Overcoming Barriers to Recovery and Return to Work: Towards Behavioral and Cultural Change

7

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7.1 Introduction

There are some fundamental precepts upon which the material of this chapter is based. Specifically:

- The main determinants of health and illness depend more upon lifestyle, sociocultural environment, and psychological (personal) factors than they do on biological status and conventional health care (Marmot 2004);
- Work is the most effective means to improve the well-being and health of people, their families and their communities (Waddell and Burton 2006); and
- Barriers to a life in work should be rigorously tackled and removed by society as a whole.

Sickness-related absence from work and sickness impairing work and productivity are major problems in all industrialized countries (Aylward and Sawney 2006). Moreover, despite improvements in health care, and most objective measures of population health in the UK (Lopez et al. 2006, Wanless 2003), people's sense of general health and well-being has not improved since the 1950s (Barsky 1988; Layard 2005). This paradoxical observation is not confined to the UK (Waddell and Aylward, 2010). It may be argued that a growing number of people seem less able to cope with health problems and suffer more chronic disability than ever before (Aylward 2006; Le Fanu 1999). Psychological, social, and cultural factors clearly aggravate and perpetuate ill health and disability (Lightman 2005; Steptoe 2005; Waddell 2002). These act as obstacles to recovery and barriers to return to work (Nimnuan et al. 2001, Waddell and Burton 2004). At this time, when health-related work absences continue to increase, there is a pressing need to identify and successfully address these obstacles and barriers to (return to) work rather than reducing sickness and disability to a personal pathology. In the UK, for example, the great majority of people in receipt of state work-incapacity benefits[1] and very many patients who consult their general practitioners (GPs) report nonspecific and subjective health complaints as the reasons why they are unable to work. Yet paradoxically these common health problems have a high prevalence in the general population who remain at work (Aylward 2004; Buck et al. 2008; Wessely 2004). For these people, it may be argued, sick-

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[1] Initially Invalidity Benefit, replaced by Incapacity Benefit from April 1995, then Employment Support Allowance from October 2008. Claimants and their characteristics remain broadly the same.

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ness and incapacity for work are determined more by personal (psychological), social, and cultural issues other than a medical one. Addressing these trends depends on better understanding of sickness and disability (Aylward and LoCascio 1995).

In the UK, the number of people on incapacity benefits[1] increased from about 700,000 in 1979 to 2.6 million in 1995 (Aylward 2004, Department of Health 2005). Since then, it has plateaued, but has remained stubbornly high. An increasing proportion of people receiving state incapacity for work benefits report "common health problems" that mainly comprise musculoskeletal symptoms and mental health problems which are not always supported by recognizable evidence of underlying disease (Waddell and Aylward 2005). Ill health in people of working-age is estimated to cost the UK Government £100 billion per annum, which emphasizes the pressing need for a more flexible model of the relationships between health and work and a more proactive approach to rehabilitation (Black 2008).

7.1.1 Challenging Conventional Assumptions: Disease, Sickness and Disability

The unfortunate and loose use of words such as "ill," "sick," "disease," and "disabled" as if they were interchangeable causes great confusion. This lack of precision contributes to the paradoxical observation of increasing levels of reported illness versus general improvement in population heath in the more developed countries. It is imperative that we have clear definitions and understanding of these fundamental concepts (Boyd 2000; Hofman 2002; Twaddle and Nordenfelt 1994). Their more precise definition and differentiation are offered in Box 7.1.

An accurate interpretation of these concepts is fundamental to defining entitlement to work-related benefits in many social security and insurance systems and for the assessment of work (in) capacity per se (Aylward and Sawney 1999). Diagnosis alone provides little information about (in)capacity for work (Aylward and LoCascio 1995). Impairment is a biomedical definition—it provides the most objective measure of a health condition, but does not give much information about the experience of the individual. Sickness and disability are social definitions, which focus on the individual's experience and functioning, and not just the health condition. "Disability" is not synonymous with incapacity: in the UK, about half of all disabled people are working, including 25 % of those who say that their limitations are severe (OECD 2003). Most importantly, the reporting of symptoms does not necessarily mean illness or incapacity for work. Symptoms, disability and incapacity for work must therefore be distinguished, conceptually, in unravelling the aforementioned paradox, in assessment of functional capacity and as the basis for sick certification and work-related benefits.

Box 7.1 Concepts of ill health and their differentiation

Disease	Objective, medically diagnosed, pathology
Impairment	Significant, demonstrable, deviation or loss of body structure or function
Symptoms	Bothersome bodily or mental sensations; generally bothersome or of concern to the person aware of them
Illness	The subjective feeling of being unwell
Disability	Limitation of activities and restriction of participation
Sickness	A social status accorded to the ill person by society
Incapacity (work)	Inability to work because of sickness or disability

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7.1.2 Symptoms and Common Health Problems

Symptoms may be defined as "*subjective bodily or mental sensations that reach awareness and*

are generally bothersome or of concern to the person who experiences them" (Waddell and Aylward, 2010). They manifest as clinical representation and manifestation of disease but may well be associated with normal or, more commonly, unaccustomed activities of daily living in healthy persons. They may not be readily and reliably associated with any identifiable disease and are ubiquitous and omnipresent in society (Buck et al. 2008; Deyo et al. 1998; Eriksen et al. 1998; Ursin 1997). Moreover there is a limited correlation between their expression and illness, disability and (in)capacity for work (Waddell 2004; Waddell and Aylward 2005).

Common health problems may be perceived as "less severe" but that does not mean that they are less important for those people who experience them. These symptoms are very real, justify health care and may cause temporary limitations. Nevertheless, they are called "common health problems" on the basis that they are similar in nature and sometimes even in degree to the bodily and mental symptoms experienced at times by most adults of working age. The results of a survey of 1000 adults undertaken in the UK (Buck et al. 2008) are given in Table 7.1. That study sought responses to an "open question" followed by a structured inventory to document the nature and extent of commonly encountered health problems in the working-age population surveyed.

