process injuries develop slowly and progressively over time. They usually result from a combination of factors, including:

- a person’s exposure to particular properties or characteristics in a work task or environment
- non-work activities
- degenerative changes due to the ageing process.

This chapter outlines the clinical experience and care associated with gradual process injuries, as well as specific return to work considerations, and describes how ACC can help people with work-related injuries.

## Clinical experience

- Gradual process injuries develop slowly, usually over a month or more. They are distinct from series of events injuries, which develop over a shorter time-frame and usually in association with unaccustomed activity for which the patient isn’t conditioned.
- Functionally repetitive work processes are often a causative factor, as can be lack of task rotation, inadequate breaks or micro-pauses, and faulty work techniques.
- Typically, a variety of contributory factors in the workplace combine to create gradual process injuries. The key is to address all of these rather than focus on single causes such as workstations or physical loads. The factors to consider include work organisation, workplace layout and awkward positions, task invariability, forceful movements and load, and environmental factors such as temperature and vibrations.
- Person-specific factors (such as non-work physical activities, diet issues, smoking, and other lifestyle choices) also contribute to the causes and prolongation of symptoms. Remember to consider these as well as psychosocial factors such as work and non-work relationships.
- Gradual process injuries commonly include hand/wrist tendinosis, elbow epicondylitis, and rotator cuff injuries.
- Many of these conditions are known to occur spontaneously from age-related degeneration, with work a contributing factor with varying significance. For example, the incidence of tennis elbow increases with age, reaching 10% in women aged 42–46<sup>1</sup> – an age group where the condition often occurs spontaneously, without injury.
- Gradual process injuries may take a long time to heal fully.
- Often, you’ll be able to advise your patient to keep working. Occasionally though, your examination findings or the history may indicate they need to modify their work temporarily or permanently.

- If your patient needs time off work, see the Graduated Return to Work chapter (page 13), which outlines tools and transitional approaches you can use to help them achieve a sustainable return to work. For example, you can help by:
  - making early contact with your patient’s employer or supervisor
  - developing a return to work plan with your patient
  - monitoring their progress
  - recommending specialist referral if necessary
  - liaising with the ACC case manager and employer where appropriate.
- If your patient’s return to work is delayed, it’s vital that you provide indicative timeframes and information to them and their employer to help with job retention.

## The importance of accurate assessment

Gradual process injuries are not uncommon, but because of their multi-factorial aetiology, they can be hard to assess adequately. This means you need to take a detailed history of the onset of your patient’s symptoms and of their job tasks. They may also need a workplace assessment before diagnosis and cause can be confirmed. Early contact with your patient’s case manager may also be useful, to confirm the requirements for ACC purposes.

Make sure you do a careful physical assessment to distinguish any physical injuries from non-specific pain disorders that have no physical damage and require very different management.

As with most other injuries, you should encourage and support patients with gradual process injuries to stay at work or return as early as possible following treatment such as surgery. A workplace assessment and guidance from an occupational therapist or physiotherapist can be helpful in many cases.

## Clinical care

Reaching an accurate diagnosis and establishing causation are the first essentials in medical management. However, assessments can be time-consuming, so you may need to refer your patient to an occupational medicine specialist. Once the cause has been identified, then management (including any steps to prevent further injury) can start.

## Specific treatment

Many gradual process injuries require specific treatment, such as carpal tunnel release surgery for carpal tunnel syndrome.

## Cause and prevention

Just as accurate diagnosis is important, so is the need to determine why the injury occurred to your patient at this particular time. After all, there’s no point in treating them and returning them to the same environment that caused their injury.

The cause(s) of injury must be identified and eliminated or minimised.

Talk to your patient’s case manager if you think a workplace assessment would help – this will identify any possible injury causes and recommend any modifications to the workplace and/or equipment to minimise the risk of aggravation or re-injury.

Appropriate modifications are usually achievable in combination with education and self-management. However, sometimes the patient and their job can’t be matched and the only solution is a change of job.

## Reassurance and encouragement

In most cases, people with gradual process injuries can continue working or return to the same workplace with modifications to help prevent further injury.

However, your patient may be concerned about returning while they still have symptoms, so it's important to reassure them (and their employer) that an early return is an important part of their rehabilitation and functional recovery. You also need a strategy to help achieve this, including good support networks in the workplace.

Your patient may need alternative or modified duties while their injury is being treated or during rehabilitation. If they need to change jobs, ACC can help with vocational rehabilitation.

## Identifying barriers

Work with the case manager or co-ordinator to identify and address barriers such as difficulties travelling to/from work, job dissatisfaction, unsupportive work mates or managers, and home or personal problems. By giving positive, practical advice and dealing definitively with anxieties about an early return to work, you'll promote your patient's recovery.

## Return to work plans

When the severity of your patient's condition or their need for treatment indicates they require temporary time off work, you need to develop a return to work plan. This should:

- state whether they need alternative work duties and suggest possible options
- identify any barriers and address them up front
- consider if a gradual return is necessary, and advise on timelines for achievement (eg. how long temporary changes may be required)
- consider safety aspects (eg. workers with gradual process injuries often drop things, which may be unsafe at work or at home and risk further injury)
- monitor recovery and symptom control, and modify strategies that are not working
- determine if a permanent change to work duties, different employment or re-training is required.

The goal is, where possible, to manage your patient's safe and sustainable return to their pre-injury work duties and hours. For more detail on return to work plans and their development, see page 18.

## Timelines for returning to work

To avoid unnecessary and potentially harmful delays in time off work, encourage your patient to stay at, or return to, work as early as they feel able (with appropriate modifications if required).

Return to work is usually safe within days rather than weeks, with your patient's time away from the workplace depending on their severity of symptoms, the treatment or surgery required, their job and available alternative duties.

For example, although our factory worker, Christine, may be able to return to normal duties within a day of a corticosteroid injection into her elbow, a road worker may need two weeks on light duties before considering returning to normal duties. However, it's important to remember that this may only relieve symptoms temporarily; in most cases, the contributing factors will need to be addressed for a long-term solution.

The Medical Disability Advisor durations may be a useful tool if there is uncertainty over how long to certify patients as fully unfit or fit for selected duties.<sup>2</sup> Shorter periods off work with regular review allow progress to be monitored and, if required, the treatment modified.

Where return is delayed, the provision of indicative time-frames and information to the patient and employer is vital to help job retention.

## Summary

- *Gradual process injuries can be among the most difficult to diagnose and treat because of the time required to thoroughly assess all the causation factors.*
- *Treatment without managing causation is doomed to fail if your patient goes back to the causative work environment.*
- *Workstation layout is rarely the sole cause of gradual process injury.*
- *Achieving effective rehabilitation often requires a workplace assessment and the involvement of an occupational therapist or physiotherapist.*
- *To maintain meaningful employment for your patient, it's important to liaise with their case manager and employer.*

## How ACC can help

Our criteria for assessing gradual process injuries focus on three key elements:

- The particular characteristics of either the workplace or the person's job that may have contributed to the injury.
- Whether the particular characteristics are present to any material extent in the person's non-work activities or environment.
- Whether the risk of suffering the injury is significantly greater for people who do the job or work in the employment environment than for people who do not.

Referral for a specialist opinion from an occupational physician may be required in some cases.

If your patient's injury has been caused by a work-related gradual process, we can help in their care and rehabilitation through:

- co-ordination via a case manager or co-ordinator
- treatment such as physiotherapy
- education and training programmes to minimise re-injury
- vocational rehabilitation
- a workplace assessment
- modified work equipment
- pain management (page 61 on Managing Chronic Pain)
- travel and home assistance, if required.

While this type of claim is being assessed, ACC will pay for GP consultations and treatment eg. physiotherapy.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

## References

1. British Medical Journal. *Clinical Evidence Concise*. UK, British Medical Journal Publishing Group Ltd, December 2003;10:280-281.
2. Reed P (ed). *Medical Disability Advisor: Workplace Guidelines for Disability Duration*, 4th edition, Boulder, Colorado, USA, Reed Group, 2001.

# Mild Traumatic Brain Injuries (MTBI)

## CASE STUDY

### Jane

*Jane, a 23-year-old receptionist, crashed in the downhill section of a mountain-bike event. If she lost consciousness, it was only for a few seconds – she remounted her cycle and completed the race. That evening she needed paracetamol for a headache and chose bed rather than joining her friends for a Saturday evening party. Her headache was severe the next day and she felt exhausted. Noise irritated her, and she could neither watch TV nor read. Nor could she face work on Monday.*

### Tony

*Tony, a 33-year-old builder, skidded off the road while driving home from work and was possibly unconscious for three to five minutes. He was reluctant to be taken to the Emergency Department (ED), insisting he felt 'fine'. He was rude to ambulance and ED staff, who attributed this to the alcohol they could smell on his breath – they didn't believe that he had only consumed one glass of beer. Tony's recordings caused them no concern and a CT head scan showed no abnormality. They were pleased to discharge him to his wife's care after a few hours' observation.*

*Tony slept most of the evening in front of the TV, occasionally complaining about its loudness, then went to bed and slept heavily. He returned to work the next morning and attempted to mark out the foundations of a new house. Plan reading, measurements, and calculations proved difficult and he developed a severe headache. When his foreman pointed out basic errors in his work, he walked off the job. His wife convinced him to visit his GP – she knew that this was not his usual behaviour.*

### Graham

*Graham, a 56-year-old construction contractor, was assaulted while leaving a bar. He lost consciousness for a minute or two but neither his recordings nor his scan caused concern when he was assessed by the Emergency Department. He took a week off work because of headaches and fatigue, then returned to part-time duties. He realised he was more tired than usual, that he was forgetting to return phone calls, and that he was somewhat impatient with his family. However, the information sheet he'd been given had warned him this was possible and he didn't feel the need to see his GP.*

*Two months later Graham went to his GP in crisis. He had made major calculation errors in two major job quotations he had prepared in the three to four weeks immediately after his return to work. He had failed to include the costs of significant sub-contractors in the quotes he had provided and was certain he faced financial ruin. He wasn't sleeping and his severe headaches had returned – he felt worse than he had felt immediately after the assault.*

## Introduction

While the impact of any injury differs from person to person, this is particularly true after mild traumatic brain injury (MTBI), as you can see in the above case studies.

Some patients will be symptom free within hours or days, and most young people will be back to normal duties in seven to ten days. Meanwhile, others will have enduring symptoms disproportionate to the apparent extent of their injuries. The problem with MTBI is that it's not possible to be sure about the actual damage caused by the injury.

Some people will have one or two symptoms, while others will claim the ‘full house’ of symptoms, commonly termed ‘post-concussion syndrome’ (PCS). The Guideline suggests that PCS is a term best used after a patient has demonstrated persistence of post-concussive symptoms extending over a three-month period. Often these symptoms are more a ‘post-traumatic syndrome’ than an indication of physical brain injury. However, management is required whatever their origin, and similar approaches are useful whatever the cause may be. Most MTBIs resolve fully in two to three months, but a small number of people never return to work fully.

Post-traumatic symptoms and PCS don’t respond in concert to single management interventions, which further indicates that PCS is not a syndrome in the classical sense. It does help to provide general education about MTBI and PCS symptoms, and their prognosis and management, but individual PCS symptoms require individual consideration and attention.

It’s important that you evaluate the severity of each significant symptom and provide the best possible management while considering your patient’s personal and work environments. If you can’t apply symptom management strategies in their workplace, return to work will probably fail, which is then likely to intensify all their symptoms.

## Managing MTBI symptoms

### Pain

Pain, especially headache and neck-ache, is common after MTBI and if severe will prevent your patient returning to work. However, the persistence of some pain need not exclude a graduated return – and the earlier resumption of normal activities may even have a positive effect on their pain. If you wait for your patient’s pain to resolve completely before they return to work, you may impede the speed of their recovery.

As increased physical or mental activity may aggravate pain, more regular paracetamol and NSAIDs may be needed when your patient first returns to work (note: post-traumatic migraine may require specific migraine medication). You can then ‘tail off’ the dosage and frequency over subsequent weeks.

While ‘headache’ may really reflect neck injury, be aware that manipulative therapy can aggravate symptoms from ligament or facet joint damage and that cranosacral therapy is specifically contraindicated.

### Fatigue

Fatigue demands additional rest. Make sure you emphasise sleep hygiene principles for your patient, and day-rests where they are necessary and appropriate during their return to work. ‘Power-naps’ (20-30 minutes’ rest or withdrawal to a quieter space) help some people to manage an earlier return to work.

For most people, an increase in work hours of one hour per day at weekly intervals will return them to normal hours within one to two months. If their fatigue is minimal, they will achieve a full return to work much more quickly. Note they need to have enough mental and physical energy to travel home safely and continue other domestic (spouse or parent) and work-related responsibilities.

Headache and fatigue need to be well managed to avoid intensifying all other post-injury symptoms.

### Sleep disturbance

Sleep disturbance both contributes to, and is aggravated by, fatigue. MTBI patients sometimes avoid daytime rests in the hope of sleeping better at night, but this usually increases rather than decreases their nocturnal sleep disturbance. If your patient needs medication for sleep disturbance, a low-dose tricyclic may be more appropriate than benzodiazepines. Carbamazepine may also be useful for sleep disturbance and pain (either head or neck) and an SSRI (selective serotonin reuptake inhibitor) may be most appropriate if your patient’s sleep disturbance has depressive characteristics.

## Memory difficulty

Memory difficulty doesn't have to prevent your patient returning to work, but it's important to encourage them to use a diary, reminder lists, 'post-it' reminders and other written (or recorded) memory back-up devices. Many people worry that writing things down is 'giving in' and slowing recovery, but the opposite is probably true. Being systematic about places for things (keys, pens, and glasses etc) might remove the frustration evident in some MTBI patients.

## Poor concentration

Concentration and attention will be enhanced by focusing on one job at a time and avoiding distraction. Providing your patient with a quiet room or corner (or ear-plugs) may enable them to return to work earlier, while an open-plan office with multiple phones and background music can aggravate any persisting MTBI symptoms. Working from home may be a short-term solution.

If your patient's concentration is wavering or they're making mistakes, they probably need a rest period – and planning and scheduling each day's work might increase their organisation and confidence in daily activities. Demanding tasks need to be scheduled when their function is best (usually early in the morning).

All return to work programmes should have elements of general oversight and monitoring. However, you need to be particularly careful if your patient's job demands critical calculations or measurements, or their opinions or decisions have major impacts. In these cases, an early return to work after MTBI may only be appropriate if a colleague can provide oversight or monitoring and when your patient is willing to accept this loss of full independence. If you can't arrange (or your patient can't accept) suitable oversight, their errors may mean they lose their job or the business loses clients, negating the goals of an early return to work.

## Mood issues

Mood issues will affect an MTBI patient's fitness to return to work. Irritability is common and needs to be recognised by both your patient and their colleagues. Any uncharacteristic rudeness, anger, sensitivity or tearfulness may appear to be a personality change and will often be more apparent if other symptoms (especially headache and fatigue) are poorly controlled.

This behaviour may also indicate that your patient has exceeded their work capacity and needs more rest or 'time out'. If they get sympathetic responses from informed colleagues, they may feel comfortable doing this, but colleagues' exasperation or frustration may further demoralise and intensify their incapacity.

You may need to educate colleagues on your patient's needs, with the employer and other workers agreeing on a cue to use if they see your patient reaching a breaking point (such as, "George, I think it's time for us to go for a coffee"). A cue that's been agreed to in advance is much less likely to be met with a further angry outburst.

## Anxiety

Your patient may feel anxiety about returning to work, especially if their MTBI happened there or if their self-confidence has been damaged by PCS. They may also be anxious that an unsuccessful return to work will result in their losing their job and their ACC payments. In this case, their case manager will be able to advise and reassure them on their entitlements.

Arranging cognitive behavioural therapy (CBT) with an experienced psychologist may provide your patient with strategies for avoiding or coping with stressful situations. In some people, pre-existing anxiety traits may become more prominent after MTBI, and psychologist input may be useful here too.

## Depression

Depression occurs in 20–30% of MTBI cases. It can reflect pre-injury vulnerability, be a direct consequence of the brain-injury effect, or be a reactive response to the loss of self-image that happens when someone loses their ability to cope with regular tasks and activities.

You can help your patient by recognising their depression early and helping them to manage it appropriately. A psychiatric assessment is worth considering if the diagnosis is uncertain or if pre-existing depression worsens.

### **Impaired judgement**

An injured person with impaired judgement may return to work too early or do too much when they get there – with potential risks to them and their colleagues' personal safety. Alternatively, the person may see their impairment as more severe than it is, with fear-avoidance behaviour hampering efforts to return to work. Again, CBT and peer support can help here.

### **Balance and co-ordination issues**

These issues will affect safety in many workplaces. This may be unimportant to an office worker, but will have grave implications for someone working on scaffolds or ladders.

If your patient does this kind of work, consider their balance function carefully – and refer them to a specialist assessment and/or MTBI clinic if necessary. If you're not sure about the risks in your patient's workplace, a workplace assessment by an occupational therapist could be helpful – and they can also contribute to and oversee the return to work programme. Your patient's case manager can arrange this.

It's also important to consider educating your patient's employer and colleagues about – and inviting their support of – their return to work programme. Advice on alcohol or drug use may also be important in avoiding delayed recovery or additional injury.

Patients with MTBI can usually drive a short distance if they are not fatigued, but longer distances at the end of the day may not be suitable.

Note that unpaid workers (eg. mothers and some other carers) may never have the luxury of formal time off work to recover, or the ability to delay their return to work until they have at least partially recovered. They may need other help and support in day-to-day activities like home care, meal preparation, and childcare.

## **Summary**

- *MTBI symptoms vary greatly from person to person.*
- *A small number of patients have persistent effects well after their initial injury.*
- *Most patients recover fully and return to full-time productive work.*
- *A return to work programme can be enhanced with initial symptom management, and workplace assessment and adaptation by an occupational therapist.*
- *Patients with severe and/or prolonged injury effects should have an appropriate specialist assessment and be referred to an MTBI clinic.*
- *It is critical to manage patient anxiety and depression, whether or not it is wholly a consequence of their injury or a pre-existing condition that has been aggravated.*
- *Concurrent psychosocial or health issues will intensify the severity of symptoms. While they are not a consequence of MTBI, the MTBI has reduced their capacity to cope and they will need more help than was previously the case.*

## **How ACC can help**

ACC funds several MTBI clinics offering medical and psychological assessments and support for persistent post-MTBI symptoms. You can arrange appointments through each clinic's administrator or your patient's case manager.



We have also sponsored case managers to attend traumatic brain injury rehabilitation courses run by Professor Barry Willer with the Brain Injury Association. Most of our branches have case managers who have undertaken this additional training.

