Occupational wellbeing

Management of injured workers with psychosocial barriers

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BACKGROUND
Although most injured workers return to work with minimal intervention, approximately 20% show levels of distress and disability beyond that expected for the injury. The level of morale in a workplace seems to play a major role in this. Workers who experience positive emotions leading to increased morale are more likely to be resilient following injury.

OBJECTIVE
It is important for general practitioners to recognise the nonclinical factors that exert a significant influence over employee wellbeing and return to work outcomes. Some management strategies are presented.

DISCUSSION
General practitioners who work collaboratively with all major stakeholders, who identify and manage psychosocial barriers early, who take an active role in promoting positive expectations, and who focus on the immediate problem rather than its industrial associations will achieve better outcomes for their injured patients.

Individuals with compensable injuries frequently exhibit worse health outcomes than nonclaimants with similar clinical profiles[1] and can be very challenging to manage clinically. Nevertheless, most injured workers progress through treatment and return to work with minimal intervention and angst. Indeed, across all workers' compensation jurisdictions, approximately 80% of injured workers progress straightforwardly, while the other 20% exhibit levels of distress and disability that appear to be excessive when considered in relation to their initial injury. A further 5% go on to exhibit 'apparently disproportionate outcomes' where levels of long term disability and distress cannot be explained by the initial injury.[2]

Occupational wellbeing

The psychosocial flags model[3] has become an influential framework for identifying potentially complicating psychosocial factors that are predictive of poor return to work outcomes and long term disability, particularly in relation to pain related injuries. Our own research in this field has focused more specifically on work related psychological wellbeing using the organisational health framework.[4] This approach overlaps with the flags model in terms of highlighting a number of nonclinical factors that exert a significant influence over employee wellbeing and return to work outcomes.[5]

In contrast to the traditional focus on negative emotional indicators in the occupational stress literature, organisational health research finds that indices of positive emotional states (which we term morale) are important determinants of a range of workplace people related outcomes. For example, we have shown that a decline in level of morale is typically a stronger driver of stress related workers' compensation claims among cohorts of teachers and serving police officers than a substantive increase in levels of distress.[5,6] When morale declines, individuals begin to doubt their capacity to cope and focus more on distress related symptoms and negative aspects of their environment. Conversely, we have found that individuals and work teams with higher levels of morale are more resilient in managing their operational demands and pressures and exhibit less withdrawal behaviours including absenteeism and stress related workers' compensation claims.[5] Levels of morale are strongly influenced by environmental factors, and in the workplace, the most potent factors are supportive leadership styles and the overall quality of work team climate.[7]

This approach to occupational wellbeing also intersects with recent clinical research on the construct of 'resilience'.[8] Across a range of populations, Fredrickson et al[9] have demonstrated that it is the experience of positive emotions that enables individuals to bounce back from adverse experiences. More specifically, positive emotions increase personal coping resources, reduce lingering negative emotions and return a range of physiological functions (including cardiovascular reactivity) to baseline levels more rapidly.

Organisational health research suggests that when individual morale declines beyond a certain level, individuals start to disengage and begin to actively seek evidence of lack of organisational support and unfair treatment in the workplace.[7] These findings also have relevance to physical injuries where levels of supervisory support have been shown to influence the submission of workers compensation claims for musculoskeletal injuries and significantly mitigate the effects of chronic pain on work performance.[10] Hence, poor supervisory and organisational support is now increasingly recognised as a significant psychosocial barrier contributing to both psychological and physical injury outcomes.

The following are some practical approaches to treating injured workers, irrespective of whether they are presenting with psychological or physical injuries.

Work collaboratively with key stakeholders

Poor alignment and communication between key stakeholders (eg. other treating practitioners, employer representatives and workers compensation authorities) increases the likelihood of poorer return to work outcomes.[11] Some general practitioners and other health practitioners cite confidentiality concerns as a key barrier to communicating with other stakeholders.[12] However, good practice in this field involves clarifying up front with the patient that while personal information will remain strictly confidential, communication with other stakeholders about the functional impact of their health condition, return to work management issues and alternative duties are critical to achieving positive return to work outcomes.[1]

Where a worker is highly resistant to proceeding in this manner, this response should be considered to be indicative of a likely psychosocial flag (ie. significant work problems) that should be actively addressed.[13] In this situation, standard clinical interventions are likely to be less effective and the best option is to liaise with case managers and psychology service providers to address work issues or consider developing alternative return to work goals.

Additionally, most workers' compensation authorities now have in house clinical advisors who can be readily accessed by treating practitioners for assistance in managing workers and advice regarding return to work issues. It is also important not to unwittingly foster an adversarial approach toward the employer or workcover authority as this increases the risk of poorer outcomes.

