



Mitigation: Health Impacts

Second Edition, 2018

Core Body of Knowledge for the
Generalist OHS Professional



**Safety Institute
of Australia Ltd**



**Australian OHS Education
Accreditation Board**

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Mitigation: Health Impacts

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**Core Body of
Knowledge for the
Generalist OHS
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Dedication

This chapter of the OHS Body of Knowledge is dedicated to the work of

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In recognition of his contribution to improving the occupational health of Australian workers as a consulting occupational physician and through sharing his knowledge and expertise to educate others in occupational health.

Mitigation: Health Impacts

Abstract

Although the activities of injury management, claims management and return to work may not be core activities for generalist Occupational Health and Safety (OHS) professionals, knowledge of the key principles of mitigating health impacts is required to minimise the impact of work-related injury, ill health and disease on individuals and organisations. Increases in work time lost and the size of workers' compensation payments for serious claims underline the importance of such knowledge. This chapter discusses: key concepts of early intervention, return to work and social support; the roles of professionals involved in injury management and return to work; and strategies to achieve early and effective return to work. The special cases of critical incidents and workplace fatalities are also considered. The potential role of the generalist OHS professional is highlighted at the end of sections, and the chapter concludes with a summary of implications for OHS practice.

Keywords

health, injury, early intervention, rehabilitation, return to work, compensation, good work

Readers should refer to Chapter 1, Preliminaries, for a full list of chapters and authors, and a synopsis of the *OHS Body of Knowledge*. Chapter 2, Introduction, describes the background and development process while Chapter 3, The OHS Professional in Australia, provides context by describing the role and professional environment.

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1 Introduction

The *OHS Body of Knowledge* focuses on the prevention of work-related fatality, injury, disease and ill health. The evolving role of the generalist OHS professional is moving to a holistic approach that encompasses prevention and health in a broad sense with the relationship between work and people and their health seen in a positive context. This perspective informs the *Australian Work Health and Safety Strategy* for “healthy, safe and productive working lives” (SWA, 2012, p. 3).

Two concepts underpin this expanded approach: firstly, the World Health Organisation (WHO) definition of ‘health’ and, secondly, the concept of ‘good work.’ The definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” is one of the key principles of the WHO Constitution adopted in 1946 (WHO, 2018). While other definitions have been proposed and the WHO definition has been criticised for being too vague, it is still the most widely recognised definition of health. Applying this definition within a workplace requires workers to be not only free from disease or infirmity, but to be in a state of “complete physical, mental and social well-being.” This definition is the basis for the concept of good work, which is “about balancing the interests of individuals, employers and society in order to deliver performance, engagement and fairness” (Parker & Bevan as cited in AFOEM & RACP, 2013, p. 9).¹

A key requirement of good work in supporting health in its broad sense is appropriate management of, and support for, workers who have been injured or made ill at work in order to mitigate the impacts on them as well as on the organisation as a community. The role of the generalist OHS professional needs to include development of strategies to mitigate such health impacts and to facilitate implementation of action plans in the event of such occurrences.²

The mitigation role can be described as part of the time sequence of accidents as proposed by Haddon (e.g. 1980), Viner (2015) and others. In Viner’s (2015) Generalised Time Sequence Model, mitigation would occur within the consequence time zone, during which damage commences, is detected and proceeds to completion, followed by recovery or stabilisation.³ Clearly, planning for such mitigation must have been in place well before any incident occurs.

¹ A future *OHS BoK* chapter will address ‘good work’ and psychologically healthy workplaces.

² Planning for mitigation through emergency management is addressed in *OHS BoK Mitigation: Emergency Management*.

³ See *OHS BoK Models of Causation: Safety*.