Recognising that providing patients with information about MTBI and PCS reduces the frequency and severity of PCS symptoms, ACC produces a number of information booklets you can use to help your patients understand their symptoms and reinforce the information you provide. The booklets also outline coping strategies for your patients.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

All the standard ACC entitlements are potentially available to patients after MTBI – simply talk to your patient’s case manager about what’s available and how it’s arranged. You’ll also find a number of resources on traumatic brain injury at [www.acc.co.nz/for-providers/resources](http://www.acc.co.nz/for-providers/resources).

### **Resources for patients**

Caring for your mild head injury (ACC257).

### **Resources for GPs**

The New Zealand Guidelines Group’s guideline on *The Diagnosis, Acute Management and Rehabilitation of People After Traumatic Brain Injury* is due to be published in 2006. Sponsored by ACC, the guideline contains evidence-based medicine and expert advice on managing traumatic brain injuries.

Acute Management of Traumatic Brain Injury, June 2001 (ACC601).

Traumatic Brain Injury Rehabilitation Guidelines, June 2001.

The Brain Injury Association of New Zealand is another valuable resource, available by phoning 0800 272 464, emailing [bianz@brain-injury.co.nz](mailto:bianz@brain-injury.co.nz) or writing to PO Box 74-323, Market Road, Auckland. You can also visit [www.brain-injury-nz.org](http://www.brain-injury-nz.org).

### **Vocational services**

A number of ACC vocational services, arranged by the case manager/co-ordinator, can help MTBI patients to return to work:

- The Employment Maintenance Programme is an early intervention programme for people who can’t return to work immediately after their injury because their employers have no light or alternative duties to offer them.
- The Graduated Return to Work Programme is undertaken in the workplace and eases employees back into full duties gradually as they recover.
- Work preparation programmes are available for people who’ve been out of the workforce for more than six months. They comprise a series of seminars and activity sessions that address the physical, psychological and vocational elements of rehabilitation.



# Living With An Injury Or Permanent Disability

## CASE STUDY

*James had been operating the compressing rollers at a small-goods-processing factory for four years. He still has no idea how or why he tried to clear the rollers without stopping the motor. He suffered a de-gloving crush injury to his right dominant hand. His thumb, index and middle finger had to be amputated at the carpo-metacarpal level.*

*"I had 10 operations in all," he says. "They tried to save my hand. At the end of it all I couldn't grip anything with the fingers I had left 'cause I'd lost so much of the palm."*

*James lost more than his dominant hand function; the force of the rollers caused a traction injury to the brachial plexus. He had weakness of musculocutaneous and axillary nerves, and neuropathic pain.*

*James had a lot to adjust to. He was 28 when the accident happened and was living with his girlfriend. He saw his two children (aged six and four years) from a previous relationship each Sunday and was very keen on his sport.*

*"League was my main thing, I trained two nights a week," he says. "Most of my mates were from the team. I didn't see that much of them for the six months I was in and out of hospital. They called round but I guess I put them off."*

*Once the injury stabilised, it was clear that the loss of function in a dominant limb made all sorts of things difficult for James. It took him half an hour just to get dressed. He couldn't manage his own cleaning or anything more than simple cooking. The right arm tired quickly and James struggled with the slower dexterity of the left hand. Driving his manual car was out of the question.*

*"...I think that's when it really hit me that things were going to be like this for the rest of my life. That was the real low point. I think I just turned my face to the wall. I didn't want to talk about it. I ignored the kids, my partner, everyone."*

## Introduction

GPs are often 'spectators' in the early days of a significant injury, as surgery and stabilisation take precedence. But in the weeks and months that follow discharge, as the rehabilitation focus shifts to the patient in an outpatient setting, you play an important role in ensuring that your patient's rehabilitation continues to be integrated and appropriate.

Your patient's long-term outcome will improve if they take an active role in their rehabilitation. You can significantly affect this process through:

- helping your patient to see past their disability and to focus on goals
- anticipating and screening for complications
- being a pro-active member of the therapy team.<sup>1,2,3</sup>

## Clinical aspects of rehabilitation in general practice

### Actively manage pain

Pain is part of injury, but unrelenting pain or pain that is psychologically tied to the experience of fear or distress can quickly escalate. Pain can interfere with sleep and relaxation, inhibit activity and affect mood. These factors impact negatively on rehabilitation so the management of pain is an essential early intervention.

Tailor your approach to suit your patient. Medications, cognitive behavioural therapy, relaxation, meditation, incremental increase in exercise, and other physical therapies and psychotherapy may be used to reduce the effect of pain. You will have some of these tools available in your practice.<sup>4</sup>

Remember to ask about whether prescribed medications are being taken as suggested. Before moving to the next tier of treatment, ensure the dose and frequency of simpler medications are adequately tested. Check for side effects and remember that non-pharmacological approaches are powerful adjuncts to medication, although your patient may need some training on these.

If pain is not responsive to basic interventions, refer your patient for pain management assessment and treatment. Your patient's case manager can tell you about the pain management services in your area.

### Be aware of the effects of sleep disturbance

Poor or interrupted sleep increases the severity of the pain experience, contributes to central pain sensitisation, and is also a risk factor for depression and anxiety disorders. It is associated with increased muscle tension, poor decision making and self care, and impaired control of obesity, heart problems, and diabetes.

Basic sleep hygiene measures include:

- maintaining a good (low sugar) diet
- avoiding all caffeine after 3pm
- regular exercise before 5pm
- avoiding alcohol
- practicing a relaxation technique before retiring for the night
- having a regular bedtime in a calm environment
- avoiding late night TV, music, etc.

A sleep diary may help keep track of patterns.

Regularly take your patient's sleep history and advise on sleep hygiene.<sup>5</sup> Altered sleep patterns that don't respond to basic interventions need psychological therapy.

### Ensure appropriate assistance is available

As independence is a key rehabilitation goal patients are entitled to appropriate help and equipment. Patients may be frustrated and demoralised by practical problems in managing the activities of daily living, such as transport, childcare, paid work, and housework. Find out about their changing disability level and communicate this clearly to therapists, assessors, and case managers. Encourage your patient to be 'active' in the assessment and help them to develop positive relationships with therapists, carers, and case managers.

Rehabilitation outcomes are better when the patient is assertive, maintains an internal locus of control, and avoids an invalid's role as much as possible.

### Acknowledge the effect on the psyche

Relationships and roles are often irrevocably changed after injury. Self-image and self-identity can be drastically affected by physical or mental impairment. Frequently the hidden emotions and feelings that follow profound loss are poorly addressed and become risk factors for both poor rehabilitation outcomes and mental illness.

Your patient may not be able to manage the avalanche of feelings and emotions associated with his injury so it is important to include a psychological approach early in the rehabilitation process. Encourage your patient to understand that these feelings are normal and offer some practical help, but be prepared to refer them to a psychologist or counsellor.

You can offer practical preventative advice such as:

- get plenty of rest and learn relaxation techniques
- eat well and exercise regularly
- avoid using alcohol and drugs
- don't hide your feelings....ask for help, find someone to talk to
- keep in touch with people who 'lift' your spirits
- focus on one day at a time
- stay active and keep doing the things you enjoy even if it seems 'mechanical'
- have some short-term goals, including social goals.<sup>6</sup>

For some patients, adjusting to their injury involves a spiritual dimension. It helps to ask about this aspect and help your patient find the right person to talk to. Depending on the cultural context, injury can take on different meanings and impact in different ways. Access someone who understands your patient's culture to ensure rehabilitation adequately caters for them.

Families often find it difficult to know how to show their support and can be daunted by the emotional intensity of the situation. Your patient may need help to deal with the complexities of these relationships.

### **Check for mental illness**

Perhaps not surprisingly, chronic injury is associated with a high incidence of depression, anxiety disorders, and post-traumatic stress disorder (PTSD). Depression and PTSD are associated with poorer general health outcomes, social isolation, and increased dependency. These may not occur immediately after the accident so it is important to incorporate screening and psychological help when planning your patient's clinical management (refer to the New Zealand Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals<sup>7</sup>). Psychological intervention may be needed at different stages of your patient's rehabilitation.

Remember to assess suicide risk if depression has been diagnosed. Substance abuse is common in people with chronic injury and may mask or compound psychological problems.

### **Return to work considerations**

Work is a key role that defines us and contributes to our self-esteem and sense of worth. Being out of the workforce as an invalid or unemployed person is associated with poor general health, poor psychological health, and increased symptom focus. Conversely, returning to some form of work helps other aspects of rehabilitation.

Your patient is more likely to return to work if they still have connections with the workplace, have a supportive supervisor and colleagues, and a job to move into that gives them reasonable task control. However, many people with a permanent disability may not be able to go back to their old role.

Actively talk about work with your patient and support the process.

- Discuss work goals early after their injury, and encourage your patient to think about options and barriers, and to be active in the process.
- Advocate for a team approach involving you, your patient, therapists, their case manager, and their employer. Ask for a case conference if it would help.
- Consider the functional and stamina limitations of your patient's disability and any other medical conditions or medications.

- Consider the identified aspects of intended work tasks, intensity, and duration. Recognise that adapting to new processes, aids or tasks is an additional temporary stress. Suggest referral to a counsellor or psychologist if necessary.
- Aim for a return to work plan that involves 50% of your patient's available stamina and build it up steadily and gradually. A formal plan to which everyone commits is best. There will usually be a supervising occupational therapist or physiotherapist.
- Ask your patient about their symptoms during and after work, sleep patterns and other secondary signs eg. relationships, ability to prepare food, and self care. Encourage them to discuss any difficulties with returning to work, and involve other therapists early.

Keep the return to work plan active. Be ready to step in and advise on pegging hours back or restricting tasks if your patient's stamina is being exceeded. Be available to advise your patient's employer, therapist or case manager promptly about the medical limitations of their injury.

In some cases, the workplace won't be able to accommodate the limitations imposed by your patient's injury. In this situation ACC can offer assistance with their vocational rehabilitation. Your patient can be helped to identify interests, career strengths, and experience that could be transferred to another job setting. This is quite a challenging prospect and it is normal for them to feel some anxiety about moving into a new area of work. Encourage your patient to discuss their concerns about vocational rehabilitation with you, and to be actively involved in the assessments and work trials. Make sure you clearly communicate the medical aspects of the disability so that supervising therapists can safely manage the work trial.

#### CASE STUDY *CONTINUED...*

*The business that employed James kept his job open but the role couldn't be modified for a person with effectively one arm. However, 18 months later, the business offered James part-time quality control work to which he could upskill with some on-the-job training. He wasn't keen at first, but went through the job requirements with an occupational therapist and eventually started on 10 hours a week.*

*"I didn't want anything to do with the place," he says. "It was unbelievably hard going back but I do feel I'm doing something for myself. I go in every morning and I'm increasing my hours every couple of weeks."*

*James was helped into an automatic car so he can now shop and visit his children. At home he's found ways to do most of the things he thought were out of range. Fatigue and pain are still limiting him and he hasn't found anything to take the place of his rugby league.*

*"Everything takes so long, it can get you down. Sometimes I have to sit down and think out how I'm going to tackle what I have to do. When I look back over the past two years... I've come a long way."*

## Summary

- *Rehabilitation works best when your patient is in charge and actively involved in setting their own goals.*
- *Acknowledge feelings, emotions, and spiritual, family and cultural aspects.*
- *'Work' is a healthy goal and, in most cases, achievable.*
- *You can help by:*
  - *being an excellent communicator and the hub of the interdisciplinary 'team approach'*
  - *maintaining a holistic knowledge of your patient's clinical condition*
  - *being aware of their changing difficulties with the activities of daily living, such as transport, childcare and housework*
  - *screening often for depression, anxiety, sleep disorder, substance abuse and pain and knowing what to do with the results*

- *providing clear, informed advice about restrictions and limitations*
- *supporting your patient in their return to work or vocational rehabilitation*
- *regularly keeping in touch with the ACC case manager.*

## How ACC can help

ACC has a wide range of services and facilities for people coping with a permanent injury and disability, and to help meet their short- and long-term needs. These include:

- Treatment: acute hospital care, primary medical and nursing treatment, specialist medical treatment, radiology, elective surgery, counselling, psychological services, occupational therapy, hand therapy, podiatry, acupuncture, chiropractor, physiotherapy, audiology, and pharmaceutical entitlement
- Pain management: interventional pain services, comprehensive pain assessment, psychological treatment, activity-based programmes, and residential pain management
- Orthotics: artificial limbs services
- Social rehabilitation: social rehabilitation assessment services (assessing people's needs for a range of social rehabilitation and nursing services, including personal support, rehabilitation equipment, modifications to homes and motor vehicles, training support, nursing services etc), residential support services, disposable medical needs, and Training for Independent Living Programme
- Vocational rehabilitation: initial occupational assessment, initial medical assessment, functional capacity evaluation, vocational independence occupational assessment, vocational independence medical assessment, Work Preparation Programme, Work Ready Programme, Work Hardening Programme, workplace assessment, Graduated Return to Work Programme, and Employee Maintenance Programme.

The glossary (Appendix 1 page 99) describes more generic services and facilities. For example, work-related programmes and pain management services and facilities.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

Contact the Provider Helpline on 0800 222 070 or your patient's case manager for more information.

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# Overcoming Hurdles – Targeted Assistance

A number of barriers can prevent injured people returning early to work, even if they are highly motivated – and the longer they are away from work, the more likely they are to become increasingly frustrated with these barriers and therefore demotivated. However, once identified, many barriers can be easily overcome.

Injury barriers can relate to safety, biomechanical, cognitive, perceptual and functional limitations. However, as specific safety issues often concern only part of a job, you can identify what your patient can still do and use this as a starting point in returning them to work.

Individual barriers include psychosocial, age, gender, education-level, and family/whānau situation issues. You can help to resolve these by talking with your patient and other interested parties. For more detail on dealing with psychosocial issues see page 57.

Clinical issues, such as impairment type and intensity, can delay a return to work. Other common clinical barriers include excessively lengthy treatment programmes, extended treatment waiting times, fragmented, unco-ordinated care and/or a failure to understand that early return to work is a positive intervention.

Workplace and other external barriers relate to job satisfaction, work organisation, relationships with managers and co-workers, transport to and from work, and claim processing delays. You can help to resolve many of these concerns by talking them over with your patient and contacting their case manager/co-ordinator for help.

# Psychosocial Issues

## CASE STUDY

*Katrina is 26 years old and works on a production line in a factory. She sustained an injury to her lower back while lifting a door. The occupational health nurse from the factory encouraged her to continue at work on light duties, but Katrina went to her GP seeking a medical certificate to be off work.*

*The back injury appeared straightforward. Katrina had lumbar discomfort, but there was no radiation of pain. On examination, the lumbar spine was tender but mobile, with no evidence of radiculopathy.*

*The most prominent feature from the history is Katrina's obvious desire to have some time off work. On further discussion she described significant stresses at home, and said she found it difficult to manage both the home and work environments. A phone call to the occupational health nurse at her work confirmed significant absenteeism and conflict with her supervisor.*

## Introduction

Psychosocial factors, also known as yellow flags, may be significant barriers to an injured person's rehabilitation and return to work.<sup>1</sup>

'Psychosocial' refers to the person's personal attributes and their social environment, and the effect these have on their behaviour. Yellow flags are the psychosocial factors that may delay recovery and increase the risk of long-term disability and work loss.

## Clinical experience

As yellow flags may be unrelated to the accident or presenting injury, they can easily be overlooked at your initial injury assessment.

Yellow flags can be personal and/or environmental (See Appendix 7 for a comprehensive list). Personal yellow flags include:

- relationship or communication problems at work or home
- negative thought patterns (eg. always thinking the worst)
- a belief that activity or work is harmful
- an external locus of control (the patient expects recovery without any personal effort)
- a preoccupation with entitlements
- reduced physical activity
- anxiety or low mood
- substance abuse (eg. alcohol, marijuana, tobacco, and self-medication).

Environmental yellow flags include:

- social isolation
- an overprotective family/whānau
- previous accidents
- unsociable hours or very heavy work
- an unsupportive employer
- receiving treatment that does not fit best practice.

It's important to identify and manage yellow flags early in the rehabilitation process – rehabilitation becomes significantly more difficult once a patient has established a sick role or chronic pain syndrome. In clinical practice, the concept of the 'heartsink' patient<sup>2</sup> equates well with the presence of significant psychosocial yellow flags.

In motivating a patient's return to work behaviour, it's vital that they are aware of the value of their work. It may meet more needs than the patient appreciates, as is illustrated in the poor physical and psychological outcomes of those who remain off work.<sup>3</sup>

## Motivating return to work

A patient's motivation to return to work relies on three key elements:

1. Value: they must believe that returning to work is in their best interests ie. it will do them more good than staying at home.
2. Expectancy: they must believe that it's possible to regain their work fitness.
3. Self-efficacy: they must believe they have the personal qualities and ability to progress through the rehabilitation process ie. that their effort will result in success.<sup>5</sup> Any success fuels self-esteem and a sense of mastery, leading to an increase in self-efficacy.

Any interventions to address psychosocial yellow flags must work to improve these elements. For some patients, all three areas may need work, while others may need a small step in just one area.

## Specific techniques<sup>6,7,8</sup>

The following steps are a guide for you, recognising that individual patients will need to dwell on one area more than another. Some will move through the steps quickly and others slowly.

1. Build a partnership
  - Be supportive and create an atmosphere of unconditional positive regard.
2. Listen to the patient's agenda
  - Avoid adding your own judgements, criticisms, opinions, and beliefs, and feelings.
  - Aim to understand your patient's disability from their perspective, their beliefs, attributions (causation), and expectations.
3. Enhance awareness, knowledge, and understanding
  - Identify areas of concern that are both personal and specific to the patient.
  - Explore their areas of concern, especially the positive and negative consequences of returning to work.
  - Discuss short-term versus long-term benefits.
4. Negotiate change
  - Address each of the three essential elements of motivation: value, expectancy, and self-efficacy.
5. Identify specific resistances to rehabilitation (see yellow flags)
  - Go back to step 1 if there are still significant yellow flags.
6. Develop a collaborative plan of action
  - Small steps rather than big steps are more likely to be successful and will help enhance self-efficacy.
  - Involve your patient's employer, case manager and significant family/whanau members in the plan of action.
  - Refer to other health providers as appropriate.
  - Consider a psychologist referral via ACC (or request on the ACC18 Medical Certificate).
  - Use the help available from ACC eg. graduated return to work programmes, activity-based programmes.