Table 7.1 Prevalence of common health problems in UK adults in the Cardiff Health Experiences Survey

	Male (%)	Female (%)
Open question:		
Musculoskeletal problems	11.7	14.0
Mental health problems	4.8	8.7
Other problems	9.4	15.2
Inventory of common "symptoms":		
Musculoskeletal	24.6	34.0
Mental health	18.1	28.8
Other	26.0	42.7

On specific questioning, 66.4 % reported at least one (usually mild or moderate) symptom. In open response, 28 % reported "problem(s)," but these were usually more severe

Responses to open questions about health (without prelabelling and using non-medicalized terminology) and to an inventory of common symptoms. Reproduced with permission from Waddell and Aylward, Models of Sickness and Disability, Royal Society of Medicine Press, 2010

When patients seek medical advice for these symptoms, diagnosis is often nonspecific; the symptoms are not assignable to a particular cause, condition, or category (ODE 2005). Such diagnoses are often "nominal" in that they are simply labels. But the illusion that they are well understood can be misleading and cause iatrogenic harm. These health problems are characterized more by symptoms and distress than by consistently demonstrable pathology (Barsky and Borus 1999). A number of diverse terms have been used to categorize them: "subjective health complaints" (Ursin 1997), "symptom-defined illness" (White 2005), or "medically unexplained symptoms," which emphasize the limited evidence of objective disease or impairment (Page and Wessely 2003). In a clinical sense, they are recognizable but only in terms of bodily or mental function and physiological disturbance, rather than disease or permanent impairment. Patients commonly seek and doctors regularly issue sick certificates endorsing absence from work for subjective health complaints. Family doctors in the UK are well aware of these predicaments and the conflicting roles many of them may have to play in the medical consultation (Chew and May 1997; Cohen 2008).

Waddell and Burton (2004) gave common health problems the following characteristics and argued that they are insufficient *in themselves* to explain long-term incapacity:

- Objective evidence of disease or permanent impairment is unusual;
- They have a high prevalence in the general (working) population;
- Most acute episodes settle quickly—at least sufficiently to permit a return to most normal activities, even if some symptoms persist or recur;
- Most people with these common problems remain at work, and the great majority of those who take sickness absence return to work quickly; and

- Overall, only about 3 % of episodes of sickness absence associated with common health problems go on to long-term incapacity.

Evidently, these are manageable health problems: recovery to optimal functioning is to be expected provided that proper advice and support are given and received. *Long-term incapacity for work is thus not inevitable*. Consequently, a conceptual and practical distinction exists between largely subjective common health problems and objective disease.

7.1.3 Benefit Dependency and Common Health Problems

Workers' compensation and social security systems were originally designed for people with severe medical conditions and permanent impairment. Nevertheless, in the UK such conditions account for less than a quarter of long-term sickness absence from work, and their prevalence has been stable for many years (Waddell and Aylward 2005). About two-thirds of long-term sickness absence and ill-health retirement are now due to common health problems (Black 2008; Sissons et al. 2011; Waddell and Burton 2004).

Sissons et al. (2011) reported the findings of a two-wave survey of people who claimed the UK's Employment and Support Allowance (ESA) between April and June of 2009. This research examined the characteristics of ESA claimants and explored the employment trajectories over approximately 18 months. ESA claimants were slightly older than the general population of working age and were more likely to be male. The main health conditions among ESA claimants at the baseline survey are listed in Table 7.2.

The prevalence of musculoskeletal problems (37 %) and mental health conditions (32 %) varied considerably by demographic characteristics: mental health conditions were more common among women and younger people while musculoskeletal conditions more common among men and older people. In the survey population, multiple health problems and fluctuating conditions were reported by 66 and 55 % of the respondents, respectively. In those who were working prior to claiming ESA, 72 % had a physical health condition dominated by musculoskeletal conditions; in 50 %, the health condition was of recent origin and 27 % of these conditions were attributed to work and they were mainly men that were associated. By contrast, among those claimants who were not working before their claim, mental health conditions (38 %) were most commonly reported and tended to be long-standing. Only a minority (11 %) considered their health condition as work-related. Not unexpectedly, in those with non-work backgrounds, 25 % had literacy difficulties and 28 % were in a disadvantaged group. Moreover, the survey findings identified improvements or stability in health as pivotal to a return to work. Attitudes to work were important influences on the likelihood of return to work. Encouraging people in the belief that work assists their health is thus more likely to achieve a successful return to work.

Table 7.2 Common health problems as reported causes of long-term sickness in 2945 respondents presenting with health conditions at baseline (Sissons et al. 2011)

Reported causes	Percentage (%)
Musculoskeletal condition/injury	37
Mental health condition	32
Long-term systemic condition	16
Don't know/prefer not to say	2

These findings support the observations of Waddell and Aylward (2010) that among those in receipt of UK long-term incapacity benefits, musculoskeletal (18–20 %) and mental health conditions (40–44 %) dominate. If recipients with a secondary mental health condition are included, these statistics rise to more than 50 %.

While health is a pivotal factor influencing return to work, other factors, such as skills and qualifications, social disadvantage, beliefs in the benefits of working, and distance from the labor market are among the important factors in explaining future employment trajectories.

Shiels et al. (2004) reported that common mental health problems and musculoskeletal

conditions represent 40 and 23 %, respectively, of sick certification among general practitioners in the UK. Common mental health and musculoskeletal problems in people on long-term sickness absence from the workplace are respectively the leading cause in non-manual and manual workers (CBI/AXA, 2007; CIPD 2007). Ill-health retirement, mental health and musculoskeletal problems are by far the most prevalent and in some schemes accounted for more than 80 % of the reasons for early retirement (Waddell and Aylward 2010).

7.1.4 Barriers: Negative Influences on Return to Work

Many disability benefit recipients are not completely incapacitated but still retain (some) capacity for (some) work. Most benefit claimants have a genuine health condition, and many genuinely believe that they cannot or should not work. These beliefs are often reinforced by medical advice (Anema et al. 2002; Sawney 2002), by employers who will not permit return to work until symptoms are "cured" (James et al. 2002) and by the benefits system (Fordyce 1995; Waddell and Aylward 2005). Virtually all claimants say that illness or disability affects their ability to work, and about three-quarters report that it is the main reason they are not working or seeking work. However, less than one in four claimants report that they could not do any work at all. Ninety percent of new incapacity benefit claimants initially expect to return to work in due course and one-third to one-half of all recipients still want to work. All of these figures are based on what people say, subject to all the qualifications of self-report (Aylward and Sawney 2006).