Identify and manage potential psychosocial barriers early

Early screening for potential psychosocial barriers should be a standard element of clinical practice with injured workers. Pursuing a stepped care approach where usual clinical practice is monitored against normally expected recovery timeframes can be used to trigger a clinical review and additional intervention.[14]

A legitimate complaint psychologists sometimes make is that workers with significant psychosocial barriers are often not referred until 12+ months postinjury. The evidence suggests that psychosocial barriers can be accurately identified within 3 months postinjury, and much more effectively addressed at that time.[3,15]

Good practice also suggests that return to work goals and timelines should be incorporated into treatment from the outset. Again, where a worker is highly resistant to engaging in return to work discussion, this should be viewed as a psychosocial barrier to be actively addressed. One option to consider here is case conferencing with other stakeholders in order to develop appropriate strategies and formulate additional interventions.

Where the worker is angry and harbours perceptions of unfair treatment by the employer, one approach that can be helpful is to undertake a cost-benefit analysis of the increased risk of long term disability if the worker does not concurrently positively engage with return to work processes. They can be advised that they are entitled to pursue redress for perceived injustice, but that this should not postpone efforts to resume normal functioning and vocational involvements. The power of medical reassurance and encouragement to focus on specific goals cannot be underestimated here. Referral to a clinical psychologist at this point can also be a useful adjunctive intervention. Where there may be significant work problems, the case conferencing process or liaison with a case manager can be used to consider alternative duties or a different work location. This may be a more realistic interim goal to encourage the worker to maintain or redevelop a level of positive vocational engagement and inhibit the progression of the declining morale trajectory. The operative principles here are attempting to 'maintain morale' by minimising time off work and 'keeping the injured worker connected to the workplace'.

There should be a very clear and strong clinical rationale for providing any ongoing total incapacity certification. For pain related injuries, 3 weeks is frequently recommended as the limit after which increased intervention and rehabilitation management should be considered.[15] Less attention has been devoted to psychological injuries in this respect, although earlier guidelines have recommended a resumption of partial employment by 14 days for stress related problems.[12]

Active expectation management

Evidence suggests that the time taken to return to work can vary by up to one-third as a direct function of education and recovery expectation setting in the initial treatment sessions. This occurs irrespective of the type of treatment being provided and the nature of the injury.[14] Accordingly, explicitly establishing positive recovery expectations and providing information about expected recovery trajectories is crucial. Moreover, as noted above in relation to psychosocial barriers, the power of medical reassurance and encouragement in contributing to the maintenance of morale should not be underestimated.

Maintain a focus on the work injury

Some injured workers present with pre-existing or concurrent problems that are not directly related to their compensable injury. Addressing these issues in the context of a workers' compensation claim can contribute to poorer return to work outcomes. For example, a worker who happens to have a history of childhood abuse may exhibit a worse overall outcome if the abuse related issues become the focus of treatment. This is also an issue to consider when referring to psychologists because some use holistic counselling models that encourage a focus on underlying issues, and which are actually not suitable for use with this population.

The recommended approach here is to 'recognise – acknowledge – quarantine'. That is, it is appropriate to recognise these problems and to acknowledge them with the worker. However, rather than then directly addressing these issues, the worker should be advised that they will be more effectively dealt with if resumption of optimal functioning and vocational involvements are first achieved. Thus, they should be 'quarantined' and psychologically accepted without engaging or indulging in internal thoughts and feelings related to these unresolved problems. Such issues are more effectively addressed from a stronger morale base. There is emerging evidence that psychological acceptance strategies as opposed to active engagement with negative internal thoughts, feelings and memories, promotes better functioning.[16]

Don't try to solve management and industrial issues through clinical management

Be cautious about forming views about the workplace based solely on information provided by the distressed worker. While some workers are poorly treated by harsh employers, some distressed workers also very selectively describe workplace issues to treating practitioners and significantly over report negative experiences in the workplace. This is mostly not an issue of 'malingering' but is more likely to reflect the personality characteristic of high level trait emotionality.[17] In the general population, approximately 17% of people have high trait emotionality and are disposed toward reporting higher than average levels of distress and negative workplace experiences.[18]

Issues of unfair treatment are usually best pursued through workplace fair treatment review mechanisms, with the assistance of a support person. The question that often needs to be considered in these situations is whether additional time off work will actually help deal with outstanding work matters, or is it simply delaying the inevitable and reinforcing avoidance behaviours? Of course, if the worker has been subjected to any substantive harassment or related problems, then an alternative worksite will be a more appropriate goal to pursue. Organisational health research suggests that where human resource/industrial issues are blurred with health issues, there is an increased risk of a worse overall outcome.[7]

In this respect, excessive advocacy can be a risky strategy that often unwittingly further entrenches problems, increases dependency, and reduces the prospect of a positive longer term outcome.

Conclusion

Health outcomes for injured workers with significant psychosocial barriers can be enhanced through a focus on morale maintenance, establishing positive recovery expectations, working collaboratively with other stakeholders, containing underlying distress problems, and ensuring at least partial vocational re-engagement as early as possible.

Conflict of interest: none declared.

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