## CASE STUDY *CONTINUED...*

*It became apparent that Katrina was experiencing significant problems with her boyfriend and his family, with whom she lived. She believed her work was yet another external stress that added to the difficulties in her life. Her overall feeling was of powerlessness to do anything about her circumstances – and she'd decided that a brief period off work would provide a short respite from at least one of her many stresses.*

*In terms of value, expectancy, and self-efficacy, Katrina saw little value in her work except her pay. She believed she would return to work, but she expected her back injury to recur. Her level of self-efficacy was low and she didn't believe any effort on her part would make a difference to her back problem or her life situation.*

*The GP, who had built a collaborative relationship with Katrina, listened to her and explored the value of her work. This helped her to understand the many social, physical, emotional, and financial benefits her work brought to her life, and she came to see her work as positive and healthy. She was also given information about managing back pain and the importance of her role in the rehabilitation process.*

*The process so far had significantly improved the value she attached to work and she now believed that a full recovery was possible. However, Katrina's sense of self-efficacy remained fragile. So as part of the collaborative plan of action, she embarked on a regular walking programme and changed her diet, choosing healthy foods and avoiding her usual high caffeine intake.*

*Gradually, she began to feel better about herself. Her weight stabilised, her pain improved and her new awareness of work as a factor that enhanced her life meant she co-operated with the occupational health nurse and her supervisor to regain full work fitness.*

*Katrina's relationship with her boyfriend and his family, and her home situation, were clearly central to her stress and dissatisfaction. However, to be ready to make changes to these relationships, Katrina needed other significant supports. With time, Katrina's work and her improved self-esteem may help her to make healthy choices in other areas of her life.*

*Katrina is still at risk of work difficulties, including re-injury and poor rehabilitation, but identifying and managing her yellow flags has significantly aided her recovery and improved her outlook for the future.*

## Summary

- *Psychosocial factors are barriers to rehabilitation and return to work.*
- *Yellow flags may be unrelated to the presenting injury, so can be easily overlooked at the initial assessment.*
- *To return to work, injured people must:*
  - *value a return to work*
  - *expect to regain work fitness*
  - *have a sense of self-efficacy.*
- *It's important to work with your patient to identify areas of concern and raise awareness, knowledge, and understanding of potential yellow flags. Negotiate change and develop a collaborative plan of action to achieve a successful return to work.*

## How ACC can help

If your patient finds it difficult to address significant yellow flags, discuss these issues with their case manager. Depending on the yellow flags identified, they may be able to help with:

- some environmental yellow flags by, for example, liaising with an unsupportive employer or arranging a workplace assessment to ensure suitable duties are available to suit the patient's capacity
- if appropriate, social rehabilitation services
- a referral for psychological services. If your patient is getting weekly compensation and has significant yellow flags, they may qualify for a referral for psychological services.

ACC also has a number of programmes to help injured people to regain and maintain their work fitness, which may alleviate some yellow flags. These include:

- graduated return to work programmes
- activity-based programmes
- employment maintenance programmes.

If your patient has lost their job, we also have a work preparation programme to help them find employment.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

To contact the case manager/co-ordinator, phone 0800 222 070.

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# Managing Chronic Pain

## CASE STUDY

*Philip, a 55-year-old electrician, twisted his right ankle while climbing some steps at work. He felt some localised pain and irritation around the ankle, and the next morning his forefoot and ankle were painful and swollen. He consulted his GP, who gave him some paracetamol and strapped his ankle.*

*A day later, Philip's ankle was too painful to weight bear. He went back to his GP, who sent him for an X-ray and signed a medical certificate for five days off work. The X-ray showed some soft tissue swelling in the lateral part of his right ankle and forefoot, but no fracture. Philip was prescribed codeine, additionally, but the pain and swelling continued.*

*After another week, his GP prescribed dihydrocodeine as well as some anti-inflammatories. He gave Philip another medical certificate, this time for a week off work, and encouraged him to elevate the leg. Philip couldn't bear the strapping so it was removed.*

*The swelling tracked up Philip's forefoot and he noticed some colour and temperature changes. He also couldn't tolerate anything touching his lower leg. Fearful of harming his leg further, he confined himself to bed and his GP gave him a further month off work.*

*Six weeks later, as his condition had worsened, Philip's GP referred him to a pain medicine specialist. The specialist diagnosed complex regional pain syndrome and multimodal therapy was instituted.*

## Introduction

Chronic (or persistent) pain, with its biological, psychosocial, physical and emotional dimensions, comprises a disease entity in its own right.<sup>1</sup> Continuing nociceptive inputs can have a wide range of effects on the individual, from changes in receptor function to mood dysfunction, inappropriate cognitions and social disruption.<sup>1</sup>

Apart from the suffering (to the affected person and their family/whānau) and the quality of life issues involved, an economic burden of this size affects health care costs and working-age populations owing to the patient's reduced functionality and work performance.<sup>2,3,4</sup> Pain is a strong predictor of reduced work ability and well-being.<sup>5</sup>

This chapter describes the condition of chronic pain, identifies risk factors for its development and discusses measures to prevent this development. It also offers guidance on managing return to work for patients with chronic pain.

## Clinical experience – effective pain management and return to work

It is becoming clear that unrelieved acute post-injury pain (post-traumatic and post-operative) is a risk factor in the development of chronic pain, although psychological and environmental factors are at work as well. Each year, between 0.05% and 1.5% of all post-surgical patients have pain after one year,<sup>6</sup> while 25% of patients referred to chronic pain treatment centres have persistent post-surgical pain.<sup>7</sup>

Chronic pain is not merely acute pain that persists with time; changes occur at different levels of the pain transmission system<sup>8</sup> and long-term neurobiological changes happen much more quickly than previously anticipated (within hours of acute injury).<sup>9</sup>

After some injuries, the hyperphenomena (primary and secondary hyperalgesia, mechanical allodynia) that are normal in the first days or weeks after injury do not regress but persist beyond the usual course of an acute injury.<sup>10</sup> Local inflammation in injured tissue increases the sensitisation of specialised peripheral sensory neurones (nociceptors), leading to repeated afferent input into the central nervous system and central sensitisation.<sup>11</sup>

Current evidence suggests that continued peripheral nociceptive input from the perioperative noxious injury barrage might maintain central sensitisation, amplify post-surgical pain, and contribute to chronic pain.<sup>6</sup> The concept of 'neuronal plasticity' (the ability of neurones to profoundly alter their structure, function or biochemical profile in response to repeated afferent sensory input) is now central to understanding the development of chronic pain from acute pain.<sup>11</sup>

Post-traumatic neuropathic pain is a major contributor to chronic pain affecting roots, nerves, the plexi and central structures. Chronic pain after surgical injury is common following procedures such as inguinal hernia repair (12%), thoracotomy (up to 67%), breast surgery (up to 57%), limb amputation (up to 83%), sternotomy (27%), and gallbladder surgery (up to 56%).<sup>9,12</sup>

Musculoskeletal pain is associated with impaired health-related quality-of-life scores, and is comparable with complicated diabetes mellitus, chronic liver disease prior to liver transplantation, and terminal cancer.<sup>13</sup>

Epidemiological studies have shown that chronic pain is a major public health problem.<sup>2</sup> The latest prevalence study of chronic pain, undertaken on a Norwegian population, shows a prevalence of 24.4%, similar to the prevalence in the Australian population.<sup>14,15</sup> Chronic pain also contributes to an invisible but significant drain on productivity, and the under-treatment of acute pain associated with musculoskeletal and surgical injuries remains a growing concern.<sup>16</sup>

The single best approach to persistent acute pain is to prevent it. The evidence that pain has an early and significant impact on the quality of life of sufferers reinforces the need for early treatment and primary prevention.

## Risk factors

The risk factors for developing chronic post-injury pain can be tagged with blue, yellow and red flags, where:<sup>17</sup>

- blue flags indicate the peri-injury risk factors
- yellow flags indicate the psychological and environmental factors at work
- red flags indicate the post-traumatic physical disorders that need treatment.<sup>17</sup>

Identifying injured workers at risk for chronic disability early and accurately, lets you target them for early intervention to promote their return to work and normal functioning.

### Pre-injury blue flags

#### *Pain before injury*

Pre-injury pain significantly influences the post-operative pain experience<sup>18</sup> and is one of the best predictors of severe pain in the early post-injury period and in indicating the appropriate level of opioid consumption.<sup>19,20</sup>

Opioid-dependent patients have special needs in the peri-injury period.<sup>21</sup> To prevent under-medication, doses of opioid may have to be titrated and adjusted frequently. This practice could clearly result in an overdose in opioid-naïve patients.<sup>21</sup>



### ***Injury site and extent***

After an injury, the number of body areas affected, the injury severity (Injury Severity Score  $\geq 25$ ) and the person's gender (female) are significant independent predictors of worse long-term functional outcome.<sup>22</sup> Persistent pain is a well-recognised problem after various types of surgery such as major limb amputation, thoracotomy and sternotomy, major cancer surgery (mastectomy),<sup>23</sup> major orthopaedic surgery, and abdominal surgery.<sup>24,25</sup>

In acute musculoskeletal injury, there is limited evidence (level 3) that the location and extent of injury will predict reports of pain and poor functional activity outcomes.<sup>26</sup>

### ***Re-injury***

Re-injury often leads to more pain or pain that is difficult to control. For example, one study has shown that the incidence of permanent pain or discomfort was unexpectedly high (15%) after recurrent hernia repairs.<sup>27</sup> After returning to work, many people experience re-injury or report persistent functional limitations, even at six months following their initial injury.<sup>28</sup>

## **Post-injury blue flags**

### ***Unrelieved pain***

Unrelieved, acute post-injury pain is a risk factor in developing chronic pain.<sup>29</sup> Under-treatment of acute pain can also result in greater use of health care resources and ultimately lead to poor outcomes.<sup>30</sup>

### ***Severe pain***

It has been suggested that the severity of post-injury pain is an important predictor for chronic pain development.<sup>9</sup>

In older patients, high post-operative pain intensity has been associated with delayed ambulation, post-operative pulmonary complications, longer hospital stays, long-term functional impairment, and chronic pain syndromes.<sup>31</sup> You need to identify injuries usually associated with the development of severe pain so you can implement preventive measures. Encourage your patients to report unrelieved pain.

### ***Sleep disturbances***

Sleep quality and pain have a reciprocal relationship.<sup>32</sup> Noxious stimuli and painful disorders interfere with sleep, but disturbances in sleep also contribute to the experience of pain.

## **Yellow flags**

### ***Psychological factors***

Psychological (behavioural) and social environmental factors are increasingly being recognised as determining a person's progression to chronicity.

Pain is a multi-factorial, dynamic experience, not just a sensation. Emotion, perception, and past experience all affect a person's response to noxious stimuli. Try to understand your patients' attitudes and concerns about post-injury pain,<sup>37</sup> as pain-related beliefs (such as fear avoidance and catastrophising) and prior pain experiences may influence the duration of their disability.<sup>33,34</sup>

Factors such as worries about, or expectations of, chronicity may increase the risk of chronic symptom development.<sup>35</sup> People with pre-event distress or behavioural factors may have a higher risk of developing persistent pain after injury.<sup>35</sup>

Fear of re-injury or movement is also a potential predictor of chronic disability,<sup>36</sup> and pain behaviour and psychological distress can influence the return to work of people who have suffered soft tissue injuries.<sup>32</sup> If your patients display negative or uncertain expectations, you may need to probe further and provide interventions on psychosocial factors to help in their recovery.<sup>37</sup>

### **Social environmental factors**

The development of chronic pain has been independently linked to low self-rated health in the general population,<sup>2,38</sup> while individual income is strongly associated with self-rated health.<sup>2,39</sup>

The odds for developing chronic pain are 1.9 times higher for people with less than 10 years education than for people with an education record of 13 years or more.<sup>2</sup> Compared with married people, divorced or separated people have 1.5 higher times the odds of developing chronic pain.<sup>2</sup>

You need to identify any yellow flags and put in place early preventive measures.<sup>17</sup> You can also use behavioural interventions (cognitive therapy) to modify any behaviour that could increase pain and prolong disability. These need to specifically target catastrophic thinking.<sup>40</sup>

### **Red flags**

Red flags indicate post-traumatic physical disorders that need treatment, such as infection, bleeding, organ rupture or compartment syndrome.<sup>17</sup>

## **Managing chronic pain**

### **Measure outcomes**

It's important to measure outcomes. The Brief Pain Inventory, Short Form-12 and Short Form-36 can be used.

The Short Form-36 scores for bodily pain and emotional response can be useful in identifying patients at risk of prolonged disability.<sup>22</sup> Hazard ratios can be seen in people with lower Short Form-36 scores on physical component summary, physical function and bodily pain, and higher scores for disability and fatigue.<sup>41</sup>

### **Measure pain – the ‘fifth vital sign’**

Pain is the ‘fifth vital sign’ and needs to be measured alongside temperature, blood pressure, heart rate and respiratory rate.<sup>42</sup>

An inability to assess pain may be an important barrier to providing analgesia.<sup>43</sup> The mere fact that pain is measured leads to considerable improvement in pain management.<sup>44</sup>

To assess pain by subjective self-report, you can use verbal descriptors (adjective scale), a four-category verbal rating scale (VRS-4), an 11-point-numeric rating scale (NRS-11) or a 100-mm visual analogue scale (VAS).<sup>19,45</sup> Patients and nurses have indicated they prefer verbal ratings.<sup>19</sup>

### **Adequate multimodal pharmacological analgesia**

Many studies suggest that injury pain (after trauma or surgery) is often under-treated because health care providers are inadequately educated in pain management, contributing also to provider fears of causing opioid addiction.<sup>19,46</sup>

Multimodal analgesia combines multiple modalities of pain relief to provide more effective analgesia and a lower incidence of adverse effects.<sup>17</sup>

By identifying the type of pain (nociceptive, neuropathic, visceral), you can more efficiently treat pain by selecting the most appropriate intervention of multimodal analgesics.<sup>17</sup>

You should always use primary analgesics to manage acute pain after an injury. Commonly, a baseline of paracetamol 1000 mg six hourly is used. Codeine is inadequate on its own because it has a ‘numbers needed to treat’ (NNT) of 17, so use it in combination with paracetamol and monitor your patient for side effects. For acute persistent and chronic pain, use a combination of paracetamol with opioids (codeine, dihydrocodeine, tramadol).

For patients with chronic pain who develop a tolerance of, or side effects to, codeine, tramadol in combination with paracetamol can be used instead. Tramadol has an NNT of 3.4 for mixed nociceptive-neuropathic pain<sup>47</sup> and is generally well tolerated by elderly people. It is also an effective analgesic in long-term treatments with reduced pharmacological interactions and a low incidence of constipation.<sup>47</sup> In comparison with non-steroidal anti-inflammatory drugs (NSAIDs), tramadol lacks their gastrointestinal, platelet, and renal toxicity as well as their bronchospastic and hypertensive potential.<sup>a</sup>

NSAIDs can be used in chronic pain for short term only or as rescue medication provided no relative contraindications exist. If NSAIDs are to be prescribed as rescue analgesics for longer than six months, they may be combined with proton pump inhibitors as this may be useful in preventing/healing ulceration.<sup>48</sup> Simple peripheral neural blockade with local anaesthetics can greatly help pain management in the acute phase.<sup>49</sup>

Make sure you regularly review all your chronic pain management interventions (physical, pharmacological, psychological, for rehabilitation) for their efficacy and patient tolerance. In some instances, you can adjust or even 'tail off' pain medications as your patients recover.

### **Individualised analgesic packages and follow-up**

Prescribe a multimodal post-analgesic regimen tailored to your patients' expected pain levels. Make sure your treatments are flexible and specific to each patient.

Use patient regular follow-up to get feedback on the effectiveness of your treatment plans – and monitor and review your patients' medication use to ensure their compliance and to attenuate any adverse events. This especially applies where your patients have multiple co-morbidities requiring medicines other than primary or secondary analgesics.

### **Address patient attitudes and concerns**

Providing your patients with the best possible care may include addressing their modifiable risk factors, such as smoking and alcohol consumption.<sup>50</sup>

This will rely on good, clear communication – recognising that many feelings, beliefs and behaviours are relevant in your interactions when treating the pain and preventing persistent problems occurring.<sup>51</sup>

Your first meeting with a patient offers a unique opportunity to shape their attitudes and behaviours and to enlist them as partners in their treatment. Initially, simple explanations and reassurance will form the basis of your patient education package.<sup>51</sup> Physician education, as well as adequate training in doctor-patient communication skills, is also important.<sup>52</sup>

Once you've ruled out serious pathology and explained this to your patient, you can encourage their gradual return to normal activities using self-management strategies. For patients with sub-acute, non-specific lower back pain (of 4-12 weeks' duration) there is weak to moderate evidence that a graduated programme that combines exercises and cognitive behavioural treatment is more efficient than usual care in returning them to work.

There is strong evidence that these programmes reduce work absenteeism.<sup>53</sup> For example, people with arthritis (that can be precipitated by injury) can boost their ability to do everyday activities through mental stress management, stretching and strengthening exercises, and aerobic exercises.<sup>54</sup>

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<sup>a</sup>. Under ACC's purchasing requirements, tramadol is available as a second line treatment, and is subject to specific prescribing criteria. Refer to the For Providers part of the ACC website (<http://www.acc.co.nz>) or the ACC Helpline 0800 222 070 for the current criteria.

## Early specialist referral

The psychological and environmental factors discussed above can help you to identify patients in need of additional help and support.

Patients with acute pain that persists beyond six weeks may need to be referred to pain medicine specialists of the Australian and New Zealand Faculty of Pain Medicine or to a pain management centre for appropriate physical and pharmacological interventions on the pain tracts themselves.<sup>16</sup> You could also refer them to psychological services (via a case manager or ACC18 Medical Certificate).

## Early mobilisation

The reported benefits of mobilisation include earlier return to work, decreased pain, swelling and stiffness, and a better preserved range of joint motion.<sup>55</sup> Evidence supports the use of an early mobilisation regime for soft tissue injuries of the neck.<sup>56</sup>

## Dialogue and return to work

After trauma, inactivity and time off work appear to increase the risk of chronic symptoms.<sup>35</sup>

The risk factors outlined above offer you a means to identify early your patients who are at risk of developing chronic pain – and to take early action to promote their return to work and normal functioning. You'll also need to consider the treatment options available for patients who have developed or are developing chronic pain and for whom a delayed return to work is a risk.

Following work-related injury, the two things that can help patients return to work are:

- your ability to explain the nature and prognosis of their injury
- their employers' willingness to accommodate them.<sup>27,57</sup>

The main barriers to a return to work are workers' misunderstandings and fears about the nature of their injuries, and non-supportive supervisors and co-workers.<sup>57</sup> Job satisfaction may help prevent the development of chronic pain and disability after acute onset back pain.<sup>58</sup>

If you have a patient off work with chronic pain, talk with them and their employer. Encourage their return to work and help to achieve it through medical interventions and light duties. Rehabilitation programmes may be of use in chronic cases.<sup>59</sup> ACC can help with these – or discuss with ACC its range of vocationally-based programmes. Note employment factors (such as job tenure, physical work demands, the availability of modified duty, and earlier reporting) are strong predictors of functional improvements and return to work.