7.1.5 The Psychosocial Dimension

How people think and feel about their health problems determines how they deal with them and what their impact is (Mechanic 1968). There is extensive clinical evidence that beliefs and psychological factors aggravate and perpetuate the course and outcome of human illness (Gatchel et al. 2007; Gatchel and Turk 2002; Halligan and Aylward 2006; Linton 2002; Main et al. 2008; White 2005) and in the more subjective health problems person's beliefs exert a major influence (Main and Spanswick 2000). Psychological factors influence when common bodily or mental symptoms become a "health problem" (Mechanic 1968) and when sickness absence is taken (Alexanderson and Norlund 2004). They strongly influence the process of recovery (Mondloch et al. 2001) and rehabilitation (BSRM 2000), the return to work (Krause et al. 2001) and the duration of long-term incapacity (Waddell and Aylward 2005). It must not be forgotten that psychological factors affect the nature and course of all illnesses, including the manifestations of severe medical conditions. Nevertheless, they are particularly important in common health problems where the more nonspecific and subjective the health condition, the more important role they play (Wormgoor et al. 2006). Functional capacity may be limited by a health condition, but performance is limited by how the person thinks and feels about that health condition (Nordenfeldt 2003).

Some personal characteristics and psychological processes are deeply rooted in, or beyond the control of the individual, but conscious choice, motivation and effort may still exert a pivotal role in sickness and disability (Aylward 2003; Halligan et al. 2003; Leonard et al. 1999). Human beings may be driven by both self-interest and altruism, but self-interest is often dominant. Nevertheless, and the pragmatic stance taken by the law in many jurisdictions, is that choice, free will and personal responsibility for one's actions are taken to be the norm unless there is strong evidence to the contrary (Gordon 2000). Choice, however, may be restricted by genuine (even if mistaken) perceptions and beliefs, and by social or occupational factors. Decisions about being (un)fit for work, taking sickness absence or claiming benefits are nonetheless generally taken to be conscious decisions.

Among the psychological factors that do influence sickness absence and return to work,

perceptions of health and its relationship to work appear to be the most important. These are:

- The subjective experience of illness and disability may not be reflected in objective findings.
- Beliefs, attitudes, and thereby expectations expressed by the person and family, health professionals, and employers may interact and reinforce each other.
- Moods, emotions, values, goals, coping strategies, and uncertainty.
- Resilience, motivation, and effort.
- Psychological distress, anxiety, depression, fear, and risk avoidance.

The relative importance and impact of these influences will vary in different individuals and settings, and over time (Waddell and Aylward 2010).

Although the emphasis is usually on the person's attitudes and beliefs, this is equally relevant to attitudes of health professionals and employers, which may significantly reinforce illness behaviors. Attitudes and beliefs about work and health can be listed as follows:

- Individual perceptions of physical and mental demands of work.
- Low job satisfaction and limited attendance incentives.
- Lack of social support at work (coworkers and employer).
- Attribution of health condition to work.
- Beliefs that work is harmful and that return to work will do further damage or be unsafe.
- Low expectations about return to work.

Organizational policy, process, and practice-related factors include the following:

- Inappropriate medical information and advice about work.
- Sick certification practice.
- Lack of occupational health support.
- Employers' beliefs and fears of worker's reinjury and liability associated with demanding the restoration of full fitness before permitting return to work.

Table 7.3 Negative influences on return to work: principal barriers elicited in study population ($N = 1294$)

Principle barriers	%	Rank
Psychological/cognitive	38	1
Workplace	32	2
Social	11	3
Economic	9	4
Symptom perception (pain, fatigue, etc.)	7	5
Impairment	3	6

In an exploration of the negative influences on return to work among a cohort of people who had been absent from work for between 2 weeks and 3 months because of a reported health problem, only 10 % admitted that the barrier to return to work was due either to impaired function or symptoms they continued to experience (Aylward 2010). By far the most common reasons people gave why they were not returning to work were psychological or workplace issues (Table 7.3). The most commonly elicited negative influences on return to work were false beliefs about their presenting health problem, low self-efficacy, and poor relationships with their line-manager/supervisor.

The exercise was not intended to document positive influences, which would aid return to work but the following factors strongly emerged:

- Respect for employer.
- Job satisfaction.
- Strong health literacy.
- Positive attendance incentives (especially work colleagues).
- Well managed chronic health condition.

Dominating positive attendance incentives were perceptions of posing extra burdens on work colleagues and rejoining a friendly team at work. These findings reemphasized that barriers to return to work are primarily personal and psychosocial rather than medical problems and that workplace culture and organizational features play a substantial role.

7.2 The Relationship Between Work and Health

Work forms a large part of most people's lives bringing a range of benefits to individuals, in addition to the financial benefits of a wage and pension. Work can provide people with a sense of dignity, purpose, opportunities for social interaction, develop new skills and give something back to the community; all of which can help boost an individual's confidence and self-esteem. In short, work allows full participation in our society. In a broad sense, however, work does need to be for financial gain: voluntary or charity work brings many of the non-financial benefits of employment. This aspect of rewarding work is particularly pertinent when jobs are no longer for life and many people may choose or need to work for longer.

It does not necessarily follow that an illness, injury, or disability results in an inability to work. Examples are the legion of people who work despite severe illness or disability. People with disabilities who want to work should be given all the opportunities, encouragement and support to do so. As emphasized earlier, far too often health professionals and others have associated the occurrence of an illness, injury, or disability with being unable to work.

Work and health are intimately related. Health is not always a necessary condition for work, and work is not always a risk factor for health. There is now strong evidence that work is generally good for health, and that the beneficial effects of work outweigh the risks of work and the harmful effects of a life devoid of work (Black 2008; Waddell and Aylward 2010; Waddell and Burton 2006). Certainly, the beneficial effects of work depend on the nature and quality of that work and its social context and, importantly, reverse the adverse effects of unemployment. Furthermore, and most pertinent to policies and practices which focus primarily on tightening gateways into sickness-related benefits, the evidence is compelling that moving people off benefits without entry in to work is associated with deterioration in health and well-being (Waddell and Burton 2006).