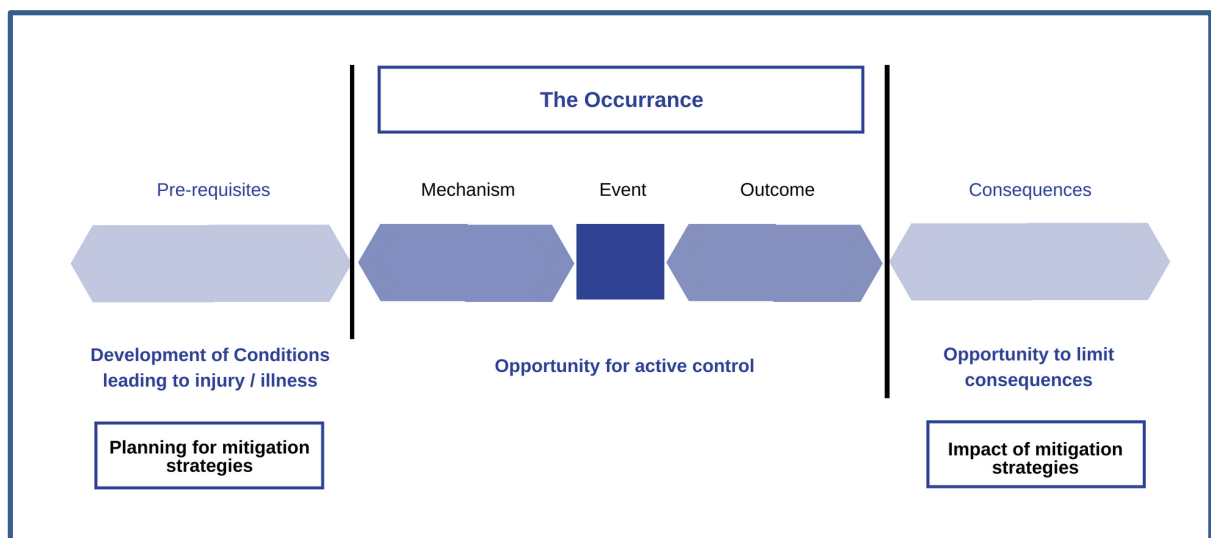


Figure 1: Mitigation in the accident/illness time sequence (modified from Viner, 2015, p. 47)

This chapter discusses principles of mitigation of health impacts of workplace injury and ill health relevant to the generalist OHS professional. It takes a broad view of the relationship between work and injury or ill health that is not predicated on the acceptance of a claim for workers' compensation. As the focus of the chapter is on mitigation, it does not address health promotion and wellness strategies, which are recognised as important components of health in the workplace. Also not addressed are management of mental health in the workplace and details of claims management and return to work as these areas have their own specialised bodies of knowledge. For ease of reading, the term 'return to work' (RTW) should be considered to also encompass 'stay at work' (SAW).

After a brief review of the historical approach to post-injury management, the extent of the problem in terms of injuries and work days lost, and the legislative framework, section 5 presents key concepts of early intervention, return to work and social support. As effective post-injury management requires a multidisciplinary approach, the roles of professionals in relevant disciplines are reviewed in section 6. Section 7 describes strategies for mitigating the impact of work-related injury and ill health. The role of the generalist OHS professional is highlighted at the end of each section, with implications for OHS practice summarised in section 8. Finally, section 9 provides an overall chapter summary.

2 Historical perspective

Historically, the approach to worker health and injury management has been driven by legal processes and workers' compensation systems. It is only in recent years that health

professions have taken the lead in framing the approach to worker health and injury management.

The traditional approach to preventing and managing work-related health impacts has its roots in the 18th century when incidents of injury and disease were perceived as inevitable outcomes of the production process. In the 19th century, this perspective supported a focus on minimising legal redress for work-related injury claims on the legal grounds of voluntary assumption of risk and contributory negligence by the worker. Workers' compensation programs evolved around the end of the 1800s in response to greater acceptance of the inherent risk of work-related injury and the necessity to treat it as a cost of business rather than the responsibility of individual workers (Industry Commission, 1994, Appendix F).

Workers' compensation legislation in the United Kingdom and Australia initially required proof of negligence for a successful claim. In Australia, the concepts of 19th century compensation law (with the emphasis on compensation rather than recovery) remained largely unaltered until the 1980s. Following several reports, including the Byrne (1980) report in South Australia and the Cooney (1984) report in Victoria, most Australian state and territory governments enacted new or revised workers' compensation Acts with an emphasis on 'no fault' and 'rehabilitation and return to work' as the desired outcome of treatment (Industry Commission, 1994, Appendix F).⁴ This emphasis continues to drive national policy and was reflected in the *Australian and New Zealand Workers' Compensation Strategy 2010 – 2013*, which included "best practice, evidence-based injury management and return to work initiatives" as one of four priority areas (HWCA, 2010).