## Summary

- *Chronic pain requires early intervention and an active management approach.*
- *Active surveillance is important for secondary prevention.*
- *In the acute and sub-acute stages, it's important to provide adequate information, advice, and pain medication, together with timely, active interventions.*
- *Flagging pain (using blue, yellow and red flags) helps to identify risk factors in acute pain that need attention to avoid the transition to acute persistent pain and then on to chronic pain.<sup>17</sup> This offers you a unique opportunity for preventive medicine and highlights the importance of timely interventions.*
- *In established cases, undertake multidisciplinary management that addresses not only the physical aspects of the job but also the yellow and blue flags that could be obstacles to recovery.*
- *Optimise post-traumatic pain management by integrating multimodal pharmacological analgesic and rehabilitation regimes.<sup>17</sup>*
- *You can help your patient's progress in understanding the processes involved in post-injury recovery and the risk factors for chronic post-injury pain by frequently measuring the relevant psychological, emotional,*

*and physical variables.<sup>17</sup> Notable risk factors are psychosocial issues and the workplace environment – eg. attitude to workers and their welfare, the physical conditions and the design of the job. Recommend job changes if symptoms persist.<sup>17</sup>*

## How ACC can help

ACC offers a number of targeted pain management services for people with injury-related pain. These include:

- comprehensive pain assessments, which help ACC to assess and manage injured people's ongoing pain after injury. The assessments:
  - are for patients with persistent pain that has lasted 12 weeks or more
  - involve a multidisciplinary (medical, psychosocial, and functional) assessment that aims to recommend the most appropriate management options
  - are a gateway to all pain management services (except activity-based work-hardening programmes).
- activity-based programmes, which help people with persistent pain problems of at least six weeks' duration to:
  - self-manage their pain
  - achieve the maximum possible level of functional independence
  - participate in their usual activities at work and at home.

The programmes engage patients in a wide range of physical activity and exercise routines, and also provide cognitive and behavioural guidance, which supports the activities and develops their self-management skills.

The three types of activity-based programme are:

- work-hardening programmes
  - standard programmes
  - activity-focused programmes.
- interventional pain management, which is designed for people with persistent pain conditions that haven't responded to conventional therapy and medication. It involves skilled interventions by pain medicine specialists to diagnose and control pain.
  - the Multi-disciplinary Persistent Pain (MDPP) Programme, which is for people with significant pain that has persisted for 12 weeks or more. The Programme:
    - involves three weeks of intensive education and therapy
    - aims to modify the participants' responses to pain, rather than remove the pain stimulus.

Participants learn to:

- monitor their pain and implement strategies to manage it and prevent its escalation
- increase participation in agreed activities at home and work.

Psychological services that offer cognitive behaviour therapy, education and support may also be appropriate for people with persistent pain.

ACC case managers/co-ordinators can advise you on these services. A case manager will complete a pain questionnaire with your patient to determine the level of risk before deciding on the appropriate assessments and services. The pain questionnaire (which is a modified form of the acute low back pain screening questionnaire) is used to identify patients likely to develop pain-related disability and work loss.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

To contact an ACC case manager or co-ordinator, please phone 0800 222 070.

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# Depression

## CASE STUDY

*Tony was involved in a fight at a local sports event, receiving kicks and punches to his head and suffering a broken jaw. His friends reported that he was unconscious for several minutes. On arrival at the emergency department, his Glasgow coma scale was rated as 15/15. He was treated and discharged, with arrangements made for plating his broken jaw.*

*Although he made a rapid physical recovery, Tony continued to complain of dizziness, fatigue, headaches, and poor concentration. He underwent assessment at an interdisciplinary concussion clinic, which identified impairments in attention, learning, and processing speed.*

*At three months post-injury, Tony returned part time to his job as an animal research assistant. Despite working reduced hours and attempting only light duties, he struggled to concentrate and became frustrated at his inability to do tasks he'd previously managed easily. He felt alienated from his work colleagues and his relationship with his boss deteriorated. Outwardly, Tony appeared fit and healthy and he felt this contributed to his colleagues' lack of support and understanding.*

*Psychometric testing indicated that Tony was making a good recovery from the effects of concussion. However, he continued to perform poorly at work and at home. He lost his previous interest in sport and became withdrawn from friends and family. He continued to complain of fatigue, low mood, and poor motivation.*

## Introduction

An early return to work for people still recovering from an injury can be part of the rehabilitation process and is important in preventing depression. However, depression is still a common complication of injury – and early detection and treatment is an essential part of injury rehabilitation.

## Clinical experience

- Studies suggest depression is still frequently missed in general practice.<sup>1,2</sup>
- Early detection and intervention reduces the severity, duration, complexity and cost of depressive illness.<sup>3</sup>
- Depression is a recognised consequence of traumatic brain injury.<sup>4</sup>

Accidents and injuries that affect people's fitness to work increase the risk of depression through a sense of loss of physical health, financial security, social support, and independence. Depression causes personal suffering, which is further compounded by the stigma of having a mental illness, and also the loss of self-esteem that comes with feelings of failure at work and home.

Chronic or recurrent depression may also be pre-morbid and a barrier to vocational rehabilitation.

## Clinical management

- As depression is a barrier to vocational rehabilitation,<sup>5</sup> you should consider it if your patient's rehabilitation is not proceeding as expected.<sup>6</sup>

Ask your patient about low moods, sleep deprivation and loss of interest in usual activities.<sup>7</sup> You may find it useful to determine the severity by using validated screening questionnaires, such as the PHQ-9 quick depression assessment.<sup>8</sup>

- Start treatment early. Discuss the treatment options clearly and fully so that your patient can make an informed choice. Base all your psychological interventions and antidepressant medication choice on: <sup>9</sup>
  - patient preference
  - the risk of self-harm
  - side-effect profile
  - co-morbidities
  - drug interactions.
- Note that, although Māori suffer depression at the same levels as non-Māori, they have much lower treatment levels. If your patient is Māori, ensure they have additional support and follow-up.

## Returning to work

When considering return to work and depression, it's important to ensure flexibility, collaboration and a graduated return. All activities that your patient and their family/whānau consider important in their lives will be part of the rehabilitation process, including a return to work.

If your patient has depression:

- consider their options for reintegration into the workforce, as this often needs to be gradual<sup>10</sup> and both employer and employee need to be flexible: options may include reduced hours, alternative duties, and job sharing
- focus on good communication and joint problem-solving with your patient, their employer, and the ACC case manager; a case conference may be a good idea
- use a written return to work plan to avoid confusion and misunderstanding: review it regularly and keep it flexible
- respect their desire for confidentiality.

## Vocational rehabilitation benefits

Working offers a number of therapeutic benefits by providing a social support system and an opportunity for people to regain their sense of self-esteem and self-worth.<sup>11</sup> Overall morale in an organisation will rise if its employees are treated with care and consideration.

In turn, workplaces benefit from breaking down the stigma attached to mental illness. This can be achieved by encouraging:

- open discussion
- education
- an acceptance of the person's difficulties
- flexibility in managing individual needs.

Undiagnosed mental illness has a high cost in the workplace. If left undetected, work quality and productivity can be affected and relationships may be damaged beyond repair.

## CASE STUDY *CONTINUED...*

*Tony found it humiliating to stay in the same job while performing well below his own expectations. This added to his sense of failure and loss, and may have been a significant factor in his depression. Despite improvements in his neuropsychological assessment, his enthusiasm and motivation continued to decline, resulting in low mood and withdrawal.*

*At this stage Tony's GP considered depression. Tony resisted this diagnosis, which in his mind added further to the stigma he already felt. However, after discussing the pros and cons he agreed to a trial of treatment with antidepressant medication and individual counselling.*

*A case conference, fully funded by ACC, was arranged with Tony and his partner, his employer, his GP and his ACC case manager. ACC agreed to fund the counselling and slow down Tony's return to work programme until his depression responded.*

*As his depression improved, the team reviewed Tony's return to work programme. In conjunction with his employer, he developed a return to work plan outlining the tasks he felt capable of managing and the hours he could work. As his depressive symptoms and work expectations improved, Tony began to see the small gains he was making and became much more positive about his future.*

## Summary

- *Consider depression if your patient's rehabilitation is delayed.*
- *Early detection and intervention reduces the severity, duration, complexity, and cost of depressive illness.*
- *Good communication and joint problem-solving among everyone involved is more likely to lead to a successful result.*
- *A written return to work plan can be useful as long as it's flexible and reviewed regularly.*

## How ACC can help

ACC will fund:

- psychological support for patients who have:
  - a mental injury arising from a physical injury
  - a mental injury arising from a sexually abusive crime (as listed in Schedule 3 of the Injury Prevention, Rehabilitation, and Compensation Act 2001). The Sensitive Claims Unit manages these claims because of their confidential and personal nature.

A 'mental injury' is defined as a clinically significant behavioural, cognitive or psychological dysfunction.

Approval for up to 10 hours counselling is through the ACC case manager. After that, more counselling may be available for those patients with a sensitive claim, depending on your patients' circumstances and approval from a Sensitive Claims Unit case manager.

- case conferences if arranged by ACC.

ACC case managers/co-ordinators can:

- approve and arrange for counsellors/psychologists
- liaise with employers
- support you in a co-ordination role with the people and parties involved
- organise and facilitate case conferences.

Discuss any concerns about your patient with the case manager/co-ordinator, as they may be able to suggest other options to support your patient's recovery.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

To contact a case manager/co-ordinator, please phone 0800 222 070.

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# Co-morbidities

## CASE STUDY

*John, a 28-year-old Polynesian, drives a forklift for a well known warehouse company but has been off work for three weeks after an arthroscopy for a knee collateral ligament strain and haemarthrosis.*

*His employer supports a progressive return to work programme, but John, whose rugby mates describe him as 'massive', is having problems with regular activities – including driving his car. His GP considers that he would be a danger to himself and others if he continued to drive his forklift.*

*As a result, John's muscular bulk is rapidly becoming soft and he finds it harder, rather than easier to move around; he spends his days lying on the couch. His BMI is now well over 30, his blood pressure is 160/100 and he has a family history of diabetes.*

## Introduction

The relationship between incapacity for work owing to accidental injury and the presence of other illnesses or injuries is a complex one.

A pre-existing disability caused by serious or chronic illness or a previous injury is a risk factor for unemployment, low job retention after temporary incapacity, and a reduced return to work rate. Particular problems relate to mental ill health and include anxiety, depression (see page 71) and alcohol and drug abuse (see page 81).

These conditions can also be caused, or made worse, by being out of work. Workers who have co-morbidities have a 30% higher risk of becoming permanently unable to work than those who don't.<sup>1</sup>

Conditions that increase the risk of long-term incapacity include:

- the presence of other injuries
- mental illness
- chronic musculoskeletal disorders
- cardio-respiratory disease
- diabetes
- obesity
- age-related frailty.

## The presence of other injuries

The presence of other injuries is the strongest risk factor for work capacity loss after an accidental injury, irrespective of whether the injuries were sustained at the same time as, or before, the current injury. Studies indicate that concurrent injuries increase the risk of work disability by 50%.<sup>2</sup>

Limb, neck and soft tissue injuries often slow the recovery rate and may lead to work disability, even though the injuries themselves are not necessarily incapacitating. This is because:

- multiple injuries can indicate a more complex and/or severe injury pattern, and their effects may be synergistic rather than additive
- some injuries may interfere with the recovery, rehabilitation, and return to work processes. For example, a patient with a head injury associated with a concurrent minor injury may not be able to cope with pain or may have interpersonal difficulties with their employer

- in the case of joint injuries this may mean patients can't participate effectively in physiotherapy exercises
- in the presence of more serious injuries, minor injuries can be overlooked and unresolved in treatment and rehabilitation programmes.

As a GP, you can address many of the barriers to return to work caused by multiple injuries, recognising that complex or more severe cases may require more intensive interventions.

If you believe a patient's recovery may be delayed by the effects of other injuries, arrange the involvement of a case manager straight away to ensure early intervention and the best possible rehabilitation. In addition, if patients with complex conditions aren't making their expected progress, ask ACC to provide extra support.

### **Mental illness**

Mental illness plays a significant role in slowing people's recovery and may complicate a number of non-incapacitating accidental injuries, to the extent that the affected person can't go back to work.

Anxiety and depression, whether it precedes or is a consequence of accidental injury, reduces people's motivation, increases their pain and reduces their work capacity. You may need to provide symptomatic relief for distress and depression and, where necessary, psychiatric assessment and intervention.

People with a prolonged incapacity to work often turn to alcohol and/or drugs – and when impaired by them are at major risk of being involved in accidents at work, at play, and on the road. You need to manage this during rehabilitation to overcome any barriers to return to work.

### **Chronic musculoskeletal disorders**

Regaining mobility and strength are crucial rehabilitation goals for injured people.

Those who have chronic rheumatic or musculoskeletal disorders may experience stiffness and weakness that significantly delays their return to work. In addition, chronic inflammatory disease and the associated effects of its medication (such as steroids) can interfere with healing and recovery of function. It's therefore very important that you assess the potential effects of chronic musculoskeletal disorders when developing rehabilitation plans, and continually monitor progress against the conditions.

If you think a patient's musculoskeletal disease is likely to interfere with their recovery or may be less well controlled than it could be in the acute injury phase, it may be worth seeking a specialist rheumatologic opinion. Evaluating the treatment regimen may reveal that they need extra treatment, or physical therapies that can help them overcome other potential limitations, such as stiffness and weakness.

### **Cardio-respiratory disease**

Ischaemic heart disease or respiratory disease such as COPD and asthma can limit an injured person's ability to participate in exercise and rehabilitation programmes. Indeed, the effort to move and work may well increase if an injury leaves some residual functional limitations.

The extra energy demands of working with a disability may aggravate symptoms in patients with known cardio-respiratory disorders who are otherwise symptom free when doing regular duties. A person who was in poor physical condition before they sustained a serious injury may initially experience a marked reduction in their aerobic exercise capacity.

To help manage a patient's symptoms of cardio-respiratory disease, you can:

- recommend they do general conditioning exercises, with the exercise tolerance gradually increasing
- ensure their cardiac rehabilitation before they attempt any physically demanding work
- extend their rehabilitation programme (this may help to achieve a successful first attempt at return to work)
- provide supportive therapy such as vasodilators and bronchodilators
- plan their rehabilitation programme carefully to minimise acute exacerbations of their disease symptoms

- recommend they avoid exercise stress, paced work, night work, and extreme thermal environments until their work capacity increases
- ensure they have adequate monitoring and supervision at their workplace to detect any acute exacerbations and manage them appropriately
- help them to modify and reduce other cardiac risk factors, such as smoking, obesity, and psychosocial stress.

## Diabetes

The presence of diabetes and acute injury together can limit or slow down rehabilitation programmes that aim to achieve a return to work.

Diabetes can slow healing and is associated with micro-vascular disease, which can impair blood circulation. In patients with established polyneuropathy, rehabilitation must take into account any motor and sensory deficits and be tailored to overcome the problems inherent in disturbed gait, loss of balance etc.

The stress of injury and functional limitations can also interfere with a patient maintaining adequate anti-diabetic control. This in turn can further exacerbate the complications of diabetes, such as skin ulceration, retinal complications and other progressive microvascular and polyneuropathic symptoms.

To help manage a patient's diabetes symptoms, you can:

- compile a baseline profile of their diabetic status before their injury
- assess the extent of their current microvascular and polyneuropathic complications ie. visual disturbances and paraesthesias
- assess their capacity to do regular duties given the combination of diabetes and their injury
- if required, modify their oral or injected anti-diabetic therapies to prevent hypo/hyperglycaemic episodes
- monitor and manage any weight gain or obesity that results from inactivity from an acute injury
- assess and manage their psychosocial stress factors; depression may affect their regular diabetic regimen
- manage any associated cardiovascular risk factors, such as hypertension and hyperlipidaemia
- ensure they monitor their blood glucose before and after exercise and rehabilitation programmes
- treat any infections from wound injuries aggressively
- prevent hyperglycaemic episodes that are secondary to insulin resistance.

## Obesity

Severe obesity can significantly impair an injured person's rehabilitation and increase the physical demands for working, social participation and mobility – even the activities of daily living.

If your patient is mildly obese, advise them that they'll need fewer calories while they're incapacitated. Working with their rehabilitation team, you can also educate them about the risk factors of a reduced mobility state and help them to change their behaviour to suit.

People off work can find it hard to restrict their calorie intake, given that they have more free time and may be bored, anxious or depressed – so emphasise that they need to match their food intake to their general energy output. It's much easier to prevent weight gain than lose any weight they gain during their period of inactivity.

To help manage this you can:

- introduce a calorie-restricted diet as a frontline management approach to severe obesity; this may need to be formalised through a weight reduction plan
- take a multidisciplinary approach (with dieticians and occupational therapists) if your patient is already being treated for obesity
- involve all health providers in the loop of patient care and treatment changes post-injury
- if possible given their body size, get your patient involved in graduated, modular-type exercise and body conditioning programmes that can be undertaken under your close supervision and encouragement

- arrange transport services if your patient's injury compounds the problem of limited activity already present owing to their obesity
- manage obesity-related co-morbidities such as heart disease and respiratory impairment.

If your patient is severely obese (BMI  $\geq$  35) ACC may be able to fund appetite-suppressant drugs, as long as they are well motivated and participating in a weight-reducing dietary modification programme. You and the case manager can decide whether this is appropriate.

ACC can also help with initiatives like case conferences rather than fund definite therapeutic options for obesity. We can also fund work conditioning courses and help your patient with the costs of getting to and from work if you and the case manager consider this appropriate.

## Summary

- *Co-morbidities can significantly delay return to work and increase the risk of work disability.*
- *You need to be aware of your patient's health status before their injury, and keep all co-existing medical conditions stabilised after their injury.*
- *Regaining mobility and strength are crucial rehabilitation goals for an injured person. ACC can facilitate or fund initiatives that will promote an early return to work.*
- *Rehabilitation plans that help to achieve an early return to work must recognise the potential effects of co-morbidities on exercise tolerance and functional capacity.*
- *Many complex cases require a multidisciplinary approach. ACC case managers can advise you on the resources available for your patients.*
- *The combination of a co-morbidity and an injury can aggravate other psychosocial stress factors, such as depression. It's important that you're aware of this and manage it appropriately.*
- *Remember to monitor and manage any weight gain or obesity that happens as a secondary result of inactivity from an acute injury.*

## How ACC can help

Many of the co-morbidities covered in this chapter (diabetes, obesity and cardio-respiratory disease) are not covered by ACC. However, as each case is individual, ACC may be able to help with therapeutic options that are part of social rehabilitation entitlements. These can include setting up and managing case conferences if a combination of pain stressors is affecting a patient's rehabilitation and/or work capacity.

Note that most injury claims made in conjunction with other medical conditions need careful analysis before ACC can decide on the help to which your patients are entitled. However, we may be able to help with:

- a 'one-off' psychiatric or psychologist referral if a pre-existing mental illness worsens secondary to your patient's injury and affects their return to work
- access to alcohol/drug evaluation programmes if alcohol/drug addiction is impairing rehabilitation efforts and prolonging a patient's work incapacity
- transport costs, if your patient is eligible, and needs help getting to and from work and rehabilitation programmes.

