

Return to work and psychosocial issues

» A distillation of best practice reflecting ACC's current position

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- Psychosocial factors, also known as yellow flags, may act as significant barriers to an injured worker's rehabilitation and return to work (RTW).
- Yellow flags can be personal, environmental and/or occupational work barriers, and may be unrelated to the accident or presenting injury.
- Management of yellow flag concerns often require the negotiation of change and the development of a collaborative plan of action to achieve a successful RTW.
- Interventions to enhance early RTW may involve any of the three elements necessary for successful motivation i.e. value, expectancy and self-efficacy.
- Occupational work barriers include perceptions surrounding work and 'objective work characteristics.' Both have recently been shown to significantly influence recovery and return to work.

Background

Psychosocial factors, also known as yellow flags, may act as significant barriers to an injured worker's rehabilitation and return to work.¹ These factors arise from behavioural traits, which reflect the relationship between an individual's personal attributes and social environment.

Diagnosis

In order to diagnose and manage psychosocial issues, the provider must explore stressors that do not necessarily fit into a defined category of 'medical' conditions. Awareness of issues out of the usual clinical range can prevent recourse to unnecessary investigations and medications, and save time and effort on the part of both provider and patient. Cultural differences also pose problems in the understanding and management of psychosocial issues. Providers need to be adept at cultural competency skills, which are noted to facilitate better relationships and improve clinical outcomes.²

The 'heart-sink'³ patient with psychosocial issues poses a huge challenge for providers. By being alert to yellow flags, which may be personal, environmental or occupational, providers can, in conjunction with other support networks like ACC, plan an effective rehabilitation programme.

Factors influencing recovery and return to work

A recent evidence-based literature review shows psychosocial aspects to be strong predictors of return to work outcomes.⁴ Since the risks from most psychosocial issues develop from a belief system about injury and pain, rehabilitation interventions should address basic coping strategies and those that help change perceptions about the 'work role' following an injury. For some claimants, the attitude to work or the ability to self-motivate interest in work is linked to family influence, interactions with other social groups, and the effects of environmental or occupational risk factors.

A recent study concluded that provider awareness of patient beliefs and expectations can improve rehabilitation outcomes by promoting better co-operation through shared perceptions and goals.⁵ Communication in a supportive and non-judgemental way can assist providers in determining patient expectations and help allay any of their fears or anxieties. For a patient who already experiences heightened psychological distress, any ambiguity surrounding their rehabilitation plans may negatively impact on their pre-existing psychosocial issues. The long-term implications of this can include lost productivity, increased claims cost and emotional suffering.

Direct questioning about psychological stress factors and return to work barriers should pre-empt medical solutions. General history taking is noted to have low sensitivity and predictive value for identifying distressed patients, thus formal psychological screening is recommended.⁶ The Acute Pain Screening Questionnaire¹ is a valuable tool in this capacity, and when used in conjunction with history and clinical assessment, can aid in identifying psychosocial risk factors.

Psychosocial yellow flags and occupational risk factors

Yellow flags include personal, environmental and occupational risk factors and can be further broken down into these broader categories,¹

- attitudes and beliefs about pain i.e. that pain is harmful or disabling
- behaviours i.e. increased alcohol intake or avoidance of normal activity
- compensation issues, diagnostic and treatment issues i.e. lack of financial incentive to return to work, lack of satisfaction with previous treatment
- emotions i.e. irritability, anxiety, depression
- family i.e. support needed to motivate RTW
- work - see below.

Occupational risk factors have recently been recognised as having significant potential impact on RTW outcomes. Yellow flags now highlight perceptions surrounding work and 'objective work characteristics.'⁷ Perceptions include risk factors of unhelpful management style and poor social support from colleagues. Objective risk factors are those that affect all workers equally, and include national policies (e.g. conditions of employment, sickness policy), and general working conditions. Provider awareness of occupational risk factors can support the development of a more suitable rehabilitation plan for those patients who suffer from the consequences of these RTW barriers. It shifts the focus to enlist

case manager assistance early in the rehabilitation pathway and, through their liaison with employers, to work to overcome workplace barriers.