The effects of unemployment in terms of health are thus now recognized. Unemployment causes poor health and health inequities, and this effect is still seen after adjustment for social class, poverty, age, and preexisting morbidity (Waddell and Burton 2006). A person signed off-work sick for 6 months has only a 50 % chance of returning to work. By 1 year it is 25 % and by 2 years about 10 % (Waddell and Aylward 2010). One study showed that after 6 months off-work due to ill health the majority of people were suffering from depression, whatever the initial presenting problem. Most importantly, regaining work may reverse these adverse health effects and reentry into work leads to an improvement in health (Waddell and Burton 2006). Long-term worklessness is one of the greatest risks to public health (Black 2008; Waddell and Aylward 2010). It has been argued as a compelling illustration of the health risk associated with long-term dislocation from the world of work that it is of a magnitude equivalent to smoking ten packs of cigarettes per day (Ross 1995).

Although these findings reinforce the economic, social, and moral arguments that work is the most effective way to improve the well-being of individuals, their families and their communities, the conditions for that are:

- Jobs are available.
- There is a realistic chance of obtaining work, preferably locally.
- Allowance is made for age, gender and (lack of) qualifications.
- Jobs are "good jobs" from the perspective of promoting health and well-being.

Although it is right to consider the health consequences of exclusion from a working life and unemployment, too many people are still injured or made ill as a result of their work. Unsafe working conditions may be a direct cause of illness and poor health. Improvements in health and safety risk management must continue unabated to prevent much avoidable sickness and disability arising in the workplace. This improvement leads to a broader and more balanced view of the relationship between work and health. It also means

that health and safety at work should be distinguished. Safety will always be important, but a healthy working life is much more: it is "one that continuously provides the opportunity, ability, support and encouragement to work in ways and in an environment that allows workers to maintain and improve their health and well-being" (Scottish Executive 2004).

Thus, there are profound implications for the provision of advice about work and for sick certification. Sick certification is a powerful therapeutic intervention, with potentially serious adverse consequences if applied inappropriately; not the least of which is the drift into long-term incapacity (Anema et al. 2002; Sawney 2002).

7.2.1 Models of Disability and Sickness: Tackling Barriers to Recovery and Return to Work

Models are a practical approach to moving from theory to reality (Llewellyn and Hogan 2000; McLaren 1998,) and a means of aiding understanding, research and management. There are strengths and limitations in adopting the traditional "medical model" which may be summarized as a mechanistic view of the body, in which illness is simply a fault in the machine that should be fixed. Its principal focus on pathology and its treatment (Virchow 1858), leads it to be understood as a *disease model* or *biomedical model*. Symptoms are taken to imply incapacity, so sickness absence is considered necessary and justified until full recovery (the complete relief of symptoms).

Disability groups in the UK have rejected the medical model and proposed an alternative "social model of disability" (Finkelstein 1980; Oliver 1983). It is argued that many of the restrictions experienced by disabled people do not lie in the individual's impairment but are imposed by the way society is organized for able-bodied living. Society fails to make due allowance and arrangements that would enable disabled people to fulfil the ability and potential they do have. Social models and the role of personal and psychological factors provide a better understanding of sickness and disability. They also impact on capacity for work and aid developing interventions aimed at facilitating return to optimal function and work. Social models shift the focus from the individual to society and champion the empowerment of disabled people: social restructuring assumes paramount importance and is the collective responsibility of society at large. The social model has profound implications in the provision of health care, for workplace management and social policy.

The social model approach necessitates change in the work environment and thus in the attitudes and behavior of employers, line managers and other workers. Individuals may be empowered to adapt the work environment to meet their needs, whereas other people may require education on these matters. The most powerful determinants of (ill) health are social gradients (Marmot 2004) and the linked problem of regional deprivation (Aylward and Phillips 2008; HMT 2003; McLean et al. 2005; Oxford Economics 2007; Ritchie et al. 2005).

Incapacity benefits cover diverse groups of people, with different kinds of problems, in very different circumstances. Nevertheless, many benefit recipients face multiple disadvantages and barriers to (return to) work (Waddell and Aylward 2005). Financial benefits unquestionably affect illness behavior. Work is fundamental to the family's socioeconomic situation, but in the circumstances brought by sickness or disability sick pay, social security, and workers' compensation, benefits may assume greater importance. Economic (dis)incentives do influence human behavior. However, the impact of economic incentives has been shown to be less than those of other drivers of behavior (Halpern et al. 2004; Waddell and Norlund 2000). Even more fundamentally, this economic model fails to recognize that some of the main drivers of sickness and disability are not financial but health-related and psychological.

7.2.1.1 The Biopsychosocial Model

Each of the above models poses a different perspective on disability and sickness, but each gives only a partial view. However, the biopsychosocial

model of human illness is a more complete model, which recognizes and takes account of the person, their health problems, their social contexts, and the interactions among them, which can influence the course and outcome of disability and illness (Table 7.4). This model has profound implications for health care, workplace management, and social policy. Moreover, it acknowledges that a person's functioning depends on complex interactions among health status, environment, and personal factors, including attitudes and beliefs. Engel (1977; 1980) introduced the term "biopsychosocial" which shifted the focus from disease to illness and emphasized that health care must address the subjective experience of illness. This dynamic systems approach provides for better integration of body, mind, and social context and avoids the linear causality and factor analysis of the medical model. It recognizes that actions must be taken at both the individual and social levels. Interactions among these components of a complex system and between health and social well-being have been advanced as the major contributors to illness and to health (Buck et al. 2006; Gilbert 2002; Kiesler 1999). These are bidirectional in that social context influences sickness and disability, yet people can and do modify, select, and even create their social (and cultural) context (Llewellyn and Hogan 2000). Moreover, sickness and disability are dynamic systems that evolve over time.