The last 10 years have seen a paradigm change in the way worker health is viewed, in the approach to management of work-related injury, and in promotion of RTW for the injured or ill worker. This shift was initiated by the ground-breaking work of Dame Carol Black in *Working for a Healthier Tomorrow* (Black, 2008). While Black advocated for an expanded role for occupational health to include those who were 'workless,' key implications of her work for generalist OHS professionals are that:

- Work can be good for health and wellbeing
- Illness and injury are not incompatible with being in work
- Health/wellbeing is not just a medical issue, but one where the nature and characteristics of work are important
- The concept of fitness for work focuses on what people can do instead of what they cannot do

⁴ The concept of negligence as a factor in compensation is still part of any common law action related to compensation.

- There should be early intervention through an expanded support system that not only includes medical and allied health treatment, but other support systems to facilitate people remaining at work (Black, 2008).

While not receiving the same recognition in Australia, the American College of Occupational and Environmental Medicine (ACOEM) and, specifically, the work of Jennifer Christian advocated a similar approach. The ACOEM (2006) guideline on *Preventing Needless Work Disability by Helping People Stay Employed* rests on the assumption that:

The fundamental reason for most lost workdays and lost jobs is not medical necessity, but the non-medical decision-making involved in and the poor functioning of a little-known, but fundamental practice employed by U.S. and Canadian disability benefits systems – the stay-at-work/return-to-work (SAW/RTW) process. This process determines whether a worker stays at work despite a medical condition or whether, when, and how a worker returns to work during or after recovery. The SAW/RTW process presently focuses on “managing” or “evaluating” a disability rather than preventing it.

Similar to Black (2008), the ACOEM guideline is based on preventing ‘disability’ by moving away from a medical ‘illness’ model to addressing the circumstances that prolong work disability by making changes to the work environment and support systems to facilitate stay at work/return to work.

Building on ACOEM (2006) and Black (2008), in 2010 the Australasian College of Physicians’ Australasian Faculty of Occupational and Environmental Medicine (AFOEM) prepared a position statement, *Realising the Health Benefits of Work*, followed in 2011 by a consensus statement – subsequently signed by representatives of all Australian and New Zealand medical colleges – that identified the health benefits associated with being in ‘good work’ (AFOEM, 2011, 2015).⁵ The principles espoused in the consensus statement are being promoted to government, regulators and industry through engagement and education by AFOEM.⁶

3 Extent of the problem

Australian workers’ compensation statistics for 2015-16 (SWA, 2018a) reveal that although the frequency rate of serious claims⁷ is decreasing, work time lost and compensation payments continue to increase:

⁵ SIA is also a signatory to the *Australian and New Zealand Consensus Statement on the Health Benefits of Work* (AFOEM, 2011).

⁶ Via the AFOEM HBGW Australian Signatory Steering Group and the HBGW Health Steering Group.

⁷ A serious claim is defined as “an accepted workers’ compensation claim for an incapacity that results in a total absence from work of one working week or more” (SWA, 2018a).

- There were 104,770 serious workers' compensation claims in 2015-16, which equates to 5.6 serious claims per million hours worked
- Between 2000-01 and 2014-15:
 - The frequency rate of serious claims fell by 36%
 - The median work time lost for a serious claim increased by 33%
 - The median compensation paid for a serious claim increased by 30% (adjusted for wage inflation)
 - The highest frequency rates of serious claims were among employees aged 55-64, indicating potential for further increase with an aging workforce (SWA, 2018a).

While use of worker's compensation data from the National Data Set for Compensation-based Statistics (NDS) allows measurement of OHS performance in Australia, Safe Work Australia acknowledges limitations of the dataset, including exclusion of a number of employment groups (e.g. self-employed persons) and injuries of less than 5 days, and significant underreporting of work-related diseases (SWA, 2009, p. vii).

Furthermore, this data focuses on one aspect of the problem; it is commonly recognised that extended time away from work increases the disabling impact of the initial injury or illness with associated increases in both direct and indirect costs. Estimates of the cost of work-related injury and ill health allocate 19% of costs to employers, 78% to workers and 4% to the community (SWA, 2015).

In summary, although the rate of serious claims has reduced, there are ominous increases in work time lost and the size of compensation payments, and the extent of the problem is underrepresented by workers' compensation data.

4 Legislation

Legislation relating to rehabilitation and RTW is not harmonised across Australia and, in most cases, is part of workers' compensation legislation. While there are state differences in obligations and administrative arrangements, similar themes include:

- Responsibilities of employers regarding:
 - Workplace rehabilitation/RTW programs and policies
 - RTW plans for the injured worker
 - Provision of suitable duties/employment
- Responsibilities of workers in relation to RTW
- Functions of and training for workplace RTW/Rehabilitation coordinators
- Responsibilities, qualifications and authorisation of workplace rehabilitation providers
- Responsibilities of workers' compensation authorities and insurers.