We may also be able to help with work-conditioning courses, dietician referrals and graduated activity-based programmes if your patient's obesity is compounding mobility issues caused by an acute injury. In cases of extreme obesity, the case manager will be involved in managing patient expectations and deciding on their entitlements such as appetite suppressants and surgical intervention. In these extreme situations, you can play a valuable role in working closely with the case manager to decide on the best possible rehabilitation option for your patient.



The Purchasing Guidance Research Team has recently developed strict purchasing criteria for weight loss drugs. Your patients have to meet these criteria and show evidence of motivational weight loss (in accordance with criteria specifications) before funding will be considered. For patients who are considered suitable, they must also co-sign an Individual Rehabilitation Plan (IRP) with you before claims can be made. Patients are monitored throughout the process to ensure that criteria are met.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

### **Purchasing recommendations:**

The Purchasing Guidance Research Team guidelines state:

1. Sibutramine and orlistat are suitable adjuncts to an appropriate clinical weight loss programme for obese ACC claimants and should be considered for the three categories of ACC claimants originally specified in the 2001 purchasing guidance, so long as the following criteria are met:
  - 1) Measurable and achievable obesity-related rehabilitation goals should be set for all claimants for whom weight loss products are funded.
  - 2) Claimants in groups 1 and 2 must first complete the one month “motivational test” as originally specified in the 2001 guidance.  
Short term treatment of up to six months should be considered for maximum weight loss. (*Clinical trials show that most weight loss occurs within the first six months of treatment.*)
2. Sibutramine should not be purchased where there are the following contraindications: poorly controlled hypertension, coronary heart disease, congestive heart failure, arrhythmias, stroke, severe renal or liver dysfunction or concomitant monoamine oxidase inhibitor therapy. It is relatively contraindicated in people who are at increased cardiovascular risk (ie. >10% risk of a cardiovascular disease event over 5 years).
3. Do not purchase amphetamine-related weight loss drugs phentermine and diethylpropion.
4. It may be appropriate to set client-specific time limits and/or endpoints for funding of weight loss drugs. The New Zealand Health Technology Assessment review suggests discontinuing treatment if “reasonable weight loss” (2.5kg/month) does not occur within 12 weeks of starting treatment. Similarly, realistic weight loss goals (eg. 5% of initial weight) may be set at the outset, with funding stopped once the goal is reached.



# Alcohol And Drug Issues

## CASE STUDY

*Mr X, a 40-year-old senior supervisor, presented multiple off-work certificates from his GP over a period of several weeks for short periods, usually two to three days, for illness or minor accidents. Over the same period, colleagues noted the smell of alcohol on his breath which he vehemently denied was due to alcohol but to the strong aftershave he was using. His work performance was generally good, although his physical appearance was scruffy and he was often unshaven.*

*A work colleague found Mr X consuming alcohol in his car before work. He was given a warning and suspended temporarily from work pending review and treatment of his alcohol problem. An occupational physician was consulted who recommended clinical assessment with an alcohol and drug specialist. The specialist identified Mr X as meeting criteria (DSM IV) for alcohol dependency. Marriage problems were ongoing stressors that contributed to Mr X's problematic drinking – three bottles of wine and a dozen beers per day.*

*Community detoxification with community alcohol and drug services (CADS), counselling and close monitoring by his GP followed. Depression was treated with an SSRI (selective serotonin reuptake inhibitor).*

*While at home, Mr X fell heavily down some steps, fracturing his tibia and fibula. The accident and emergency department noted alcohol on his breath and this was confirmed by his GP, who continued to monitor Mr X's progress with clinical reviews and blood tests.*

*For health and safety purposes, Mr X was suspended from work until his GP, the ACC case manager, company occupational physician and workplace supervisor were satisfied he could return. Together, he and his employer signed a return to work agreement (RTWA)<sup>a</sup> and Individual Rehabilitation Plan, outlining his rehabilitation and ongoing supervision.*

*Unfortunately, within six weeks of recommencing work, alcohol was again noted on Mr X's breath and he was immediately suspended from work. Alternative duties weren't available as Mr X had a senior role and his home circumstances were contributing to the poor outcome.*

## Introduction

Mr X's case is not unusual. Alcohol and drug problems are often hidden and prolonged. Typical related injuries and incidents include falls, fractures, head injuries, motor vehicle accidents, and spousal abuse.

Rehabilitation and return to work outcomes are often complicated by co-morbidities, and the person may be unwilling to acknowledge they have a problem. Time and expertise are needed to treat the condition and to develop well-designed rehabilitation and return to work plans.

<sup>a</sup>. 'Agreement' rather than 'plan' has been used in this chapter to reflect the mutual nature of the document (the terms of which need to be agreed and signed off by both parties) and its potential use for medico-legal purposes.

## Size of the problem

The International Labour Organization (ILO) estimates that 20% to 25% of occupational injuries involve intoxicated employees, and that absenteeism is two to three times higher for employees using alcohol and/or drugs.<sup>1</sup>

In other statistics:

- the likelihood of absence from work increases by 20% for women who drink seven-plus units of alcohol per week and for men who drink 14-plus units per week<sup>2</sup>
- 70% of drug abusers are employed<sup>3</sup>
- the highest-risk occupations are construction workers (15.6%), sales personnel (11.4%), employees in food preparation including wait staff and bar tenders (12.2%), and forestry workers<sup>4</sup>
- the most common illicit drugs of abuse are cannabis and amphetamines.<sup>5</sup>

## Other risk factors

Pesticides and solvents used in the workplace can have harmful effects on work performance, which can be synergistic when combined with alcohol and/or drugs.

Medication (prescription or over the counter) can also be implicated in workplace injuries eg. sedating antihistamines. Appropriate advice needs to be given whenever writing a prescription.

## Legislation

Abuse or side effects from alcohol and/or drugs can be viewed as a workplace hazard under the Health and Safety in Employment Act 1992 (HSE Act) and its various amendments. Relevant legislation includes:

- section 2(1) of the HSE Amendment Act 2002, which defines 'hazard' as including a situation 'resulting from physical or mental fatigue, drugs, alcohol, traumatic shock, or another temporary condition that affects a person's behaviour'
- section 6 of the HSE Act, which places a general obligation on employers to ensure employee safety at work, and in particular to 'Provide and maintain for employees a safe working environment'
- section 19 of the HSE Act, which sets out the duties of employees and requires, inter alia, 'That no action or inaction of the employee while at work causes harm to any other person'
- the Human Rights Act 1993, which excludes as a human right the freedom to engage in risk-taking behaviours when it may extend to risking others. The Act specifically excludes risks to others from the inability to perform the duties required.

In addition, the ILO Code of Practice on managing alcohol and drug problems in the workplace stresses the importance of a co-operative and preventative approach between employers and employees in developing a written workplace drug and alcohol policy.<sup>6</sup>

## Your role

Key roles for you are:

- identifying and screening early for alcohol and drug issues in your patients
- identifying high-risk occupations for alcohol and drug problems
- recommending safe alcohol consumption and early referrals for problem drinkers
- identifying accidents and injuries where alcohol/drug problems may have played a part, and managing the alcohol/drug problem along with the injury
- where applicable, supporting alcohol and drug policy rehabilitation programmes
- liaising with employers and, in particular, identifying safety-critical occupations and advising managers on risk.

If your patient has an alcohol or drug dependency problem, you can also assist rehabilitation support from ACC, by:

- alerting case managers/co-ordinators to the suspected alcohol or drug dependency
- advising them of any medical factors that may affect your patient’s treatment for their dependency
- affirming the importance and value of treatment to your patient and encouraging commitment
- providing ongoing support to your patient during (and after) the ACC programme.

## Recognising alcohol and drug problems

‘Reasonable cause’ indicators of alcohol intoxication and drug impairment may include:

- loss of inhibitions
- dizziness
- slurred speech
- lack of sleep (even sleeping ‘rough’), unkempt appearance, poor personal hygiene
- nausea, vomiting
- hangovers (headache, nauseated, thirsty, dizzy, tired)
- violent or aggressive behaviour
- impaired motor skills (co-ordination, shaky, stumbling, shuffling)
- impaired concentration, forgetfulness
- smell of alcohol
- bloodshot eyes
- frequent visits to the toilet
- erratic decision-making
- observed drinking alcohol while at work.

The initial signs of alcohol or substance abuse can often be overlooked as insignificant, but the more serious signs are mood swings, slower work pace, reduced productivity, low reliability, and poor attendance. The results are missed deadlines, excuses for not getting the job done, and accidents, often involving personal injury. Conflict and morale problems can develop among co-workers and complaints can increase from co-workers and customers on quality, timeliness, and attitude.

The Alcohol AUDIT-C Questionnaire<sup>7</sup> is a useful office-based test that can help identify problem drinkers, alcohol dependence and active alcohol abuse. The Questionnaire uses three questions on alcohol consumption:

1. HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?*	2. HOW MANY DRINKS DID YOU HAVE ON A TYPICAL DAY WHEN YOU WERE DRINKING IN THE PAST YEAR?	3. HOW OFTEN DID YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION IN THE PAST YEAR?
Response options are scored as:		
never (0 points)	0 drinks (0 points)	never (0 points)
monthly or less (1 point)	1 to 2 drinks (0 points)	less than monthly (1 point)
2 to 4 times a month (2 points)	3 to 4 drinks (1 point)	monthly (2 points)
2 to 3 times a week (3 points)	5 to 6 drinks (2 points)	weekly (3 points)
4 to 5 times a week (4 points)	7 to 9 drinks (3 points)	daily or almost daily (4 points).
6 or more times a week (4 points).	10 or more drinks (4 points).	

\* A ‘drink’ is considered to be a can or bottle of beer, a glass of wine, a wine cooler or one shot of hard liquor (eg. scotch, gin or vodka).

The responses to the three questions are summed for a possible score of 0 to 12.

A score of three or more points, or a report of drinking six or more drinks on one occasion ever in the last year, should lead you to undertake a more in-depth assessment of your patient's drinking and related problems. Based on this, patients can be offered brief interventions or referrals as appropriate.

An in-depth assessment can include one or all of the following:

- Assessing your patient's psychosocial factors and the impact of alcohol/drugs on their family, friends, relationships, and work.
- Obtaining a history of the patient's alcohol/drug issues.
- Discussing their support mechanisms, especially if being alone may be problematic.
- Undertaking a DSM IV diagnosis – are they a suicide risk?
- Organising laboratory tests – complete blood count, liver function, B12 and folate levels, electrolytes and renal function, uric acid, glucose, amylase, and thiamine levels. Consider multiple drugs of abuse and interaction with over-the-counter medications. Drug levels are possible and you should consult your local medical laboratory for advice.
- Liaising with an acute medical team, alcohol and drug specialist or acute psychiatric service if your patient is drowsy or confused, confabulating, paranoid, suicidal, severely hyponatremic, or if you suspect subdural haematoma or pancreatitis etc.
- Referring them to an occupational physician and/or alcohol and drug specialist for work readiness.

In its purest sense, brief intervention will involve some psycho-education, motivational interviewing, feedback and active follow-up. If this is beyond the scope of your practice, in time or expertise, other practical assistance may include providing:

- information and education on hazardous drinking, (eg. having ALAC and other resources on hand that identify hazardous drinking patterns and offer suggestions for management)
- contact details for helplines (eg. the national alcohol and drug helpline 0800 787 797 operates from 10am to 10pm daily)
- details on referral sources and nationwide services, such as district health board alcohol and drug units.

In many cases, patients may be reluctant to acknowledge that their drinking is problematic – so while referral to an alternative intervention source is an option, they may not take it up or recognise that it's needed. Follow-up will often be necessary.

## Other typical symptoms and effects of drug abuse

Amphetamine abusers are prone to accidents because the drug causes excitation and grandiosity followed by excessive fatigue and sleeplessness. Taken intravenously, amphetamines can lead to aggressive behaviour and precipitate a schizophrenic episode.

The prolonged use of methamphetamine can produce anxiety reactions during which the person is fearful, shaky, and concerned about their physical wellbeing. Amphetamine paranoid psychosis can result, where the person misinterprets others' actions, hallucinates, becomes unrealistically suspicious and suffers delusions of persecution and feelings of omnipotence.

They may also experience an exhaustion syndrome, which involves intense fatigue and a need for sleep after the stimulation phase; it also includes a prolonged depression, during which suicide is possible.

Cannabis can produce a dreamy state of consciousness with alterations in time, colour and spatial perceptions. Many of the psychological effects relate to the setting in which the drug is used. Anxiety reactions can occur, and communication and motor skills can be impaired. This makes cannabis (and other drugs of abuse) a significant hazard for those in the transportation industries or safety-critical areas eg. monitoring, surveillance and security.

Cannabis has other important pulmonary effects on large airways, resembling chronic bronchitis, and research in progress indicates an increased risk of lung carcinoma beyond that expected with cigarette smoking alone.

There are many other potential drugs of abuse eg. BZP (N-benzylpiperazine, a stimulant approximately 10-20 times more potent than amphetamine), Ecstasy (3,4 – methylenedioxymethamphetamine), ketamine, PCP, Rohypnol and anabolic steroids. Although these drugs are not commonly reported in the workplace, you should be aware of the long list of possible other drugs of abuse.

All of the above drugs are secreted in breast milk and pose a hazard for the newborn.

## Alcohol and drug testing

Drug testing may be done by breath (alcohol), blood (alcohol, amphetamines, cannabis, cocaine, opiates or tranquilisers) or urine samples (amphetamines, barbiturates, cannabis, cocaine, opiates or tranquilisers) or by using clinical and other methods of detection as the circumstances permit.

You may be asked to participate in workplace alcohol and drug screening for a variety of reasons:

- The workplace may require this as part of its pre-employment medical screening.
- The workplace alcohol and drug policy may require its employees to undergo periodic or reasonable suspicion testing.
- The workplace alcohol and drug testing policy may require testing before an employee can return to work following a rehabilitation programme.
- A statutory body, such as the Civil Aviation Authority or Maritime New Zealand, may require this as part of a medical assessment of fitness for duty.

The Australian/New Zealand Standard 'Procedures for the collection, detection and quantitation of drugs of abuse in urine' (AS/NZS 4308:2001) outlines the requirements for drug testing in the workplace.

Drug testing will normally be of the chain of custody type and undertaken by approved centres according to approved and monitored practices. The method is intended for workplace, medico-legal or court-directed detection of any of the above drugs of abuse. The detection and reporting of other drug classes is not precluded.

The process typically involves:

- a witnessed urine collection by suitably trained staff
- urine temperature monitoring
- checking the specimen for adulteration.

Note: the AS/NZS 4308:2001 Standard doesn't cover testing urine samples following excessive intake of therapeutic drugs or vitamins, exogenous hormone intake or ingestion of performance enhancing drugs that may be used by sports participants.

An employee refusing to undertake a urine drug specimen can result in a standoff between them and their employer, especially if there is no clear policy on the process in this circumstance.

Environmental Science and Research (ESR) has a large number of accredited practices throughout New Zealand who are approved to undertake chain of custody urine specimens.<sup>8</sup>

Even if you're not directly involved in the testing process, you may be called on to advise and support your patient. For more information, visit <http://www.esr.cri.nz/competencies/workplacedrugtesting/testing-programmes.htm>.<sup>8</sup>

## Return to work agreement (RTWA)

An RTWA is a written document that sets out an employer's expectations of an employee who has completed mandated treatment for alcohol and/or drug problems. It also sets out the consequences if these expectations are not met. An RTWA often also forms part of an Individual Rehabilitation Plan agreed between the injured person and ACC.

Developing an RTWA requires:

- coordination between the employee, their employer, the union, the Employee Assistance Programme (EAP) and/or treatment professionals
- compliance with the employer's policies and legal obligations, as well as medical recommendations
- prior notification through company policy that an RTWA is expected as a condition of continued employment.

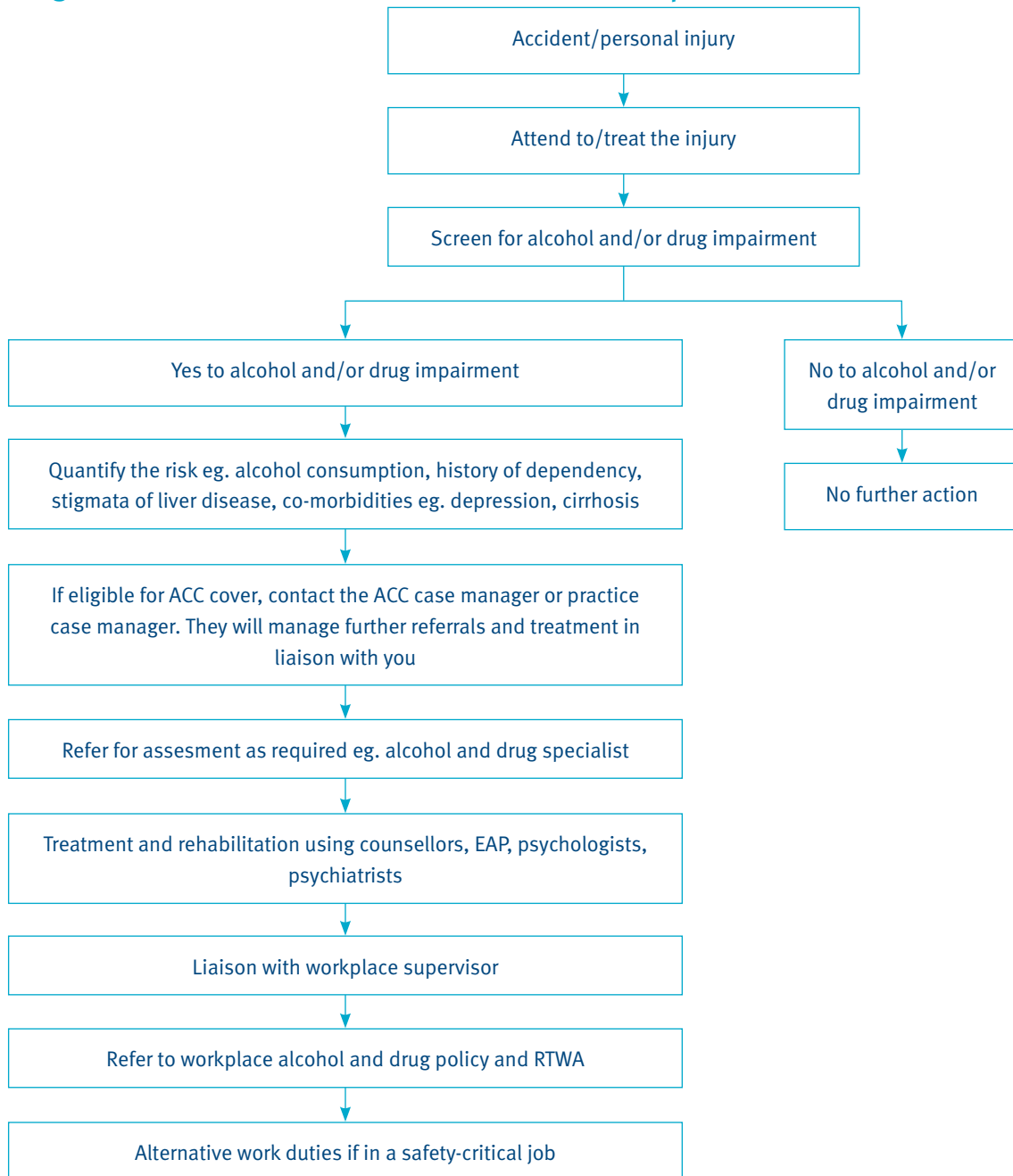
An RTWA normally forms part of an alcohol and drug workplace policy.

