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Work Rehabilitation

I. Know that the longer workers remain absent from work the more likely they are to remain off work, and appreciate the importance of, and need for, early intervention (Waddell 1998).

II. Understand that workers presenting with painful back conditions require a clinical examination and screening for the potential presence of serious spinal diseases and for nerve root pain. Radiological imaging is not normally indicated at an initial assessment (Veterans Health Administration 1999; Waddell et al. 1999). Examination findings suggestive of poor outcome (return to work) include:

   A. Age greater than 50

   B. More severe symptoms

   C. Long duration of symptoms

   D. Symptoms that affect the ability to work

   E. Poor response to previous treatments or rehabilitation

III. Know that appropriate early management of mechanical (nonspecific) spinal pain includes the provision of adequate analgesia and advice on remaining at or returning to work as soon as possible (Carter and Birrell 2000).

IV. Know that most workers are able to remain at work with symptoms of pain and that although work may exacerbate symptoms, in most cases it is unlikely to cause harm (Andersson 1997; Dionne 1999).

V. Understand that the decision by a worker to be absent from work is not directly predicted by clinical features or the physical demands of work, but is a complex interaction among occupational, individual, and psychosocial factors (Dionne 1999; Burton and Main 2000; Waddell et al. 2003).

VI. Know that, in the case of low back pain, a simple stepped care approach should be applied starting with simple, low-intensity, low-cost measures and “stepping up” the intensity of intervention until the patient does manage to return to his or her normal activities (Von Korff and Moore 2001; Haldorsen et al. 2002).

VII. Understand that psychosocial factors are the main determinants of disability and are significant predictors of prolonged work absence in painful conditions (Burton and Main 2000; Main and Burton 2000; Waddell and Burton 2000).

VIII. Know that those who remain absent from work for more than 3–6 weeks require a specific assessment of psychosocial and occupational risk factors.

   A. This assessment should include:

      1. The workers’ attributions about the cause of their pain.
      2. Their assumption about continuing work.
      3. Their attitude to their workplace, including safety.
      4. Their perception of the attitudes of others, including coworkers and supervisors.

   B. Know that in this context, equating work-related symptoms with work-related injury is counterproductive (Kendall et al. 1997; Marhold et al. 2002; Waddell et al. 2003).

IX. Be able to identify obstacles to recovery (Kendall et al. 1997; Burton and Main 2000; Main and Burton 2000; Nachemson and Vingard 2000), including:

A. Fear of (re-)injury associated with physical activity and working.

B. Low expectations of recovery/return to work.

C. Low mood, anxiety, and withdrawal from normal social interaction including work.

D. Reliance on passive treatments.

E. Negative attitude to physical activity and self-management.

F. Poor relationships with coworkers and supervisors.

X. Understand that a successful, comprehensive rehabilitation program includes general exercise, cognitive therapy, and vocational elements (Waddell and Burton 2000; Waddell and Watson 2004).

XI. Understand that early intervention strategies lead to quicker return to work and reduced long-term disability. Simple low-intensity interventions (advice, information, activity management) are appropriate for with those with work loss of short duration or those who do not demonstrate factors associated with poor outcome (Wood 1987; Linton and Andersson 2000; Marhold et al. 2001; Haldorsen et al. 2002).

XII. Know that simple low-intensity interventions are not suitable for workers with significant barriers to recovery or for those with prolonged (more than 6 months') work absence (Marhold et al. 2001; Haldorsen et al. 2002).

XIII. Understand that clinical management is more effective if combined with a rehabilitation strategy and promotion of self-management techniques. Rehabilitation requires a combination of therapeutic, psychosocial, and work-related interventions that address both the clinical problem and issues in the individual's physical and social environment (Waddell and Watson 2004).

XIV. Understand that those who do not return to work within a few weeks require intensive multidisciplinary approaches, which should include active exercise, addressing distorted beliefs about pain, enhancing positive coping strategies, and promoting self-management (Haldorsen et al. 2002). Such approaches should be delivered as near to the worker's place of work as possible; removing workers from their workplace for rehabilitation may, in some cases, prolong work loss (Loisel et al. 1997; Waddell and Watson 2004).

XV. Know that managing the risk factors associated with poor outcome assists return to work (Haldorsen et al. 2002).

XVI. Understand that even those who have been absent from work for many months can be rehabilitated successfully through a comprehensive work rehabilitation program (Jordan et al. 1998; Watson et al. 2004.

XVII. Be aware that managing the worker's workload and physical workspace may facilitate earlier return to work, provided this is an initiative provided by the employer and that it is time-limited and regularly reviewed (Krause et al. 1998).

XVIII. Know that positive management of the workplace environment, including managing occupational risks (including stress management), monitoring sickness absence, and promoting job satisfaction and good industrial relations can reduce the incidence and duration of work absences. Joint employer and employee approaches to the management of pain in the workplace may be beneficial.

XIX. Know that modification of the physical workplace alone is ineffective in reducing sickness absence. Modified work programs can be effective in returning workers with pain problems to work (Krause et al. 1998: Marnetoft and Selander 2000). These programs include:

A. Modified work programs including light duties (a temporary or permanent restriction in work activity that is less than full duties),

B. Graded work exposure, in which the hours of lighter duties or usual duties are gradually increased until the worker return to full duties.

C. Work trials, in which a worker is give the opportunity to work in a job at the discretion of an employer.

D. Supported employment, which involves paid work with the support of a vocational coach or advisor in the workplace.

XX. Understand that there is little evidence to demonstrate that evidence-based guidelines are implemented in practice (van der Weide et al. 1997, 1999; Volinn 1999).

XXI. Know that a Functional Capacity Assessment (FCA) is a "detailed examination and evaluation that objectively measures the client's current level of function in terms of the demands of competitive employment" (American Physical Therapy Association 1997).

XXII. Know that FCAs are often used to monitor the progress of the workers and to make decisions about the worker's suitability to return to work (King et al. 1998; Mooney 2002). FCAs are used to inform about a person's progress in rehabilitation and to direct treatment to improve performance (Mooney 2002).

XXIII. Understand that FCAs are measures of physical performance and not of physical capacity. Physical performance measures are assessments of both physiological states (physical capacity) and psychological (behavioral) states (Kaplan et al. 1996; Watson 1999).

XXIV. Know that although some FCAs have been found to be reliable and valid, commercially available FCAs vary widely with respect to their validity and reliability (Innes and Straker 1999a,b). FCAs are most reliable when the domains tested are limited (Innes and Straker 1999a; Renneman et al. 2002a,b).

XXV. Understand that there is little research into the ability of FCAs to predict return to and retention in work (Jones and Kumar 2003; Reneman and Dijkstra 2003). The ability of FCAs to predict return to work is less robust than other variables such as age, duration of symptoms, and gender (Matheson et al. 2002).

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