The biopsychosocial model should not be taken to imply that psychosocial factors initiate an underlying health problem–although in a minority of contexts this causation can be activated by psychosomatic mechanisms. In general, psychosocial issues are better tackled after the health problem is addressed. The inability to diagnose pathology does not mean that the problem is a psychosocial one and neither does the manifestation of psychosocial factors exclude a genuine health problem. Moreover, undue emphasis on psychosocial factors can lead to the neglect of an underlying health problem and its appropriate diagnosis and treatment. Importantly, psychosocial factors must not be taken as diagnoses in themselves: rather, their identification necessitates more thorough appraisal of how an individual is affected by and deals with their health problem.

Table 7.4 Dimensions and interactions of the contemporary biopsychosocial model of human illness

Dimension	Interaction
Biological	Illness has at its basis biological functioning in body or brain whether or not recognized as a specific disease
Psychological	Illness is by definition subjective and invariably has a personal/psychological dimension
Social	Sickness and disability are social phenomena; illness is ultimately expressed in a social context

Sometimes application of the biopsychosocial model has focused almost invariably on a set of factors relevant to clinical psychology (e.g., cognition, mood and coping) neglecting what may be equally important less quantifiable influences on the personal and subjective experiences of illness and disability (e.g., expectations, perceptions and uncertainty). The "social" element of the model is rarely given the attention it merits and yet may well prove to be a dominating influence, which if not addressed may frustrate attempts at achieving successful outcomes.

The model must not be taken to imply that patients are the powerless victims of overwhelming psychosocial forces, which are beyond control. This notion fails to allow for free will, conscious choice, personal responsibility, and the possibility of exaggeration, abuse, or fraud (Aylward 2003). On the other hand, observer bias and a predetermined judgemental approach have to be avoided. The biopsychosocial approach also demands a more egalitarian patient–health care professional relationship (Borrell-Carrió et al. 2004).

The limited availability of validated tools to assess the role of psychosocial issues and practical interventions to tackle them is the greatest drawback to a more successful application of the biopsychosocial approach (Borkan et al. 2002; Kendall and Burton 2009; Kendall et al. 1997). There is a pressing need for more empirical evidence for biopsychosocial interventions at an

individual level. Moreover, biopsychosocial problems are occasionally considered so complex that their effective management can only be undertaken by multidisciplinary teams. That is not so—patients with common health problems are well managed in primary care by adopting a few basic principles (Cohen et al. 2012a, b). Albeit, more difficult issues will need referral elsewhere and only the most complex cases will require a multidisciplinary team.

7.2.1.2 The Social Context

The most powerful determinants of illness and health are social gradients (Aylward and Phillips 2008, Marmot 2004, Ritchie et al. 2005). In the UK, there is a tenfold variation in the rates of receipt of work-incapacity and disability benefits between local authority areas which have the least and greatest disadvantaged and deprived populations. For example, the highest rates are found in the formerly heavily industrialized areas of south Wales, northern England, and central Scotland (Waddell and Aylward 2010). These areas of deprivation exhibit mortality rates, limited life expectation and years of freedom from disability and long-term illnesses which contrast most unfavorably with corresponding statistics found in areas where populations are the least disadvantaged Waddell and Aylward 2010.

One should be mindful of the adverse social context that burdens many people in receipt of work-incapacity benefits who face multiple disadvantages and consequent barriers to return to, or first entry into, a life in work (Waddell and Aylward 2005). Coexisting health problems are common, and secondary mental health problems frequently occur as the time out of work lengthens. In the UK, more than half of people in receipt of incapacity benefits have personal commitments that make entry into work more difficult (e.g., childcare responsibilities or caring for someone with chronic illness or disability). Low skills-even basic skills, poor employment histories and absence of academic and vocational qualifications in disadvantaged groups are commonly encountered. There exists a low-skills trap (Finegold and Soskice 1988; Rees and Stroud 2004) whereby a substantial proportion of the socially excluded population finds it extremely difficult to enter the labor market. Moreover, many trapped by low skills and in receipt of social security benefits cannot command a high enough wage to make work pay. In addition, employer discrimination remains a formidable barrier, especially for people with mental health conditions (Lelliot et al. 2008).

Uncertainty is a key issue: inability to enter regular work because of recurrent health problems, negative financial consequences of moving off benefits and into work and being labelled as incapable of work raise significant barriers and reinforce other barriers (Howard 2003; Waddell and Aylward 2005). Even if the health condition itself is not totally incapacitating, it is seriously compromised by these multiple disadvantages. These social aspects of the biopsychosocial approach are frequently neglected.

Alas, there is no simple solution to limiting these formidable barriers without addressing the social structure of society as a whole. But these social barriers must be identified, assessed on an individual basis, and where possible due allowance must be made for them. In this context, potential employers can play a cardinal role in avoiding discrimination, understanding the relationships between health and work, adjusting workplace environment, and adapting ways of working. If the social context is the principal barrier to a life in work, then addressing alone the health condition and psychological elements may well render access to or return to work a forlorn hope.

7.2.2 Workplace Management

A strong business case can now be made for the effective management of health at work (Black 2008; Burton et al. 2008; Hanson et al. 2006; Price Waterhouse Coopers 2008; Shaw et al. 2007). A focus solely on health care is inadequate: effective management must also address workplace matters and organizational features (Franche et al. 2005; Hill et al. 2007; HSE 2005; Lunt et al. 2007; Waddell et al. 2008). This notion signals the need to move from traditional "treat-

ment" (i.e., health care) to a more all-embracing approach to the matter. Contemporary concepts of rehabilitation must follow a different logic to that adopted in the past (DWP 2004; Waddell and Aylward 2005; Waddell and Burton 2004).

In clinical practice, the concept of obstacles began with the consideration of factors that predict chronic pain and disability, and largely emphasized psychological influences. But these are only part of the picture. Notably, social security studies have largely focused more on social barriers to return to work (Waddell and Burton 2004). Biological, psychological and social obstacles are all important, albeit that there is interaction and overlap among the different dimensions, and their relative contribution may vary in different individuals and settings over time (Moon 1996). Thus, individual assessment of obstacles and barriers permits a problem-orientated approach that can:

- Guide clinical evaluation.
- Identify obstacles/barriers to recovery/return to work.
- Develop and introduce interventions to overcome these.
- Facilitate rehabilitation.