EAPs are confidential services that typically use counsellors to help employees to resolve personal issues, such as marital problems, that may be affecting their work. Many workplaces using EAPs find them cost effective in reducing workplace sickness, absenteeism and accidents, and increasing productivity.

You can help in the RTWA by establishing a clear case history and diagnosis, and supporting your patient's rehabilitation plan.



## Diagnosis, treatment and rehabilitation – an example



## Summary

*When a patient presents with suspected alcohol and/or drug problems, your critical role includes:*

- *identifying the signs of alcohol or substance abuse*
- *establishing a case history and, to the extent possible, quantifying the risk*
- *referring the patient to appropriate professionals for assessment and treatment or, if covered by ACC, contacting ACC to coordinate the referrals*
- *supporting the patient's rehabilitation programme.*

## How ACC can help

ACC's Alcohol and Drug Services Programme aims to help identify and address alcohol and drug issues that may be a barrier to, or hindering, a person's rehabilitation. Once identified, people can participate in special programmes to aid their recovery and support their rehabilitation goals.

The programmes offer:

- specialist alcohol and drug assessments
- counselling
- community and day treatment programmes
- residential treatment programme (in exceptional circumstances).

To qualify for these services patients must be receiving, or be eligible to receive, weekly compensation, and therefore have an entitlement to vocational rehabilitation.

In addition, if your patient loses their job or can't return to their previous employer, ACC's vocational rehabilitation services can help them to regain employment, such as through:

- curriculum vitae preparation
- work preparation programmes
- work ready programmes.

You can get more help and information from the ACC case manager assigned to the case, phone 0800 222 070.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

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# Managing Challenging Behaviour

## CASE STUDY

*You have known Jonelle for three years now. She is a nice enough patient, but she found a new partner, Bill, who decided to transfer to you as you seemed a decent sort of doctor.*

*The problem is that together with his injury, Bill brought with him his previous medical file, which contains a lot of ACC and orthopaedic reports. It seems that his back operation was not a success and you discover that he has some significant barriers to rehabilitation. Towards the end of his first visit, you sense that the 'honeymoon period' of this new doctor-patient relationship is drawing to a close.*

*Bill comes in with Jonelle and, while you are doing a pregnancy test for her, asks for some more pethidine and some of the sleeping pills one of his specialists had given him. You explain that pethidine isn't the best for long-term use and that he should be on something like imipramine rather than lorazepam. Bill becomes angry, insisting that he is not depressed and he doesn't need any of "that antidepressant stuff" because he's had them before and they were "useless". Bill then gets up out of the chair and stands between you and the door, becoming more agitated while Jonelle starts to cry...*

## Introduction

Dealing with a violent or aggressive patient can be a huge challenge for you and your practice staff. In most cases, patients are keen to return to work, but some may use injury or debilitation as a platform from which to blame health providers and the health system.

Patient violence against doctors is rare in most New Zealand practices, although research from the United Kingdom indicates that over 50% of GPs will have experienced at least verbal abuse from a patient in the previous year.<sup>1</sup> Violent and aggressive patients are a subset of the 'heartsinks' that include psychosomatics, multi-complainants, and non-compliers.

*"Patients with behavioural problems, and particularly those who behave violently and aggressively, are at the top of the list of patients who are difficult for physicians... those who are violent, demanding, aggressive, rude, and who seek secondary gain."<sup>2</sup>*

Violence ranges from verbal abuse to physical assault. While the latter is rare, the former includes intimidating and threatening behaviour. In an accident/injury setting, additional stressors stem from compensation issues such as entitlement, eligibility for treatment or investigation, the legitimisation of a 'claim' and issues of co-operation in rehabilitation.

Dealing with such patients requires early identification and harm reduction. To assist in this, various features of patient behaviour, their doctors and associated practices have been identified as being of higher risk for aggression or violence. As a result, a variety of tools for risk assessment have been developed, although most are tailored specifically for the psychiatric setting.<sup>3</sup> Their utility for general practice remains unproved and is likely to be low, judging from the data requirements.

## Patient features

These patient features can also apply to patients' family/whānau members, as they can also be violent and aggressive in their interaction with your practice.

- *A history of violence*: while an obvious risk factor, it is rarely flagged in medical records. It is essential to be alert to potential signs, and your frontline staff should be particularly adept at picking up 'danger signals'. Early detection can lead to appropriate harm-reduction actions being successfully implemented.
- *Other violence indicators*: these include family/whānau members presenting with results of domestic violence, a family history of violence, or the patient themselves being a victim of family violence.
- *Substance effects/abuse*: alcohol and drug addiction problems can compound violent and aggressive tendencies in some people.
- *Mental illness*: always keep psychosis in mind when confronted by a violent patient. Support from the Police or a mental health team may be essential in these circumstances. Patients with some personality disorders are more likely to manifest with aggression.
- *Psychosocial factors*: family stress, major life events, the loss of jobs, lack of work availability and previous injury experience, for example, can push individuals to vent their frustration and anger at health care providers.
- *Chronic injury state together with chronic pain*: the chronicity of symptoms and debilitating pain can lead to frustration and dissatisfaction with medical treatment and rehabilitation.
- *Head injury*: mood swings, irritability and depression may lead to aggressive behaviour. They can result from either a current injury or persisting head injury effects from a previous injury.
- *Communication*: this can be the pivotal difficulty area between patients and their health care providers, practice staff and other providers or ACC. This includes situations where there are cultural differences between GPs and patients.
- *Adverse experiences of the health system*: this can include patients still undergoing investigation for illnesses or where symptoms show no sign of resolution under current therapies. Previous experience with poor healing or complications post-procedures can also lead to later problems for primary care providers.

## Practice features

- *Location*: doctors working in practices in higher deprivation communities are at higher risk of patient aggression and violence,<sup>1</sup> as are those in emergency rooms or multipurpose clinics.<sup>4</sup>
- *Time*: after-hours work is a high-risk situation.
- *Risk antecedents*: the problems generated by the above practice risk factors are compounded by the lack of continuity of care frequently noted in high-risk situations. Violent and aggressive patients also end up more frequently in emergency departments, where easy access is attractive to them and staff don't have the benefit of a shared historical relationship with them. A long-term clinical relationship between patient and doctor protects the risk of the relationship deteriorating to aggression. With doctor and patient knowing each other's personalities and behaviour, the resulting 'social capital' greatly aids this protection.

## Doctor features

- *Gender*: women GPs are more likely to be subject to verbal abuse than male doctors.<sup>1</sup>
- *New doctor in town*: any GP who has set up a 'new shop' knows the attraction this has for the disenfranchised, the aggrieved, and patients disillusioned with the health care system, including ACC. Be aware of the 'honeymoon' period when high patient expectations of the new clinical relationship are rife. In this phase, patients may use several mechanisms to influence their GP favourably. These are challenging situations where a GP can make a significant contribution to a patient's healthy engagement with the system.
- *Easy touch doctors*: in line with the same attractions some general practitioners have for those seeking drugs of abuse, some doctors are known targets for patients wishing to manipulate the ACC system.

## Prevention and action

Sudden, violent attacks are rare in medicine; most incidents are preceded by mounting tension or frustration or escalating threats. It's essential to recognise the warning signs and take appropriate action – together with good communication with the patient, family/whānau, practice staff and other providers this can go a long way to reduce or eliminate patient hostility.

### Practice based

'Forewarned is forearmed', so if a patient with known aggressive tendencies makes an appointment with you, you can take a number of measures to prevent any adverse results. The key to recognising and dealing with aggressive or violent patients is involving the whole practice team in planning and communicating the approach.

Before a patient arrives:

- *identify the risk*: make sure frontline staff are trained in detecting and dealing with potentially violent or aggressive patients
- *have information*: make the collective practice knowledge of a high-risk patient available to frontline staff, such as through a confidential list of known high-risk patients and/or an alert device, such as a sticker or code on clinical notes or computer systems
- *monitor the waiting area*: ensure that frontline staff are alert to signs of possible aggression in a patient – to do this, they need to be able to see all patients in the practice waiting area.

When the patient makes the appointment:

- *fast track appointments* for high-risk patients: this may help to reduce frustration, especially for mental health patients
- *have confidential alerts* on the appointment book
- *make longer appointments* for high-risk patients.

When the patient arrives, if the risk can be identified at reception:

- *alert others* in the team, especially the clinician seeing the patient
- *reduce waiting room time* for patients considered at high risk for violence and aggression. This also moves them away from other patients.

When the consultation is underway:

- *employ usable and discreet alarm/notification systems*, such as a chat/message facility in your computer system or alarm buttons in the consulting rooms and at reception
- *use chaperones* in the room to mitigate risk
- *arrange monitoring* by other practice staff: a strategically-timed phone call or a knock on the door can help defuse a potentially dangerous situation.

If the patient becomes aggressive or violent:

- *activate the practice alert system*
- *contact the Police*: make sure staff know how to contact the Police and use this option if necessary
- *end the doctor/patient relationship* if necessary – the New Zealand Medical Association and the Medical Council of New Zealand can advise on this process<sup>5,6</sup>
- *use trespass orders* if necessary
- *alert ACC*.

### Doctor actions

*Cole's Medical Practice in New Zealand 2006*<sup>7</sup> states that a GP must always behave in a professional manner. You also need self-awareness and reflection, especially when you want to reduce the potential for an adverse relationship to deteriorate to aggression or violence.

As well as being aware of these features, you need to understand how your own personality or behaviour can influence patient violence or aggression. Be aware of any cultural differences between you and your patients and how they could affect communication and understanding between you. Similarly, your own reaction to aggression is important, as is the clarity of your communication.

- *Establish an agreed agenda* with your patient at the beginning of a high-risk consultation.
- *Communicate clearly*: be assertive if necessary, but avoid aggressive reactions. Analyse your reactions, especially your non-verbal communication.
- *Acknowledge* possible provider or system failings. You could explain how the system works - and remember your role in appropriate and reasonable patient advocacy.
- *Have a chaperone* (such as another member of staff) in the room.
- *Engage with the patient's family/whānau*, assuming they are not perpetrators of violence. Encourage family/whānau support at the consultation, as it may reduce patient anxiety/fear and prevent it escalating to aggression.
- *Focus on ways forward* during the consultation, rather than defend previous events.
- *Discuss the case with the ACC case manager*. Having one case manager per practice or GP greatly enhances this communication.
- *Consider referring the patient to another doctor* in your practice who has skills more appropriate to this patient than yours. Make sure this is planned with the practice team and the other doctor. If you're a solo GP, ask a nearby colleague to help.

If your doctor-patient relationship deteriorates towards significant adversity, it may help to:

- *change the consultation room layout*: make sure you're between the door and the patient
- *engage outside help* (ie. with other practice staff) as soon as things start to deteriorate
- *alert an ACC case manager*: case managers have some training in dealing with difficult claimants. They can interview patients in more secure environments to reduce the individual risk.

## Follow-up

A violent or aggressive patient in the practice is a significant event, so it's important to debrief and discuss it with your team – you can learn a lot from analysing what went right and what went wrong. You can get a resource on this from the Royal New Zealand College of General Practitioners.<sup>8</sup>

## Where to start

To deal with aggressive or violent patients properly, your practice needs to be able to assess risk and have the necessary structure and processes to deal with these situations.

Planning starts by creating a practice policy covering the above criteria and actions, with the whole team involved in implementing it. While patient violence is rare in most general practices, planning for such scenarios greatly reduces the risk of harm to you, your staff, and your patients.

## Summary

- *GPs and practice staff must always be aware they could encounter an aggressive or violent patient, and have mechanisms in place to deal with them.*
- *Detecting 'high-risk' patients early and implementing harm-reduction interventions can stop threatening behaviour escalating into full-blown violence.*
- *It's important to try to identify the antecedents that promote or encourage aggressive or violent tendencies in a patient such as patient, practice, and doctor features. Careful analysis here may lead to the cause of the problem and help in management strategies to benefit you and your patients.*

- *Take a practice team approach to planning and managing aggressive or violent patients.*
- *Contact appropriate support groups if a patient becomes aggressive or threatens violence, eg. the Police, ACC, the New Zealand Medical Association, or the Medical Council of New Zealand.*
- *Effective prevention and appropriate action are the management cornerstones in dealing with violent and aggressive patients.*

## How ACC can help

It's vitally important that you liaise with ACC case managers about violent and/or aggressive patients. They can assess the situation and determine whether antecedent factors are contributing to the hostility.

If a patient has developed a mental illness post-injury and this appears to contribute significantly to their aggression or violence, ACC can determine the appropriate entitlements. These could be psychiatric evaluations and therapy or psychologist referrals. In these cases, ACC case managers can be crucial in working with you to rehabilitate the patient and improve and consolidate the doctor-patient relationship.

If chronic pain resulting from an injury is central to a patient's frustration and escalating hostility, ACC case managers can choose pain management options, which extend to and include using activity-based programmes. This support could help you and your patient to achieve a return to work.

As already noted, patient hostility can be aggravated or caused by drug and/or alcohol addiction. In these cases, and at the case manager's discretion, ACC can help by arranging access to drug and alcohol evaluation programmes that can subsequently lead to therapeutic options.

ACC also trains case managers to deal with difficult or hostile claimants, so they can support you in getting information from these patients. Case managers usually undertake interviews in rooms that offer some protection and security, such as with two-way mirrors.

If your patient works for an accredited employer under the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

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# Monitoring and Maintaining Return to Work

Once your patient has returned to work, they'll need regular monitoring to ensure that their return to work plan is working or if it needs to be reviewed.

If an ACC case manager is involved, they'll monitor your patient's progress against the expected milestones in the plan. It may need adjusting if their recovery isn't progressing as well as expected, or if their hours or duties are aggravating their injury. Monitoring will ensure these issues are dealt with as soon as possible to get your patient back on track with their rehabilitation.

Patients who make good progress and return to normal work tasks usually have their ACC claims closed. However, the patient may still need ongoing clinical follow-up. With the ACC case manager no longer involved and alternative work arrangements discontinued, it's also important that you follow up their ability to work safely and without adverse health effects.

## Monitoring an early return to work

Specific areas and conditions may require special attention when your patient has begun a graduated return to work. For example:

- *your patient may be reluctant to return to work.* They may have anxieties about unsympathetic work colleagues, a lack of appreciation of the benefits of working, or a belief that work caused their initial injury.
  - Frequent review and reassurance may be all that is required.
- *their employer/manager/supervisor may not fully support a graduated return to work.* Some people may feel undermined or 'set up to fail'. It helps to have an agreed return to work plan, communicated to ACC and the employer, that sets clear goals within a realistic timetable for progressive recovery.
  - At each review, you or your practice nurse could contact the employer to reinforce that your patient is progressing as expected and making the appropriate effort.
- *your patient may still be in pain.* However, pain should not be seen as an indication for stopping a return to work programme.
  - Advise your patient to expect more pain on their return to work.
  - Provide regular high-dose medication. It's better to titrate down than to increase the dosage progressively until the patient tolerates higher activity levels.
  - Check that your patient takes their prescribed analgesia as advised ie. regularly and in sufficient doses.
  - If specific activities at work are causing the pain, your patient may need further workplace modifications in the short term.
- *medications may be interfering with the person's ability to work.* Analgesia may cause drowsiness, concentration difficulties or analgesic headaches at high doses. Problems with medication are more common if your patient is working extended shifts or on night shifts.
  - Advise them to avoid, in the short term, operating dangerous machinery, driving trucks or forklifts, or fast-paced work such as assembly lines.
  - Consider substituting their current medication with a comparable one and monitor it for similar side effects, or use drugs in combination at a lower dose to reduce the side effects.
- *the injury may be reducing your patient's general mobility.* Typically, injuries causing prolonged pain (or loss of function) in the back and lower limbs reduce overall mobility with prolonged standing or sitting, or when changing positions.
  - Advise your patient to rotate jobs that have different positions and movements, and suggest they use seating to reduce strain.

- If they can't move around the workplace to complete their tasks, suggest limiting the sphere of work.
- If they find it difficult to get to and from work and there's no one to drive them, ACC may be able to help with the costs of taxis for this purpose.

## Gradual process injuries

Recovery from gradual process injuries is often slow and relapses are common.

- If your patient's pain worsens during a graduated return to work programme, give it your urgent attention.
- Review your clinical management – consider changing anti-inflammatory medication, referring for physiotherapy and/or recommending additional support in the workplace.
- Consider reducing the number of hours your patient works, allowing 'recovery days' off normal work and rapidly rotating a variety of jobs they can do.
- Ask ACC to arrange a workplace assessment; it may be possible to modify tools and/or equipment to reduce strain on the affected part, or for your patient to work more ergonomically.
- If psychosocial factors are present (eg. if your patient is anxious about work and fearful of the symptoms occurring at work), consider a psychological referral through ACC.
- If your patient has lost their job, work trials through ACC's Work Ready Programme can help with developing skills and confidence. A case manager can help you with this.

Review your patient regularly, be flexible with their return to work plan, and reassure them on their path to recovery.

## Head injuries

The lack of a visible injury and the behaviour of head injury patients during a gradual return to work programme can mean that employers are not always supportive. Patients with head injuries commonly have depression, fatigue, and mood instability, which may leave them unpredictable and uncooperative.

- Review your patient regularly.
- Ask the ACC case manager to keep regular contact with their employer.
- If your patient isn't making the planned progress, consider a case conference. Involve their spouse/partner and colleagues/supervisors to find out how things are really going.
- Suggest practical support eg. checklists or working with a 'buddy' or under supervision.
- Your patient may need retraining to help them to relearn skills lost through their injury. Learning new skills may require extended retraining.
- Specific problems may require specialist referral eg. balance and co-ordination disorders may require neurological evaluation.

The Brain Injury Association is a valuable resource. It can be contacted on 0800 272 464 or [www.brain-injury-nz.org](http://www.brain-injury-nz.org).