Differences in legislative requirements across states, territories and the Commonwealth are tabulated in the *Comparison of Workers' Compensation Arrangements in Australia and New Zealand*, which is updated on an annual basis (e.g. SWA, 2017).

Role of the generalist OHS professional

Where OHS professionals have a role in RTW they should be aware of the specific legislative requirements for the states(s) in which they operate.

5 Key concepts

Three key concepts underpin the mitigation of health impacts of work-related injury and illness in Australia: early intervention, RTW and workplace social support. From the perspective of the generalist OHS professional, key factors across these concepts are organisational culture, structures and processes.

5.1 Early intervention

Early intervention is about identifying and responding to warning signs and reports of incidents, injury and ill health in the workplace.

Research has long supported the benefits of early intervention for physical injuries (e.g. McAnaney & Wynne, 2016; Alavi & Oxley, 2013; Arnetz, Sjögren, Rydén & Meisel, 2003; Hoefsmit, Houkes & Nijhuis, 2012) with the benefits of early intervention for psychological injury more recently recognised (e.g. van der Noordt, IJzelenberg, Droomers & Proper, 2014).

As identified by Comcare (2014), benefits of early intervention are that it:

- Creates a productive and supportive workplace.
- Shows management commitment to workers.
- Prevents long-term absence from the workplace and the development of chronic illness.
- Reduces any adverse affects [sic] on co-workers due to an injured colleague.
- Improves staff confidence and morale.
- Increases management involvement in the injury management process.
- Increases the probability of return to work.
- Contains the costs of incapacity and in the long term, the premium.
- Reduces indirect costs to employers such as lost productivity, recruitment and training costs for replacement staff.

Effective early intervention also provides information for workers, case managers, approved rehabilitation providers, medical practitioners, and importantly, it improves injury outcomes for the worker.

5.2 Return to work (RTW)

Compensation for injury and ill health related to work is an important social equity principle. Although compensation schemes exist to compensate injured workers for loss of weekly earnings, reasonable medical expenses, statutory benefits for permanent impairment and access to ‘common law’ rights, being within a compensation system can have demoralising and negative influences. The worst of these involves loss of work, which can have psychosocial as well as financial impacts. Loss of work affects a worker’s sense of self-worth and sense of identity, and can heighten the sense of pain from any injury. It can involve separation from social networks, lead to secondary depression and grieving for what has been lost, and have profoundly negative effects on an injured worker’s family (Sleskova et al., 2006).

The value of staying at work or early return to suitable duties to the recovery of an injured worker is now beyond doubt (Waddell & Burton, 2006); engagement with work and the physical environment of the workplace, colleagues and social networks helps to minimise the experience of secondary loss and hasten recovery (Nieuwenhuijsen, Verbeek, de Boer, Blonk & van Dijk, 2004). A 2013 review of RTW literature found that the limited available evidence indicates beneficial effects of such programs; however, beneficial effects can be negated if the RTW process is not well managed or evidence-based (Alavi & Oxley, 2013).

Since the mid-1980s, it has been known that the longer an injured worker is away from work, the longer it will take for them to return. Research has indicated that the critical time for RTW is within six weeks of the injury (Johnson & Fry, 2002). Importantly, this time is irrespective of whether the original injury was serious or trivial. The 2016 RTW rate⁸ in Australia was 58% (Social Research Centre, 2016), indicating a need to more closely examine barriers to RTW.

Determinants of RTW outcomes are multifactorial and the traditional medical model of healthcare does not address this complexity (Comcare, 2016). The World Health Organisation’s 2001 biopsychological model of health, illness and disability “highlights the multiple and interacting biological, psychological and social determinants of health outcomes,” and provides a more useful basis for developing an approach to mitigation of health impacts of workplace injury or illness (Comcare, 2016, p. 4). The biopsychosocial model developed by Foreman, Murphy and Swerissen (2006) represents the interaction of the various factors (Figure 2).

⁸ As measured by the 3-month stable return to work rate, which is “the proportion of injured workers... who were working (either part-time or full-time) at the time of the survey and had been back at work for at least 3 consecutive months (13 weeks) on a regular basis” (Social Research Centre, 2016, p.1).