As common health problems are an inevitable part of (working) life, good workplace management is about preventing persistent and disabling consequences, which may include several overlapping strategies (Linton 2002; Shaw et al. 2002):

- Positive "health at work" strategies.
- Early detection and treatment of mild to moderate symptoms.
- Distinguishing temporary functional limitations from persistent or recurrent symptoms, and
- Interventions to minimize sickness absence and promote (early) return to (sustained) work.

The workplace as, indeed, health care should identify and address all health, personal, social, and occupational dimensions of health, identify barriers to (return to) work, and provide the support, opportunities, and encouragement to overcome them. Line managers play a key role in delivering this within the context of the employer's "duty of care" to their employees (Cohen et al. 2009, 2012a; Pransky et al. 2009). Sickness absence management, assisting return to work, and promoting rehabilitation are matters of good practice, good occupational management, sound business sense, and emphasize the need to ensure that work is safe and healthy (Buck et al. 2008, 2010; EEF 2004; HSE 2004).

7.2.2.1 Vocational Rehabilitation

The biopsychosocial model and the *International Classification of Functioning, Disability and Health* (WHO 2001) are now widely accepted as the best framework for disablement (Rondinelli 2007) and rehabilitation (HSE 2005; Lunt et al. 2007; Schultz et al. 2000; Wade and Halligan 2004; Wade and de Jong 2000). Vocational rehabilitation is best defined as *whatever helps someone with a health condition or disability to stay in, return to or move into work* (TUC 2000).

The traditional approach to rehabilitation as a secondary intervention after medical treatment accepts that impairment is irremediable, and attempts to overcome, adapt or compensate for it by developing to the maximum extent the patient's (residual) physical, mental, and social functioning. Where appropriate, patients may be helped to return to (modified) work. That approach remains valid for some severe medical conditions (Wade and de Jong 2000). However, in tackling common health problems the approach to rehabilitation requires a different logic. Rather, recovery and restoration to optimal functioning should generally be expected, even if there remain some persisting or recurrent symptoms. As explained earlier in this chapter, focusing exclusively on health care is inadequate: effective management must also incorporate workplace matters and organizational features (Franche et al. 2005; Hill et al. 2007; HSE 2005; Lunt et al. 2007; Waddell et al. 2008).

Biopsychosocial factors aggravate and perpetuate sickness and disability; crucially, these factors can continue to act as obstacles or barriers

to recovery and return to work. The paradigm for effective rehabilitation then shifts from dealing with residual impairment to addressing the biopsychosocial elements that delay or prevent expected recovery and return to work (Burton and Main 2000; Howard 2003). The very same principles underpin job retention, return to work and reintegration, and are equally applicable to the general management of sickness and disability, whatever their causes. There is a strong and growing evidence base for many aspects of vocational rehabilitation (Waddell et al. 2008) and more evidence on the realization of cost-benefits than for many health and social policy areas (Black 2008; Waddell et al. 2008).

The concept of early intervention is central to vocational rehabilitation: the longer anyone is off work, the greater are the obstacles to return to work and the more difficult vocational rehabilitation becomes. It is simpler, more effective and cost-effective to prevent people going on to long-term sickness absence, Fig. 7.1.

Return to work should be one of the key outcome measures for health care and workplace management. A "stepped-care approach" allocates finite resources most appropriately and efficiently to meet individual needs (Freud 2007; von Korff 1999; von Korff and Moore 2001). In essence, the elements of this approach begin with simple, low-intensity, low-cost interventions that will be adequate for most sick or injured workers, followed by more intensive and structured interventions for those who need additional help to return to work.

Each stage involves a different set of expectations, behaviors and social interactions. The timing of health care, rehabilitation, and social interventions is critical. It is imperative that those of working age receive the help they need, when they need it. Clinical management of the majority of health complaints emphasizes the importance of restoring function as the best means of relieving symptoms. Most people recover rapidly and return to their normal activities and work; for them it may be argued that routine health care effectively does rehabilitate. For those who do not recover rapidly, health care and continued symptomatic treatment alone is not enough. In

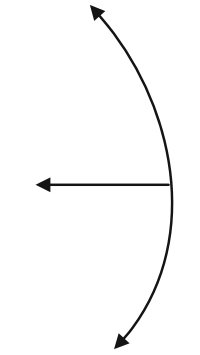
Dimensions of Disability	Obstacles to (Return to) Work	Corresponding Rehabilitation Intervention	Interactions Communication
Bio-	Health condition (+ health care) Capacity + activity level -v-job demands	Effective and timely health care Increasing activity levels & restoring function Modified work	
Psycho-	Personal / psychological factors Psychosocial aspects of work	Shift perceptions, attitudes & beliefs Change behaviour	
Social	Organizational + system obstacles Attitudes to health and disability Culture	Involvement of employer critical Social support Organizational policy, process & attitudes. Changing social attitudes	

Fig. 7.1 Biopsychosocial obstacles to return to work with corresponding rehabilitation interventions. Reproduced with permission from Waddell and Aylward, Models of Sickness and Disability, Royal Society of Medicine Press, 2010

longer-term incapacity, the biological dimension and health care are only part, and often the least part, of the problem.

Waddell and Burton (2008) advocated separating clients into three broad types based principally on duration of the period off work. These groups will most likely have correspondingly different needs, which need diverse management approaches.

1. Up to 6 weeks off work.

   In the first 6 weeks or so, the very great majority of people with common health problems can be helped to remain at or return to work by adopting a few basic principles of health care and workplace management. The objective is to encourage and support health professionals and employers to implement these principles in practice.
2. Greater than 6 weeks off work.

   Symptomatic treatment alone is not likely to impact on work outcomes. At this stage, there is strong scientific evidence (particularly for musculoskeletal disorders) that effective interventions include:
   - Well-timed recognition of those requiring further support.
   - Allocation of responsibility for management.
   - Individual needs assessment.
   - Referral for opportune help.
   - Coordination of management and interventions.