For a comprehensive yellow flag checklist, see the 2004 New Zealand Acute Low Back Pain Guide incorporating the Guide to Assessing Psychosocial Yellow Flags in Acute Low Back Pain.¹

Motivating return to work

Once a psychosocial barrier to rehabilitation is identified, motivational interviewing can help a patient move through the stages of change, e.g. from contemplation to action.⁸ Motivational interviewing is based upon a non-judgemental co-operative style of listening and guided exploration of thoughts, feelings and behaviour as they relate to rehabilitation barriers and return to work.

For motivation to be sustained and successful, three essential elements need to be present.⁹ Value: Expectancy: Self-efficacy. The patient must believe that returning to work is in their best interests i.e. will do them more good than not working; that regaining work fitness is possible; and that they have the personal qualities and ability to progress through the rehabilitation process i.e. that their effort will result in success.¹⁰ Any interventions to foster motivation must work to improve these three elements; in some patients, all three areas may need to be advanced, whereas in others a small step in just one area may be all that is necessary.

Negotiating change¹¹

Specific techniques have been shown to facilitate successful change management where psychological elements are the predominant features necessitating change. Most of these techniques focus on the need for a partnership between patient and provider. This involves the provider understanding the disability from the patient's perspective. This partnership should then extend to collaboration with the employer via mediation of a case manager in situations that warrant intervention.

ACC resources

Providers should discuss significant yellow flag factors with a claimant's case manager. Case managers can assist with some of the environmental and occupational yellow flags including arranging workplace assessments by occupational therapists or physiotherapists, or liaising with unsupportive employers. ACC can also facilitate case conferences, which support a multidisciplinary approach to psychosocial issues. Where a specialist psychological referral is required, the case manager has the discretion to arrange a one-off referral.

ACC also offers other programmes that help to rehabilitate injured workers and promote an earlier return to work. These may also be useful in the management of yellow flag concerns, and include; graduated return to work programmes; activity-based programmes; and employment maintenance programmes.

References

1. Kendall NAS, et al. Guide To Assessing Psychosocial Yellow Flags in Acute Low Back Pain: Risk Factors for Long Term Disability an Work Loss. Accident Compensation Corporation and the New Guidelines Group. Wellington, New Zealand. Oct 2004 Edition.
2. Durie Mason. Whaiora. Maori Health Development. Auckland: Oxford University Press. 1998.
3. O' Dowd T. Five years of heartsink patients in general practice. *BMJ*. 1988; 297: 528-30.
4. Waddell G, et al. Screening to identify people at risk of long term incapacity for work. London: Royal Society of Medicine Press. 2003.
5. Antoniazzi M, et al. Self-responsibility and coping with pain: disparate attitudes toward psychosocial issues in recovery from workplace injury. *Disability and Rehabilitation*. 2002; 24(18): 948-953.
6. Grevitt M, et al. Do first impressions count? A comparison of subjective and psychological assessment of spinal patients. *Eur. Spine Journal*. 1998; 7: 218-223.
7. Burton AK, Main CJ. Obstacles to Recovery from Work-related Musculoskeletal Disorders. *International Encyclopaedia of Ergonomics and Human Factors*. Ed. Karwowski W. London: Taylor and Francis 2000: 1542-1544.
8. Prochaska J, DiClemente C. Stages and processes of self-changing in smoking. Towards an integrative model of change. *Journal of Consulting and Clinical Psychology*. 1983; 51: 390-395
9. Vroom V. Work and Motivation. AICBT. 2001
10. Bandura A. Self-efficacy: The exercise of control. New York: WH Freeman. 1997.
11. Henck PJG van Bilsen. Orchestration of Motivation. AICBT. 2001.