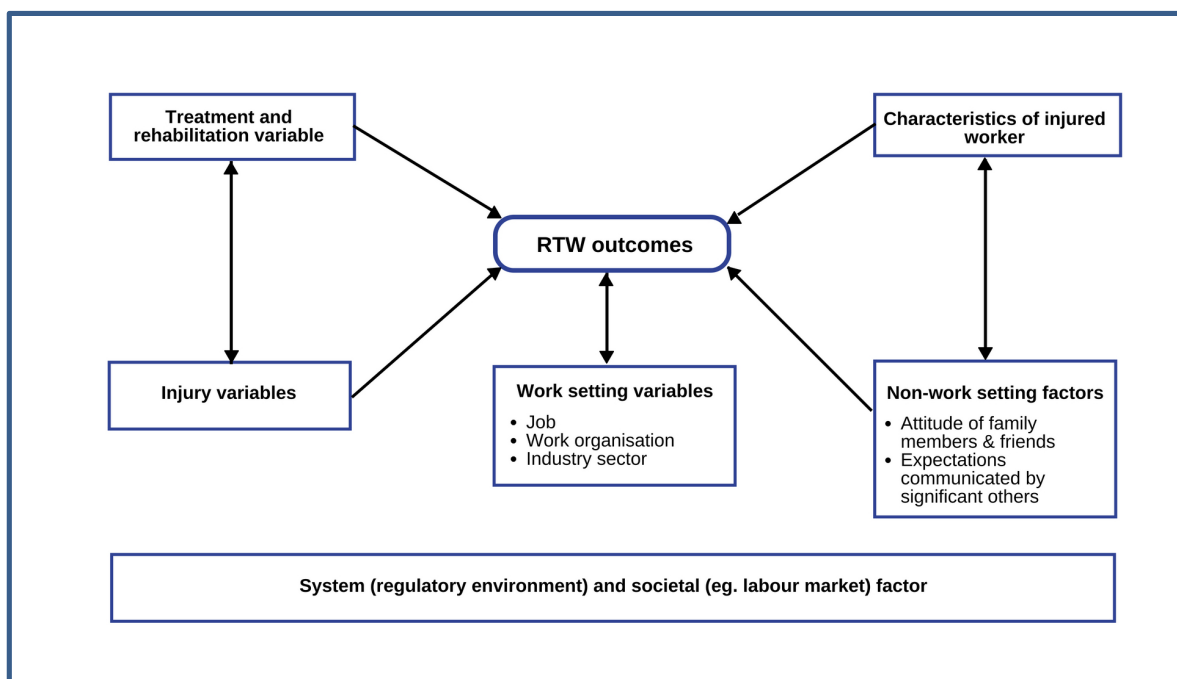


Figure 2: Summary of biopsychosocial factors influencing return to work following work injury (Foreman et al., 2006, p.12)

While this model highlights the importance of considering the relationships impacting RTW outcomes rather than focusing on a single element, the generalist OHS professional is only able to influence the workplace-related factors.

As introduced in section 1, the presence of ‘good work’ is key to the recovery and return to work of the injured worker. Good work is defined as work that:

1. Engages workers – and where necessary partners with workers and suppliers;
2. Engages with the community *culture* that reflects the local, regional and operational contexts in which the work is performed;
3. Respects procedural justice and relational fairness – promotes civility and is intolerant of incivility, discrimination and bullying;
4. Appropriately balances job demands, job control and job security and requires:
 - aware managers...who *manage change effectively*, focusing on mental and psychological wellbeing, security and life balance;
 - clear and *realistic performance indicators* to guide and acknowledge the efforts of the worker;
 - use of hard and transparent “people productivity metrics”; and
 - matching “the work” to “the individual” (AFOEM & RACP, 2013, p. 9).

Not only is the worker’s attitude to RTW affected by the organisational culture⁹ and approach to RTW, the treating doctor and their ‘gatekeepers’ (reception staff) are also

⁹ See *OHS BoK Organisational Culture* for a detailed discussion on perceptions of organisational culture.

positively or negatively influenced by the attitudes of the employer (van Duijn, Miedema, Elders & Burdorf, 2004). As noted in the AFOEM/RASCP definition, realistic performance measures and transparent people productivity metrics are important in establishing good work, which is key to the effective RTW. Conversely, intervention in the rehabilitation/RTW process to influence statistics such as Lost Time Injuries (LTIs) or Lost Time Injury Frequency Rate (LTIFR) can have a deleterious impact on RTW outcomes.