     A case management approach is preferred, which incorporates evidence-based vocational rehabilitation interventions quality assurance and an emphasis on work outcomes.
3. 6 months and beyond.

   People in this group need interventions, which address the substantial personal and social barriers they face, including help with reemployment.

7.2.2.2 Cognitive–Behavioral and Talk Therapies

Attitudes, beliefs, and behavior can aggravate and perpetuate symptoms and disability; addressing these issues is an essential part of rehabilitation management. This principle seems to apply generally across all rehabilitation for physical and mental symptoms, stress, distress, and disability.

Behavior change is not a discrete event but a gradual process. The "stages of change model" Rollnick et al. 1999; Cohen et al. 2009) illustrates the process that an individual passes through towards behavioral change. Discussions with patients about behavior change are integral to health care practice (e.g., smoking cessation, weight reduction and diabetes management). Behavior change methods are now also applied to managing rehabilitation and return to work (Chang and Irving 2008; Cohen et al. 2012a, b). Most of these psychological and behavioral approaches now combine *cognitive–behavioral* principles (Linton 2002; Main and Spanswick 2000; Waddell and Aylward 2010), which tackle the illness experience in order to change beliefs, modify behavior and improve functioning. There is a growing body of evidence, which supports this methodology in tackling common health problems (e.g., Crombez et al. 1999, Vlaeyen and Linton 2000; von Korff 2005). Moreover, for people experiencing common mental health problems at work, brief individual therapy is most effective and cognitive–behavioral therapy (CBT) has been shown to be highly effective (Seymour and Grove 2005).

Motivational Interviewing (MI) is now recognized as an important method for engagement and compliance across many areas of health care (Rollnick et al. 1999). Alongside interventions, such as CBT, MI enhances engagement and motivation and is being adopted as an essential component of many effective rehabilitation programs.

7.2.3 UK Pathways to Work Program

In the UK, about three-quarters of those people in receipt of incapacity benefits say they would like to work (Waddell and Aylward 2010). These self-reports are not always a reliable indicator of the actual return to work rates when benefit recipi-

ents are offered quite comprehensive return to work support packages (Aylward et al. 2012). People's well meaning intentions and aspirations may be frustrated subsequently by a range of barriers, which were not evident when the question about likelihood of return to work was asked.

In the UK, the "Pathways to Work" program was launched in 2003. This program offered, in pilot areas of the country, enhanced support to those who were in receipt of a state incapacity benefit. This approach included specialist personal advisers, a series of six work focused interviews and a £40 per week return to work credit and a "Choices Package." Admission to the Choices Package was voluntary. The package's components included a Condition Management Program (CMP), delivered by the NHS, to help clients better manage their condition and to reduce the disability produced by chronic illness/injury. In 2006, the pilot programs were extended to cover the whole of Great Britain. This initiative brought some measure of success in doubling benefit recipients reentering work in some regions and was well received by both the claimants themselves and case managers. The key outcomes of the program were as follows (Aylward 2009; Ford and Plowright 2009):

- Most common benefits were increased confidence and ability to cope; significant improvements in confidence and coping were independent of changes in health status, associated with successful work outcomes;
- Rather than aiming for control of a health condition, successful outcomes were dependent on learning process towards self-management and independence;
- New roles for health professionals include support and guidance rather than therapy;
- Undue and mistimed emphasis on RTW had negative effects on engagement and outcomes;
- Evidence that improvements occurred despite unaltered or deteriorating health condition;
- The outcome of work was largely independent from other outcomes; however, work outcome was highly dependent on critical elements of the support and management package and the context in which it was delivered.

The Pathways to Work program was abandoned by the coalition government in 2011, though elements of this successful approach, notably condition management, have been retained in subsequent coalition government work program initiatives.

7.2.4 Social and Occupational Interventions

Employers have a key role if return to work is to be successful. Strong evidence supports a proactive approach by employers to attendance management that encompasses temporary provision of modified work and workplace adjustments as both effective and cost-effective (Black 2008). The primary goal is to facilitate an early return to work. Analysis of findings in empirical studies strongly supports modified work as an intervention that halved work days lost and the number of injured workers who went on to chronic disability (Krause et al. 1998). Health care interventions alone, which remove people from the workplace, could well impose a formidable barrier to the successful application of this approach.

For rehabilitation to be effective, there is strong evidence favoring the requirement for both work-focused health care and accommodating workplaces (Waddell et al. 2008). As emphasized earlier, an integrated approach with coordinated interventions is essential involving all key players across the health and work spectrum.

Lower levels of organizational performance are associated with higher levels of sickness presence and absence (Ashby and Mahdon 2010). Higher rates of sickness absence are also often associated with poor line management and support. The relationship between the line manager/supervisor and employee strongly influences employee well-being (Boorman 2009; Post et al. 2005). Effective communication between and among the principal players is an absolute prerequisite for a coordinated intervention (Beaumont 2003a, b; Sawney and Challenor 2003). This process demands common goals, understanding and language, which also facilitate

training and organizational approaches that increase participation in decision making and problem solving (Cohen et al. 2012a, b). Such examples of improved communication are highly effective at reducing work-related psychological ill health and sickness absence (Michie and Williams 2003).

Policies and procedures to improve line management have been developed (Pransky et al. 2009). However, the quality of the conversation and the skillfulness required of line managers in undertaking the return to work conversation should not be underestimated. Being valued by the line manager and the organization are of high importance for employees and influences employees' attendance behaviors (Cohen et al. 2012a, b). A well-structured return to work program, agreed by both employee and employer, provides clarity and should manage expectations and facilitate the essential processes promoting effective attendance management. Addressing the psychosocial and interpersonal issues, which may confound a return to work may well be more important than modifying physical demands and job-related issues.

7.2.5 Work and Health: A Culture Shift

There is a pressing need to shift attitudes to work and health. Work and health are intimately related. This chapter attempts to demonstrate the complex relationships and interactions between the work environment and a person's health, which are consistent with the biopsychosocial model. As stated earlier in this chapter, the evidence is now extensive that the beneficial effects of work outweigh the substantial adverse effects on health brought by worklessness and the risks to health of work itself, providing that the work is "good" in promoting health and well-being as discussed earlier (Table 7.5). This notion considerably strengthens the economic, social, and moral arguments that work is the most effective means to improve the health and well-being of individuals, their families, and their communities.

