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Short Communication

Rehabilitation and return to work

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Levels of disability and health-related work absence continue to increase, yet the risk assessment and modern medicine aimed at mitigating ill health and work absence also continues to increase. There is evidence to suggest that the interaction between health and work, the economic work loss, and the influence of long-term sickness absence on health and social inequality is an important consideration for researchers and clinicians in healthcare.

From the time of Aristotle, the main determinants of health and sickness were considered to be lifestyle, healthy behaviour, and the social and physical environments, rather than biological status or healthcare. A public health researcher perspective suggests that this is also true today [1,2]. Evidence supports the biopsychosocial model (BSP) as an interactive and person-centred approach with the influence of the individual, their health condition, and their social/work-related context. The factors that influence the process of disablement and return to work, and their weighting, vary over time. Self-perceptions can also change, and individuals may change between periods of disability and ability, work and non-working incapacity [3]. Therefore, a multi-dimensional approach at several levels may be requires, which is the characteristic of many health and social policy interventions.

The BSP approach demands an egalitarian relationship between provider and patient, that is personalised, and patient centred. This is not an impossible goal: it is a major part of therapist and medical training [4]. The ultimate goal is to consider the patient and their health condition and to strike the right balance between providing care and achieving the best social and occupational outcomes. Within the occupational health environment, clinicians and researchers are interested in preventing ill health, with a reciprocal relationship of the effect of health on work and work on health. Central to this, is the concept of work and health and that early intervention is essential: the longer an individual is off work, the greater the obstacles to return to work (RTW) and the more difficult to implement work-related strategies. It is simpler, more effective, and less expensive for all stakeholders to prevent people going on to long-term sickness absence.

Each dimension of obstacle requires a different set of expectations, behaviours, and social interactions. The outcome of any intervention (e.g., healthcare, activity levels, behaviour changes, employer etc) may differ and the timing critical. All successful rehabilitation programmes include some form of active exercise or graded exposure activity as a component. The key element is in activity and the task per se, with the immediate goal of exposure to functional limitations and improving capability; in order to increase participation and recover social and physical function. These core principles are common for a mixed, mental and physical health condition, where increased physical activity has been shown to improve mental health and reduce depression, as an example [5].

The evidence supports the notion that large changes in acute loads are tolerate when they are preceded by a consistent and slowly progression history of workload or stressors. This incremental change is fundamental in being a human with often a positive response to stress. Proper implementation of increasing activity will increase a sense of well-being, confidence, self-efficacy, and recovery, which in turn will promote adherence. However, our adaptability is finite and the speed of that adaptability is limited, with careful consideration of safe exposure activity to develop strength and confidence needed.

Sickness absence management, assisting return to work, and promoting rehabilitation are matters of good healthcare practice, sound occupational health principles and good business sense

[6]. What is interesting is that the adaptability model does not just consider biomechanics, medical conditions, or physical workload in isolation. Our adaptability and response to the physical workload or our 'preparedness' for this is influenced by a range of psychosocial stressors, especially in the occupational setting. The Oxford Dictionary of English defines rehabilitation as the 'The action of restoring someone to health or normal life through training and therapy after illness' [6]. The 'World Report on Disability', defines rehabilitation as enabling people with disabilities whose functions are limited to remain in or return to their home or community, live independently, and participate in education, the labour market, and civic life [6].

Summary

Prolonged absence from normal activities, including vocation, is often detrimental to a person's mental, physical, and social wellbeing. It also has significant impact on communities and society, in terms of healthcare costs, efficiency and burden of ill-health. Conversely, appropriate and supported RTW can benefit the employee and their communities by enhancing and recovery, and thus reducing disability.

Mental and musculoskeletal conditions remain the most common presentations seen, contributing to work-related ill health and an approach to rehabilitation based upon the BSP model is necessary to identity and address the obstacles to recovery and barriers to RTW. It should also meet the needs of those employees with common health problems who do not recover within a suitable timeframe. Am employees RTW as soon as possible after injury or illness should be encouraged and supported by employers, health professionals, fellow employees, occupational health and rehabilitation services, with the use of targeted work-related adjustments. Lastly, a safe and expedited RTW preserves a skilled and stable workforce and reduced demands on health services, at a time of international workforce pressures and where access to healthcare may be more challenged.

References

1. Aylward M. Beliefs: Clinical and vocational interventions; tackling psychological and social determinants of illness and disability. 2006.
2. Marmot M, Bell R. Challenging health inequalities—implications for the workplace. Occupational Medicine. 2010 May 1;60(3):162-4.
3. Burchardt T. The dynamics of being disabled. Journal of Social Policy. 2000 Oct;29(4):645-68.
4. Waddell G, Burton AK. Concepts of rehabilitation for the management of common health problems. The Stationery Office; 2004.
5. Waddell G, Aylward M. Models of sickness and disability: applied to common health problems. Royal Society of Medicine Press; 2009.
6. Rehabilitation. In: Oxford Dictionary of English, 3rd edn. 2017. Available at: htpps://en.oxforddictionaires/com/definition/rehabialtion
7. World Health Organization, 2011. Summary: World report on disability 2011 (No. WHO/NMH/VIP/11.01). World Health Organization.