While the biopsychosocial model for factors influencing RTW (Figure 2) includes work-setting variables, it does not give due recognition to the importance of supportive conditions at work, particularly the impact of relationships between the injured worker and their supervisor and co-workers. These social-support relationships are explored in section 5.3.

5.3 Social support

MacEachen, Kosny and Ferrier (2007) draw attention to the unequal power relationship between injured workers and other stakeholders such as the insurer, the organisation, managers, supervisors and co-workers. The impact of this unequal relationship can be ameliorated by provision of social support for injured workers. One regulator gives the following advice:

As the employer, your attitude, support and understanding following an injury will affect the relationship between your organisation and your injured worker. Maintaining appropriate contact with your worker is crucial in helping them while they recover and return to work.

Key actions you can take early in the process:

- contact your worker to ask how they are and to offer support
- provide your worker with relevant return to work information
- let your worker know that your organisation takes health and safety seriously and what you are doing to address the hazards that led to their injury
- tell your worker who the Return to Work Coordinator is and that they should expect a call from the coordinator soon
- ensure your worker has received the brochure *Introducing WorkSafe, A guide for injured workers*
- be prepared to make appropriate workplace changes to accommodate your worker's return to work
- advise your other workers what you will do to support and assist them and their injured colleague during return to work and ask them to do what they can to support their colleague... (WorkSafe Victoria, n.d.).

Lysaght and Larmour-Trode (2008) present a holistic model of social support for injured workers based on the four types of social support (emotional, informational, appraisal and instrumental) proposed by House in 1981 (Wills & Shinar as cited in Lysaght & Lamour-Trode, 2008). In the workplace, social support is most likely to come from the injured worker's supervisor and/or co-workers (Table 1).

Table 1: Four-dimensional model of social support for RTW by supervisors and co-workers (summarised from Lysaght & Larmour-Trode, 2008)

Support Dimension	Supervisor	Co-worker
Emotional	While considered important by supervisors, injured workers often consider emotional support to be inadequate or absent, with a sense that support is provided as an obligation rather than true caring. When present, it is based on mutual trust between supervisor and injured worker.	Considered most important by injured workers. Based on trust, empathy, sense of caring. Requires injured worker to demonstrate that they can persevere through the rough patches.
Informational	Demonstrated through actions such as guidance on completing paperwork relating to RTW process and support on how to perform tasks on RTW plan.	Not seen as important, but when provided is seen as caring.
Instrumental	Demonstrated through actions such as: <ul style="list-style-type: none"> • Arranging ergonomic assessments • Ensuring required aids or equipment are available • Modifying workload to suit capacity of injured worker • Allowing autonomy in managing workload and breaks. 	Demonstrated through actions such as providing assistance with sharing workload.
Appraisal	Often not demonstrated as supervisors perceive ‘political pressure’ not to give negative feedback. When given, needs to be equal for non-injured workers.	Not seen as important.

Supervisors may see a “conflict between meeting their core business functions and offering suitable duties to those returning to work,” and their preparedness to engage in RTW activities is influenced by several factors, including their position in management, budget responsibilities, organisational communication and the availability of others to assist (Comcare, 2016, p.8).

Co-workers are often reported as hostile to an injured worker on a RTW plan, seeing the injured worker as receiving special attention while the uninjured carry extra work. However, co-workers play a key RTW role that is often not addressed in organisational policies and procedures; rather, their support is ‘behind the scenes’ and not always noticed (Dunstan, Mortelmans, Tjulin & MacEachen, 2015). Dunstan et al. (2015) review a 2009 study by Tjulin, MacEachen and Ekberg, which identified three types of co-worker support during different stages of the RTW process:

- *Brotherly* when the injured worker is off work
- *Helping hand* during the injured worker’s transition to work
- *Goodwill* during the injured worker’s return to full duties.

Key requirements for effective co-worker support are that:

- Co-workers understand the returning worker's condition
- The returning worker has sufficient capacity to perform the work described in the RTW plan
- The situation is considered 'fair' for all parties
- Pre-existing interpersonal relationships are favourable
- Consultation and communication occurs (Dunstan et al., 2015).