## Mental health at work

People who are anxious, stressed, or depressed can find it difficult to maintain good mental health. This can be exacerbated by pain, excessive fatigue, financial pressures, feeling unsupported at work, or an early failure in graduated return to work programmes.

- Review your patient regularly and anticipate problems that are interfering with their recovery.
- Remember that schizophrenia and bipolar disorders are likely to cause unpredictable problems with returning to work, especially if they are co-existing in a head-injury patient.
- If retraining is required, co-operation may be a problem until your patient regains stable mental health.

## The older worker

Generally, older workers do as well as younger workers in graduated return to work programmes. However, older people are more likely to have co-existing illnesses or disabilities, lose conditioning faster, and have weight gain problems after injury.

- Assess older workers for risk factors such as weakness, depression, or loss of confidence. Refer for a specialist opinion if necessary.
- Consider a more gradual programme with less demanding work. It may be useful to refer your patient for a workplace assessment.
- Consider using an occupational therapist or physiotherapist to provide conditioning or work-specific training to develop your patient's skill readiness.
- If retraining is required, your patient may require more encouragement.

Follow-up could be a simple phone call from you or your practice nurse.

## Problematic return to work

Advise your patient to discuss any problems with their return to work programme with you – and promptly. Communicate with them and their employer that setbacks are only temporary.

Your intervention is likely to restore the return to work process.

- Discuss any concerns with your patient and/or their employer and inform the case manager.
- Consider a case conference to discuss the issues.
- Recommend rest with care.
- Carefully review clinical, work, and psychosocial factors that may be impeding your patient's ability to return to work.
- Suggest modifying the return to work plan to suit your patient's current capacity.
- Check your patient's analgesia intake and reassure them that pain doesn't mean injury.
- Consider additional interventions eg. physiotherapy, work conditioning, or cognitive behavioural therapy.

Problems may arise from your patient's poor general health or physical conditioning. Where pain is also a factor, their case manager may consider referring them for work hardening through an activity-based programme. It's important to discuss a problematic return to work with the case manager as they may have options that can help your patient.

A work assessment may be required if there appear to be excessive demands from your patient's normal work. This can identify barriers owing to a mismatch between work demands and work capacity.

In some cases, patients may need retraining and/or placement into different jobs. In this case, please refer to the specific conditions mentioned earlier in this chapter.

## Maintaining successful outcomes

Generally, graduated return to work plans that involve alternative duties result in workers returning to full duties in their pre-injury jobs, or to alternative jobs with the same employers.

While doing alternative work, your patient receives considerable support – so it's crucial to maintain this support rather than withdraw it totally and/or suddenly. This is not over-medicalisation, although you should take care to not compromise patient autonomy and self-empowerment.

When returning a patient to full duties, it's important to consider the following:

- Is your patient confident of their ability to work normally?
- Have work colleagues supported their graduated return to work programme, and will they accept their return to normal work?

- Has their supervisor/manager dealt with the graduated return to work and any associated problems effectively, and supported the programme overall?
- What pain relief is required? Regular high-dose analgesia is often required during a graduated return to work programme. When your patient returns to full duties, it may be appropriate to reduce their medication and advise them how to taper off analgesic use while at work.
- Has their use of analgesia or attendance at treatment interfered with normal working?
- Once your patient is working a full day, they may have problems with transport, such as crowded buses or problems parking close to work. Identify any barriers and their solutions.
- If your patient is returning to shift work, especially night shifts, the risk of re-injury may be higher. They may need some work modification, such as manual/mechanical help with lifting, or if working alone increases their re-injury risk, may need additional supervision.

## Summary

*In monitoring a patient's early return to work, you need to:*

- *review their progress regularly*
- *be flexible with their return to work plan*
- *arrange for their duties to be modified if required*
- *adjust their medication if necessary*
- *provide reassurance and support.*

*In maintaining your patient's return to full duties once their ACC claim has been closed, you need to:*

- *make sure all their support doesn't stop suddenly*
- *review their case as necessary*
- *consider the appropriateness of normal duties eg. some modification may be required to prevent re-injury.*

## How ACC can help

While your patients' ACC claims are still open, ACC case managers can:

- monitor return to work plans
- organise workplace assessments
- arrange case conferences
- liaise with employers
- approve transport assistance eg. taxi fares
- suggest options to support a problematic return to work, eg. if they require special equipment
- arrange counselling
- organise work hardening where pain is a limiting factor.

## Work Ready Programme

This programme is suitable for people who have lost their jobs and been recommended for the programme by an occupational assessment. It tests their vocational suitability for job options and their work readiness, and re-establishes work routines. If you think this would suit your patient, discuss it with their ACC case manager.

If your patient works for an accredited employer in the ACC Partnership Programme, see pages 26 and 28 (last bullet point) for further information.

# Appendix I

## Glossary of Return to Work Terms

### ACC Partnership Programme

The brand name for the accredited employer programme – see Accredited employer.

### Accredited employer

An employer able to manage all work-related injuries for their employees, replacing ACC. Accredited employers are subject to the Injury Prevention, Compensation, and Rehabilitation Act 2001, and detailed terms and conditions under the Accredited Employer Programme Accreditation Agreement.

Accredited employers are entitled to all work-related injury information in the same way as ACC, to enable them to effectively pay entitlements and manage claims and rehabilitation.

More than 180 groups of employers are accredited and between them they cover more than 25% of the full-time workforce – see ACC Partnership Programme.

### ACC18 Medical Certificate

A form completed by a registered medical practitioner to certify a patient's time off work, and to add to or change a diagnosis previously given on the ACC45.

### ACC45 injury claim form

A form completed by an injured person and their initial treatment provider as the first report of the person's injury(s) caused by an accident. ACC uses the form to decide whether the injured person qualifies for ACC cover. In signing the form, the person consents to ACC gaining access to relevant medical information about them.

The time off work section on the form can only be certified by a registered medical practitioner.

### Activity-based Programme

See 'Pain management services'.

**Alternative duties** Duties that allow an injured employee to stay at work, or return to work. They include modified work tasks or a modified work environment, and reduced or restricted hours. Alternative duties are usually different from pre-injury duties.

**Blue flags** See 'Clinical flags'.

**Case co-ordinator** ACC case co-ordinators work from contact centres in Dunedin, Christchurch, Wellington and Hamilton and manage claims of up to 70 days' duration. They review all new claims where the claimant is likely to have ACC entitlements. They contact the injured person, assess their needs, and set up entitlement payments. If face-to-face case management is required, they refer the case to a case manager in a branch.

**Case manager** Case managers operate from branches around New Zealand and manage all face-to-face relationships and longer-term cases. They contact the injured person, assess their needs, set up entitlement payments, and co-ordinate their rehabilitation.

Clinical flags	<p><i>Blue</i>: environmental features (work or social) that may delay or become a barrier to recovery.</p> <p><i>Red</i>: problems or symptoms that require medical intervention. They indicate injury barriers.</p> <p><i>Yellow</i>: psychosocial risk factors (ie. relating to the interaction between the person and their social environment, and the influences on behaviour). They indicate individual barriers.</p> <p>(Refer to the <i>New Zealand Acute Low Back Pain Guide Incorporating the Guide to Assessing Psychosocial Yellow Flags in Acute Back Pain</i>, 2004, Wellington)</p>
Comprehensive pain assessment	See 'Pain management services'
Employment Maintenance Programme	See 'Vocational rehabilitation programmes'.
Functional capacity evaluation (FCE)	<p>An assessment of a person's capacity to perform broadly defined physical employment-related work demands. FCEs are a tool for developing and implementing a rehabilitation plan; they are not stand-alone assessments, and should be used with other sources of information about the injured employee. FCE reports show what the employee can do at a particular point in time, and the task-specific component is useful if there is only one barrier to a full return to pre-injury duties. The FCE report should be reviewed every three to six months.</p>
Graduated return to work	A gradual increase in activity and/or hours in the workplace for an injured employee through, for example, moving from modified duties to normal duties, or moving from reduced hours to full-time hours.
Graduated Return to Work Programme	See 'Vocational rehabilitation programmes'.
Individual rehabilitation plan (IRP)	<p>An ACC document developed by the case manager with the injured person, which may include input from you, their employer and their family/whanau. It details how ACC and your patient will work together to achieve their rehabilitation.</p> <p>The IRP is implemented together with your patient, you and their employer. As a working document, it's regularly updated and records rehabilitation progress against expected milestones.</p>
Interventional pain management	See 'Pain management services'.
Job analysis	<p>An investigation of a job's physical and psychological requirements. It covers:</p> <ul style="list-style-type: none"> <li>• task frequency, duration, forces applied, postures involved and cognitive requirements</li> <li>• the environment in which the job is completed</li> <li>• variation of exposure to the task or job demands such as job or task scheduling</li> <li>• determining the productivity of the task/job.</li> </ul>
Long-term rehabilitation plan	This provides a comprehensive approach to managing claimants with a serious injury. It focuses on their abilities and rehabilitation requirements, and encourages the claimant's inclusion and participation in society.

**Modified duties** Duties that have had components removed or included to match an employee's capacity – for example, varying tasks to encourage postural changes or having another person completing the lifting part of a task.

**Multi-disciplinary Persistent Pain Programme**  
See 'Pain management services'

**Pain management services**

*Activity-based programme:* a rehabilitation Programme for people with persistent pain problems of at least six weeks duration. The Programme aims to address pain issues early to prevent the development of chronic pain.

*Comprehensive pain assessment:* this assessment helps ACC to assess and manage a patient's ongoing pain after an injury. The assessment:

- is designed for patients with persistent pain that has lasted 12 weeks or more
- involves a multi-disciplinary (medical, psychosocial and functional) assessment that aims to recommend the most appropriate management options
- acts as a gateway to all pain management services (except exercise-focused activity-based programmes).

*Interventional pain management:* this is for people with persistent pain conditions that haven't responded to conventional therapy and medication. It involves skilled interventions by pain medicine specialists to diagnose and control the pain.

*Multi-disciplinary Persistent Pain Programme (MPPP):* a Programme for people with significant pain that has persisted for 12 weeks or more. The Programme:

- involves three weeks of intensive education and therapy
- aims to modify the participants' responses to pain, rather than remove the pain stimulus.

Participants learn to:

- monitor their pain and implement strategies to manage it and prevent its escalation
- increase participation in agreed activities at home and work.

**Red flags** See 'Clinical flags'.

**Return to work plan**

A goal-oriented plan to help an injured person return to work quickly and safely. It can be developed by you, a case manager or an employer's health practitioner or occupational health nurse.

The plan may involve buying equipment, adjusting duties or allowing the person to return to the workplace for partial days, gradually working up to full-time hours. This helps them to stay connected to the workplace and encourages a faster recovery.

The plan can cover multiple injuries and should be reviewed if there is an aggravation. It can also be used to enhance the IRP.

**Suitable selected duties**

Temporary duties that an injured person has a medical capacity to perform while they recover. The duties depend on factors such as the person's injury type, medical capacity, level of education or skills, and pre-injury duties and hours of work.

**Treatment provider**

The health professional responsible for a person's medical management.

## Vocational rehabilitation

Rehabilitation for injured people who need support to maintain their employment, to find work, or regain or acquire vocational independence.

ACC's vocational rehabilitation focuses on the claimant's needs and addresses any injury-related barrier that prevents their participation in work.

## Vocational rehabilitation assessments

Two assessments that occur early in the vocational rehabilitation process:

*Initial occupational assessment (IOA):* IOAs are undertaken by suitably qualified assessors for injured people who are:

- unlikely to keep their pre-injury jobs
- likely to need to find work, or regain or acquire vocational independence.

An IOA provides decision-making information about injured people's employment options, which will guide their vocational rehabilitation.

*Initial medical assessment (IMA):* IMAs are undertaken by contracted assessors for injured people who are being considered for vocational rehabilitation.

An IMA provides an opinion about the injured person's cognitive and physical ability to undertake safely the types of work identified in the IOA. The IMA also determines whether the types of work identified are medically sustainable (ie. they won't put the person's injuries at risk).

*Vocational independence assessments:* these comprise two assessments that take place near the end of rehabilitation, after the injured person has undertaken relevant rehabilitation programmes:

*Vocational independence occupational assessment (VIOA):* the VIOA reviews the vocational rehabilitation programme and identifies if it has been completed or if there are any gaps remaining. The assessor considers whether the types of work identified in the IOA are still suitable. If the injured person has gained further skills during their rehabilitation, additional types of suitable work may be considered.

*Vocational independence medical assessment (VIMA):* the VIMA focuses on the person's physical ability to work safely in the types of work identified over a durable period.

If the person isn't capable of doing the specified work types, the VIMA also considers and recommends specific medical treatment and/or rehabilitation to help them achieve that functional ability.

## Vocational rehabilitation programmes

*Employment Maintenance Programme:* an early intervention rehabilitation Programme to help maintain an employee's ability to stay at work. It is for those who could return to their pre-injury job, but their employer has indicated that no alternative duties are available.

*Graduated Return to Work Programme:* a Programme that evaluates the workplace to ensure an injured employee can work safely in their current or alternative type of work provided. It details a gradual increase in activity and/or hours and includes follow-up supervision until the person has returned to their pre-injury hours and duties.

*Work-ready Programme:* a Programme for people who have lost their jobs and been recommended to it by an occupational assessment. It tests their vocational suitability for



job options, aids their work readiness, and re-establishes work routines. The Programme is based on the work types identified in the initial occupational assessment.

*Work Preparation Programme:* a Programme for people unable to return to their pre-injury employment and who are not work ready. Participants receive physical, psychological, and vocational rehabilitation training to prepare them for vocational independence. The Programme is based around the work types identified in the initial occupational assessment.

#### Workplace assessment

This evaluates a workplace to identify and implement any changes necessary for a person to continue with, or return to, their pre-injury or an alternative role.

A workplace assessment involves:

- evaluating the physical and psychological demands of pre-injury duties (job analysis)
- identifying and evaluating the physical and psychological demands of suitable duties
- determining the mechanism of the person's injury and its history
- developing a proposed timeframe for the person's return to their pre-injury role
- assessing the person's current medical and employment status to determine specific occupational rehabilitation needs
- assessing the person's workstation, equipment and any requirements for modifications or aids, appliances, apparatus, etc
- identifying and providing recommendations to address any barriers to the person returning to work.

The case manager uses this assessment to decide if a vocational programme, such as the Employment Maintenance Programme or the Graduated Return to Work Programme, is needed to aid the person's recovery.

This information is also useful for you to complete the ACC18 Medical Certificate correctly.

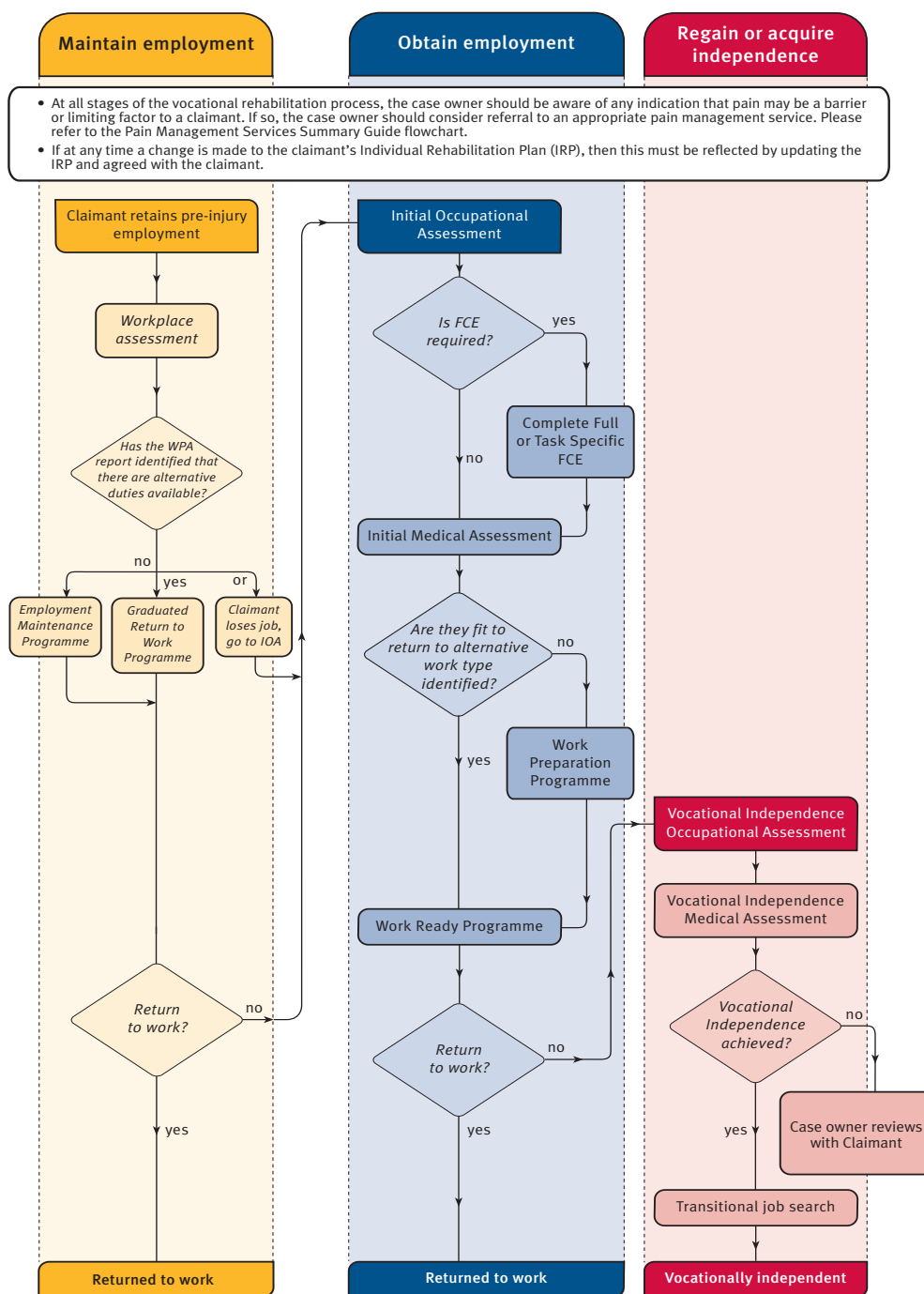
#### Yellow flags

See 'Clinical flags'.



# Appendix 2

## Claimant Participation in Vocational Rehabilitation



If at any time during the Maintain Employment phase the claimant loses their job or a 'red flag' appears, refer them to IOA.

This flowchart is a guideline only. To find information on each specific service, please go to: <http://staff/staff/informe/f-entitlements-rehabilitation-treatment/rehabilitation/vocational-rehabilitation/entitlements/>



# Appendix 3

## Return to Work Plan Template

This type of return to work plan template may be useful when reviewing your patient's progress. If your patient has a case manager/co-ordinator, please discuss the completed form with them.