Table 7.5 Health, work, and well-being (modified after Waddell and Burton 2006)

Work statement	Health impact
Work is generally good for health	Work is an integral part of life, central to an individual's identity, social roles and status and meets financial and psychosocial needs
	For people with common health problems, there is strong evidence that work: • Promotes recovery, return to optimal functioning, and rehabilitation • Leads to better health outcomes and subjective well-being • Limits the harmful physical, mental, and social effects of long-term absence from work • Enhances quality of life and well-being, and • Reduces social exclusion, disadvantage, and poverty
Worklessness is bad for health	There is strong evidence that long periods out of work can cause or contribute to: • A two to threefold increased risk of poor general health • A two to threefold increased risk of mental health problems • An increased risk of suicide • Around 20 % excess mortality, and • Higher consultation, medication consumption and hospital admission rates

These health risks are greater than those of many "killer diseases" and the risks associated with the most dangerous jobs in the construction industry or the North Sea

Rehabilitation needs to become more proactive and encompass the concept of prevention of long-term disability and work incapacity. This approach requires parallel interventions from health care and workplace rehabilitation. Furthermore, incorrect, commonly held assumptions must also be rigorously challenged to shift erroneous beliefs about health and work that:

- Rest from work is part of treatment—on the contrary, modern approaches to clinical man-

agement stress the importance of continuing ordinary activities and early return to work as an essential ingredient of treatment (Black 2008; Waddell and Aylward 2010).
- Patients should be 100 % fit before considering a return to work.

The significant number of people with health problems who enter into long-term incapacity for work is a tragedy for themselves, for their families and communities, for the economy, and for society as a whole. The evidence is now quite clear that the factors which underpin longer-term sickness and the failure to join the world of work are in the greater part personal and social rather than medical problems. These can only be understood and rigorously and successfully tackled by embracing a biopsychosocial intervention approach.

Although there is now sufficient knowledge to substantially limit sickness absence and long-term incapacity for work (Waddell and Burton 2004), the challenge remains of turning that knowledge into effective practices, targeted and validated interventions and achieving better health and well-being outcomes for all (Aylward et al. 2012). This unresolved issue presents us with a major public health challenge, which will only be resolved by a fundamental change in the ways we perceive and better understand the relationships between health and work, sickness and disability, and social determinants of heath and illness. Much sickness and work incapacity is preventable. The biopsychosocial model provides the framework and tools for achieving the desired change and better managing of a person's return to optimal function and work.

7.3 Conclusions

Much sickness and disability should be preventable, especially when they are due to common health problems, which may not be linked to any recognizable pathology and are ubiquitous and omnipresent in society. Moreover, these common health problems are insufficient in themselves to explain long-term incapacity for work. The unfortunate use of words such as "ill," "sick," "disease," and "disabled" as if they were interchangeable causes great confusion. This lack of precision contributes to the paradoxical observation of increasing levels of reported illness versus general improvement in population health in the more developed countries.

It is quite evident, however, that the management of health problems, whether common or otherwise, is not a matter for health care alone. A focus solely on health care is inadequate: effective management must also address psychosocial influences, together with workplace matters and its organizational features. This signals the need to move from traditional "treatment" (i.e., health care) to a more integrative approach to the matter.

Personal, psychological, social, and cultural factors aggravate and perpetuate ill health and disability; they also act as barriers or obstacles to recovery. Moreover, psychological factors influence when common bodily or mental symptoms become a "health problem." This situation leads logically to a biopsychosocial model of human illness that includes biological, psychological, and social dimensions, and the interactions among them that influence the course and outcome of any illness and thus may also act as barriers to recovery and return to work. Prolonged absence from normal activities, including work, is often detrimental to a person's mental, physical, and social well-being, whereas a timely return to appropriate work benefits the individual and his or her family by enhancing recovery and reducing disability.

An approach to rehabilitation based upon a biopsychosocial model is necessary to identify and address the obstacles to recovery and barriers to (return to) work. These barriers are primarily personal and psychosocial rather than arising solely from medical problems. The biopsychosocial approach should also meet the needs of those with common health problems who do not recover in a timely fashion, and identify the roles of key stakeholders. A person's return to function and work as soon as possible after an illness or injury should be encouraged and supported by employers, occupational and other health profes-

sionals, fellow employees, and rehabilitation service providers. Indeed, employers have a key role if return to work is to be successful. Strong evidence supports a proactive approach by employers to attendance management that encompasses temporary provision of modified work and workplace accommodations and adjustments as both effective and cost-effective. Successful rehabilitation is dependent on labor market opportunities, i.e., availability, quality, pay levels, and security of employment; as well as on personal capabilities related to the physical and psychological demands of work. A safe and timely return to work also preserves a skilled and stable workforce for employees and society, and reduces demands on health and social services, as well as on sickness absence schemes and disability payments.

The evidence is now extensive that the beneficial effects of work outweigh the substantial adverse effects on health brought about by worklessness and the health risks of work itself, providing that the work is "good" in promoting health and well-being. This evidence considerably strengthens the economic, social, and moral arguments that work is the most effective means to improve the health and well-being of individuals, their families, and their communities.

The most powerful determinants of illness and health are social gradients. Recognition must be given to adverse social circumstances that burden many people in receipt of work-incapacity and disability benefits who are challenged by multiple disadvantages and barriers to return to, or first entry into, a life in work. There are no simple remedies for dismantling these most challenging socioeconomic barriers but they must be recognized and in some circumstances may well be tackled on an individual basis. If the foremost barrier to gaining or returning to work is the adverse social context then only dealing with the barriers posed by the health condition and psychological elements to achieve success is a forlorn hope.

Tackling barriers to recovery and gaining more effective access to return to work is a formidable challenge but one that is vitally important to every one of working age, their families, communities, and society as a whole. Despite the current adverse global economic situation, the unimpeded return to work may be achieved but only by a fundamental change in our thinking and practices and by working together to achieve common objectives.

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