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LETTER TO THE EDITOR
Occupational Rehabilitation[1]

by
LTCOL Ross Mills [2]

DEAR EDITOR,

In her review article "Outpatient Based Injury Management versus Inpatient Rehabilitation"[1], Captain Tilbrook puts forward a case for Outpatient- based Rehabilitation with strong ties to the workplace, which she states, "is in direct contrast to Inpatient Rehabilitation which takes members away from the workplace and their normality. Psychology, illness behaviours and motivation factors play a key part in likely prognosis and response to treatment."

Captain Tilbrook is to be applauded. Worldwide, workplace-based rehabilitation is the cornerstone of civilian occupational rehabilitation. Not only does this reduce monetary compensation costs but, at the same time, also decreases patient disability and speeds recovery.

Successful rehabilitation within a compensation system needs to address all the relevant drivers, not just the medical ones. There are gains to be had both for ongoing illness behaviour and for recovery. Potential secondary gains for maintaining illness behaviour include increased attention from others, the benefits of application of treatment (particularly passive ones), potential financial remuneration (payout) or where there are job dissatisfaction issues, a "better" job. Other secondary gains include assistance with finding a less arduous or more pleasant job, an opportunity to punish an employer (for perceived wrongs) or an opportunity to make an industrial point (for example, with regard to perceived poor Occupational Health and Safety practice).

Potential perceived gains for recovery include restoration of function (and/or health) and job promotion or advancement.

Where rehabilitation has stalled, common causes for this include inappropriate or incomplete medical management, inappropriate vocational goals, psychosocial or industrial issues. Malingering may also be a cause, but this is much less common.

Ultimately, the object of the rehabilitation is to minimise disability. Loosely described, this can be interpreted as the degree to which a member's illness/ condition interferes with their life. A full recovery is the preferred way of achieving this goal although, at times, this is not possible. In some chronic rehabilitation cases, a potential danger is in over-medicalising the condition. At some point a decision needs to be made that further investigation, invasive therapies or passive treatment modalities are unlikely (on the balance of probabilities) to provide significant long- term functional gains. In most chronic musculoskeletal conditions, this decision can be made relatively quickly (usually within the first one to three months). Prolonged application of the medical model runs the risk of reinforcing illness behaviour and encouraging dependence of the member on their treatment team. This, in turn, is likely to encourage disability and prolonged rehabilitation with a poorer outcome. The sooner this decision is made and communicated, the sooner a member's expectations can be appropriately set.

A member maintaining an active response to pain management (taking control of their own rehabilitation and utilising resources offered to assist them) provides better outcomes than a passive pain response (where the

member allows or encourages others to provide him with treatment and/or cures). Examples of passive pain behaviour include reliance on pain killers, passive treatment modalities and avoiding activity.

Following an injury, an early return to the work- place is encouraged. If there is uncertainty regarding a member's physical activity tolerance or there are concerns of fear-avoidance behaviour, lack of work fitness or poor manual handling techniques, then an appropriate supervised exercise or activity programme is of great benefit to address these issues. A progressive upgrading in activity tolerance in a controlled environment reinforces to the injured member what their true activity level is and can be used as a guide in upgrading their work restrictions.

The work culture itself is also an important factor in rehabilitation. In a work environment where a member on "selected duties" is seen as a "bludger", the environment is likely to be counterproductive, whereas an encouraging environment (where the uninjured members are supportive as "it could be me") is much more productive. Where there is significant fear avoidance behaviour, disability adjustment issues or depression for example, referral for cognitive behavioural therapy is also an appropriate adjunct to this graded activity programme.

In the Australian Defence Force, we publicly espouse a philosophy of members having initiative and self-sufficiency ("improvise and overcome"). The same philosophy should also be applied to rehabilitation with this being geared towards finite goals. This process should be run primarily by the injured member, who is offered appropriate support and resources to achieve this.

REFERENCES:

1. Tilbrook GE. Outpatient Based Injury Management versus Inpatient Rehabilitation: A literature review. *Aust Mil Med* 2003;12 (2) 83-87