### Employee details

Name \_\_\_\_\_ Job title \_\_\_\_\_

Location of work \_\_\_\_\_ RTW date \_\_\_\_\_

Usual hrs worked: per day \_\_\_\_\_ per week \_\_\_\_\_

Workplace support person \_\_\_\_\_

### Goals of return to work plan

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Starting number of: work days \_\_\_\_\_ work hours \_\_\_\_\_

Target: work days \_\_\_\_\_ work hours \_\_\_\_\_

### Return to Work Outline

#### Week 1

Days work (circle)                    M    T    W    T    F    S    S

Hours per days \_\_\_\_\_

Breaks to be taken (no. & frequency) \_\_\_\_\_

Duties \_\_\_\_\_  
 \_\_\_\_\_

#### Week 2

Days work (circle)                    M    T    W    T    F    S    S

Hours per days \_\_\_\_\_

Breaks to be taken (no. & frequency) \_\_\_\_\_

Duties \_\_\_\_\_  
 \_\_\_\_\_

#### Review

Comments and actions during weeks 1 and 2:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Week 3

Days work (circle)                    M    T    W    T    F    S    S

Hours per days \_\_\_\_\_

Breaks to be taken (no. & frequency) \_\_\_\_\_

Duties \_\_\_\_\_  
\_\_\_\_\_

Week 4

Days work (circle)                    M    T    W    T    F    S    S

Hours per days \_\_\_\_\_

Breaks to be taken (no. & frequency) \_\_\_\_\_

Duties \_\_\_\_\_  
\_\_\_\_\_

Review

Comments and actions during plan period:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Review date 1 \_\_\_\_\_ Review date 2 \_\_\_\_\_

**Signed by:**

Patient \_\_\_\_\_

Manager/supervisor \_\_\_\_\_

Treatment provider \_\_\_\_\_

Case manager \_\_\_\_\_

# Appendix 4

## How to Identify Suitable Duties

### How to identify suitable duties



The goal of rehabilitation is to return the injured employee to a pre-injury position. Providing temporary suitable duties is one way to make this happen. It is an important step in achieving a safe and durable return to work, as the longer a person is absent from work the less likely they are to return.

#### What are the benefits?

- Enables you to facilitate an early, safe and durable return to work. This will help to reduce any productivity loss.
- It creates an opportunity to have “backburner” tasks completed.
- Prevents your employee from feeling isolated from their workplace.

#### What are suitable duties?

These are temporary duties that the injured employee is fit to perform while recovering. They will depend on factors such as the type of injury, medical and functional capacity, level of education or skills, and pre-injury duties and hours of work.

Suitable duties may include:

- alternative duties in the same or another area of the business
- modified duties – duties that have had components removed, or included, to match the employees capacity. For example, include different duties so the injured employees positions and actions are changed regularly. Have another person completing the lifting part of the task
- the same job, but reduced hours
- alternative job, but reduced hours.

Suitable duties should be work that is productive and adds value to your business.

#### What are my suitable duty options?

There are a variety of options that can be considered for a return to work. Always remember that the goal is to return to work pre-injury hours and duties, where possible. Below is a list of possible types of suitable duties – starting with best case scenario:

1. Modified pre-injury duties, with same pre-injury hours.
2. Alternative duties, in the same area and with pre-injury hours.
3. Modified duties, in a different area with same pre-injury hours.
4. Alternative duties, in a different area with same pre-injury hours.

5. Modified or alternative duties, in the same area with reduced hours.
6. Modified or alternative duties, in a different area with reduced hours.

### **Ideas for identifying suitable duties**

- Talk to the employee, supervisor and other employees about what duties they think could be made available. Sometimes having a brainstorming session can result in the identification of duties that would normally be missed. This also helps employees feel more supported in the process.
- Make changes to tasks the injured employee finds difficult, eg. change in technique or posture.
- Review the jobs at the work place; consider the current skill of the employee and potential areas to up-skill the employee.
- Review the demands of the selected duties, by using the job analysis guide.
- Consider work that tends to sit on the backburner because there isn't normally time in the day to complete it .
- Is there a training opportunity for this particular injured employee while they are recovering from their injury?
- Before the employee starts the suitable duties, make sure there is a clear Return to Work Plan with review dates no greater than 3 to 4 weeks apart. You must have agreed that the employee has a capacity to complete them.
- When a return to the pre-injury work area is not possible, consider internal redeployment. Internal redeployment may be temporary, but will assist in a faster and safe return to work. Where it seems likely that the employee will not be able to return to their pre-injury duties, internal redeployment may be permanent.
- Consider the employee in a coaching or mentoring role.
- Consider regular changes in body position. Doing lots of different tasks is useful, as this helps prevent boredom and overuse injuries.
- Incorporate rest periods into the job.
- If in doubt, talk to the ACC case manager.



# Appendix 5

## Work Task Overview

### Work Task Overview

Name:		Job Title:		Company:	
General Details		Days worked per week:		Break details:	
Hrs worked per week:		Hrs worked per day:		Days worked per week:	
Hrs worked per day:		Hrs worked per week:		Overtime required:	
Work Environment Details (Describe environment that employee works in eg. access, office, factory, and note any unusual features eg. heat, cold, noise or chemicals)					
Main Working Postures / Positions and Work Tasks Details					
Working postures/positions: Amount of time in posture during a day:					
record details <i>only</i> if posture is required during main work tasks (* Write <i>maximum</i> lift required )					
Occasional up to 1/3 of work time	Frequent 1/3 – 2/3 of work time	Constant all or almost all of work time	List main work tasks:		
Sitting			Do main work tasks require any:		
Standing			<input type="checkbox"/> Pushing/pulling <input type="checkbox"/> Repetitive hand/arm actions (Natural breaks/pauses – Y/N) <input type="checkbox"/> Reaching up or across <input type="checkbox"/> Reaching lower levels <input type="checkbox"/> Communication (verbal) <input type="checkbox"/> Communication (written) <input type="checkbox"/> Driving <input type="checkbox"/> Staff management <input type="checkbox"/> Communication (written/verbal) <input type="checkbox"/> Planning/sequencing <input type="checkbox"/> Problem solving/sound judgement <input type="checkbox"/> Attention and concentration <input type="checkbox"/> Stamina (cognitive and/or physical) <input type="checkbox"/> Tool usage ( <i>list details</i> )		
Walking			(Estimate % of time in each main task)		
Walking on uneven surfaces			Is there an ability to vary postures/positions during the day? (Y/N)		
Lifting (* _____ kgs )			If required are there alternative duties or can this role be modified? ( Y/N)		
Climbing (stairs or ladders)					
Bending/twisting					
Can the employee control the pace of work tasks? (Y/N)					
Is there an ability to vary tasks during the day? (Y/N)					
Other comments					
Completed by:				Date:	
Title:					

## Work Task Overview – Possible Modified or Alternative Duties

Name: _____		Job Title: _____		Company: _____	
General Details		Days worked per week: _____		Break details: _____	
Hrs worked per week: _____		Days worked per day: _____		Overtime required: _____	
Work Environment Details (Describe environment that employee works in e.g. access, office, factory, and note any unusual features e.g. heat, cold, noise or chemicals)					
<b>Main Working Postures / Positions and Work Tasks Details</b>					
Working postures/positions: <i>record details only</i> ; if posture is required during main work tasks (* Write <i>maximum</i> lift required )	Amount of time in posture during a day:			List main work tasks:	Do main work tasks require any:
	Occasional up to 1/3 of work time	Frequent 1/3 – 2/3 of work time	Constant all or almost all of work time		
Sitting					<input type="checkbox"/> Pushing/pulling
Standing					<input type="checkbox"/> Repetitive hand/arm actions (Natural breaks/pauses Y/N)
Walking					<input type="checkbox"/> Reaching up or across
Walking on uneven surfaces					<input type="checkbox"/> Reaching lower levels
Lifting (* _____ kgs )					<input type="checkbox"/> Communication (verbal)
Climbing (stairs or ladders)					<input type="checkbox"/> Communication (written)
Bending / Twisting					<input type="checkbox"/> Driving
					<input type="checkbox"/> Staff management
					<input type="checkbox"/> Communication (written/verbal)
					<input type="checkbox"/> Planning/sequencing
					<input type="checkbox"/> Problem solving/sound judgement
					<input type="checkbox"/> Attention and concentration
					<input type="checkbox"/> Stamina (cognitive and/or physical)
					<input type="checkbox"/> Tool usage ( <i>list details</i> )
Can the employee control the pace of work tasks? (Y/N)				(Estimate % of time in each main task)	
Is there an ability to vary tasks during the day? (Y/N)				Is there an ability to vary postures/positions during the day? (Y/N)	
Other comments				If required can the alternative duties be modified? ( Y/N)	
Completed by: _____				Title: _____	
				Date: _____	

# Appendix 6

## Medical Disability Advisor Disability Durations<sup>1</sup>

The US-based Medical Disability Advisor (MDA), which provides workplace guidelines for disability duration, can be a useful reference tool to complement and support the medical expertise of the health care provider.

Ordered by injury, illness or treatment name, the MDA presents disability duration tables providing minimum, optimum and maximum duration expectations based on job classification. Supporting information includes recommendations on rehabilitation therapies, frequency and duration of treatment, co-morbidities and other factors that may impact disability duration, and suggestions for returning to work, including appropriate work restrictions and accommodation.

### Example – Incapacity durations for epicondylitis

DURATION IN DAYS				
JOB CLASSIFICATION	WORK TYPE	MINIMUM	OPTIMUM	MAXIMUM
	Sedentary	0	7	28
	Light	1	10	28
	Medium	7	21	56
	Heavy	14	28	56
	Very heavy	14	28	56

#### Factors influencing duration

Dominant versus non-dominant arm, work requirements (use of wrist, forearm), conservative versus surgical treatment, and compliance to rehabilitation programme all affect the length of disability.

#### Notes

The disability duration figures are based on statistically significant data covering more than 3.5 million workplace absence cases, including data from ACC. The duration tables are physiologically based. They reflect actuarial experience and provide guidelines on the length of the recovery process consistent with a person's injury and work type. ACC uses the data in its provider education material and for monitoring purposes.

The figures reflect only those patients that are case managed, and doesn't include those that don't require any time off work. The values don't represent absolute minimum or maximum times but rather indicate key points in time for review and/or other decisions.

The *minimum* figures indicate the minimum recovery time most people require to return to work at the same performance level as before the injury or illness. Patients may be fit to return to work in a shorter period, particularly if there are suitable selected or modified duties, or other support.

The *optimum* is the time most people are likely to be able to return to work, subject to good health care and no significant complications and/or co-morbid medical conditions.

The maximum is the time at which additional review and evaluation should occur to determine when (and if) the person may be able to return to work and whether there are specific factors that need to be addressed.

## Reference

1. Reed P (ed), *Medical Disability Advisor: Workplace Guidelines for Disability Duration*, 4th edition, Boulder, Colorado, USA: Reed Group: 2001.

# Appendix 7

## Clinical Assessment of Psychosocial Yellow Flags

### ❖ Clinical assessment of Psychosocial Yellow Flags\*

These headings (Attitudes and Beliefs about Back Pain, Behaviours, Compensation Issues, Diagnosis and Treatment, Emotions, Family and Work) have been used for convenience in an attempt to make the job easier. They are presented in alphabetical order since it is not possible to neatly rank their importance. However, within each category the factors are listed with the most important at the top of the list.

**TABLE 2: CLINICAL ASSESSMENT OF PSYCHOSOCIAL YELLOW FLAGS**

#### ATTITUDES AND BELIEFS ABOUT BACK PAIN

- ❖❖ Belief that pain is harmful or disabling resulting in fear-avoidance behaviour, eg, the development of guarding and fear of movement
- ❖❖ Belief that all pain must be abolished before attempting to return to work or normal activity
- ❖❖ Expectation of increased pain with activity or work, lack of ability to predict capability
- ❖❖ Catastrophising, thinking the worst, misinterpreting bodily symptoms
- ❖❖ Belief that pain is uncontrollable
- ❖❖ Passive attitude to rehabilitation

#### BEHAVIOURS

- ❖❖ Use of extended rest, disproportionate 'downtime'
- ❖❖ Reduced activity level with significant withdrawal from activities of daily living
- ❖❖ Irregular participation or poor compliance with physical exercise, tendency for activities to be in a 'boom-bust' cycle
- ❖❖ Avoidance of normal activity and progressive substitution of lifestyle away from productive activity
- ❖❖ Report of extremely high intensity of pain, eg, above 10, on a 0-10 Visual Analogue Scale
- ❖❖ Excessive reliance on use of aids or appliances
- ❖❖ Sleep quality reduced since onset of back pain
- ❖❖ High intake of alcohol or other substances (possibly as self-medication), with an increase since onset of back pain
- ❖❖ Smoking

*continued...*

**TABLE 2: CONTINUED**

**COMPENSATION ISSUES**

- 》》 Lack of financial incentive to return to work
- 》》 Delay in accessing income support and treatment cost, disputes over eligibility
- 》》 History of claim/s due to other injuries or pain problems
- 》》 History of extended time off work due to injury or other pain problem (eg more than 12 weeks)
- 》》 History of previous back pain, with a previous claim/s and time off work
- 》》 Previous experience of ineffective case management (eg, absence of interest, perception of being treated punitively)

**DIAGNOSIS AND TREATMENT**

- 》》 Health professional sanctioning disability, not providing interventions that will improve function
- 》》 Experience of conflicting diagnoses or explanations for back pain, resulting in confusion
- 》》 Diagnostic language leading to catastrophising and fear (eg, fear of ending up in a wheelchair)
- 》》 Dramatisation of back pain by health professional producing dependency on treatments, and continuation of passive treatment
- 》》 Number of times visited health professional in last year (excluding the present episode of back pain)
- 》》 Expectation of a 'techno-fix', eg, requests to treat as if body were a machine
- 》》 Lack of satisfaction with previous treatment for back pain
- 》》 Advice to withdraw from job

*continued...*

**TABLE 2: CONTINUED**

**EMOTIONS**

- 》》 Fear of increased pain with activity or work
- 》》 Depression (especially long-term low mood), loss of sense of enjoyment
- 》》 More irritable than usual
- 》》 Anxiety about and heightened awareness of body sensations (includes sympathetic nervous system arousal)
- 》》 Feeling under stress and unable to maintain sense of control
- 》》 Presence of social anxiety or disinterest in social activity
- 》》 Feeling useless and not needed

**FAMILY**

- 》》 Over-protective partner/spouse, emphasising fear of harm or encouraging catastrophising (usually well-intentioned)
- 》》 Solicitous behaviour from spouse (eg, taking over tasks)
- 》》 Socially punitive responses from spouse (eg, ignoring, expressing frustration)
- 》》 Extent to which family members support any attempt to return to work
- 》》 Lack of support person to talk to about problems

*continued...*

**TABLE 2: CONTINUED**

**WORK**

- ›› History of manual work, notably from the following occupational groups:
  - › Fishing, forestry and farming workers
  - › Construction, including carpenters and builders
  - › Nurses
  - › Truck drivers
  - › Labourers
- ›› Work history, including patterns of frequent job changes, experiencing stress at work, job dissatisfaction, poor relationships with peers or supervisors, lack of vocational direction
- ›› Belief that work is harmful; that it will do damage or be dangerous
- ›› Unsupportive or unhappy current work environment
- ›› Low educational background, low socioeconomic status
- ›› Job involves significant bio-mechanical demands, such as lifting, manual handling heavy items, extended sitting, extended standing, driving, vibration, maintenance of constrained or sustained postures, inflexible work schedule preventing appropriate breaks
- ›› Job involves shift work or working unsociable hours
- ›› Minimal availability of selected duties and graduated return to work pathways, with unsatisfactory implementation of these
- ›› Negative experience of workplace management of back pain (eg, absence of a reporting system, discouragement to report, punitive response from supervisors and managers)
- ›› Absence of interest from employer

Remember the key question to bear in mind while conducting these clinical assessments is

“What can be done to help this person experience less distress and disability?”

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# Appendix 8

## Helping Patients Return to Work: Practical Communication Tips

As a GP, you have a great opportunity to provide early, positive messages to your patients. However, it's important to remember that your messages can set your patients' expectations for recovery, so take a careful approach:

- Be positive. Avoid negative comments and catastrophising.
- Focus on returning your patient to their normal activities of daily living as soon as possible.
- Set your patient's expectations early, and discuss how they may have to push themselves beyond their comfort zone in the return to work process.
- Reassure and inform your patient about their injury and the rehabilitation process. Use easily understood written material as an effective way of reinforcing your message.
- Arrange a follow-up appointment within one to four days of the initial consultation to monitor progress and reinforce the expectations you set and the information you gave in the first consultation.
- Arrange a subsequent review within one to two weeks.
- Prescribe time off work (unfit for any work) as reluctantly as you would prescribe morphine. The detrimental effects may be just as severe.

### Useful words and phrases

#### 1. About pain

- Pain is a normal part of life and doesn't necessarily indicate a serious problem eg. many people wake up daily with stiff muscles and joints, but this improves with movement.
- Physical exercise often leads to pain or discomfort in the joints and muscles, especially after unaccustomed activity.
- Pain doesn't mean damage or harm eg. athletes who train heavily experience pain, but it builds muscle and endurance, which is healthy.
- You've had an [x] injury and, while individual recovery time varies, you're likely to recover well within [x] to [x] days/weeks.
- The pain will settle – most people make an excellent recovery.
- Short- to medium-term pain relief like paracetamol will do no more harm than, for example, a couple of alcoholic drinks. Your liver and kidneys can handle these substances.

#### 2. About activity

- Movement and activity won't cause harm – they'll help your recovery.
- Exercise and activity are good for you because they:
  - promote blood flow to the muscles and tissues, bringing oxygen and nutrients needed for healing
  - release endorphins, your body's own painkillers
  - reduce low moods and improve sleep, which help healing.
- Gradually increase your activity early on. Modify your activities, if necessary, but stay active within tolerable pain limits.
- Expect increased pain with increased activity – carefully push the boundaries of pain and discomfort. A gradual increase in activity is essential for speedy recovery. I'll tell you what pain relief to take for it.

### 3. About returning to work

- All medical evidence shows that people who return to work early, even in a limited capacity, have the fastest recovery rates.
- Going to work encourages activity, which helps your recovery.
- An early return to work and activity is part of best practice medicine that helps to prevent chronic pain, suffering and disability.
- Work is an important part of our lives and provides us with a daily routine and self-esteem.
- An early return to the workplace is a very important step in your recovery process.
- I'll make sure that you return to work in a safe and controlled way by liaising with your employer.
- In the initial stages of your return to work, it's important to pace yourself and take regular breaks for rest and stretching. I'll discuss this with your case manager and/or employer.

Your statements can have a major impact – so choose what you say carefully.

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# Appendix 9

## Further Reading and Weblinks

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New Zealand Chiropractic Board.  
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