The overarching 'enabling' theme arising from research on the social support within the workplace for RTW is trust between the injured worker and the supervisor, and between the injured worker and co-workers. Potential barriers to providing effective social support include:

- Poor communication, which is often justified under confidentiality and privacy provisions; suggested ways to overcome such a barrier include encouraging the returning worker to disclose their condition (Dunstan et al., 2015) or have a trusted colleague provide the information on their behalf (MacEachen et al., 2007)
- Differing perceptions of an action or item of information due to personal perspectives; for example, a form letter about salary sent while the injured worker is on leave may be perceived as an administrative matter by a supervisor whereas the injured worker, possibly suffering financial stress, may perceive it quite differently (MacEachen et al., 2007)
- Supervisors with a negative approach to RTW or without the required knowledge and skills to provide effective RTW support (Lysaght & Larmour-Trode, 2008); a useful supervisor RTW competency model that addresses enabling/personal behaviours, knowledge of RTW processes and developing RTW plans is provided by Johnston et al. (2015).

Role of the generalist OHS professional

The OHS professional should be able to advise employers of the legal obligations of providing reasonable RTW and to espouse the health benefits of an individual being at work.

Provision of advice and support to managers and supervisors on the design of 'good work', development of a positive workplace culture, and consultation and engagement with workers are core functions of the OHS professional. Promotion of a positive workplace culture provides the supportive context within which the injured worker is more likely to return to work.

6 Professional roles

A collaborative, multidisciplinary approach to RTW – involving the injured worker, health professionals and the employer – appears to be most effective in achieving good health and RTW outcomes (McAnaney & Wynne, 2016; Foreman et al., 2006; Hoefsmit et al., 2012).

Professionals from various health disciplines make important contributions to management of injury and RTW. The services of such professionals may be delivered through workplace rehabilitation providers or as independent advisors. While the mitigation of health impacts of workplace injury or illness is broader than the processes commonly defined as workplace rehabilitation, this section reviews the legislated role of RTW Coordinators then considers the roles of workplace rehabilitation providers and other relevant professionals.

6.1 RTW coordinators

Some Australian jurisdictions require companies of a certain size to employ/nominate a person within the organisation as the RTW coordinator to manage the return to work of injured workers.¹⁰ While the responsibilities for this legislated role vary across jurisdictions, the coordinator is generally required to:

- Assist the injured worker to remain at or return to work while they recover from a work-related injury
- Plan the injured worker's return to work if they require time away from work to recover and make decisions to progress their return, including identifying and offering suitable duties and assisting to prepare and implement a RTW plan
- Consult with the injured worker, their treating practitioner, occupational rehabilitation provider, insurance or worker representative if they have one
- Monitor the progress of an injured worker's recovery
- Take steps to prevent a recurrence or aggravation of the injury
- Help resolve any issues or disputes related to RTW (RTWSA, 2017a; WorkSafe Victoria, n.d.).

Research indicates that functional activities by the RTW coordinator in preparing and implementing a RTW plan have the most impact on RTW outcomes in the short term, while their communication and psychological support (rather than functional support) is most beneficial in achieving RTW after a longer absence (Lane et al., 2017).

Some jurisdictions mandate RTW coordinator selection criteria such as location within the jurisdiction (South Australia, Queensland) and, in the case of Victoria, being of “sufficient

¹⁰ See SWA (2017) for requirements under each jurisdiction.

seniority and competent to perform the role” (SWA, 2017, p. 147); however, there is little guidance on the knowledge and attributes required for effective performance of the role. As a result, coordinators may have no background or formal training in health.

Analysis of the RTW coordinator role indicates that it requires good communication skills; personal characteristics of empathy, compassion, patience, assertiveness and adaptability; capacity for effective management of the RTW process; and knowledge of medical terminology and a general understanding of relevant medical conditions (Bohatko-Naismith, James, Guest & Rivett, 2015). Currently, training for RTW coordinators tends to focus on legislative requirements without addressing more practical skills (Lane et al., 2017).

Role of the generalist OHS professional

In some (smaller) organisations, the OHS professional may also carry the legislated role of RTW (or in some jurisdictions Rehabilitation) coordinator. In such situations, the OHS professional should fully understand the breadth of the role and not only carry out the legislated and functional responsibilities, but also the psychosocial supportive component.

Where a RTW coordinator is appointed in addition to the OHS professional, the OHS professional will likely work with the coordinator in identifying suitable duties, undertaking or arranging ergonomic assessments, and in ensuring a safe return to work for the injured worker. Where the appointed RTW coordinator does not have a health background or is new to the position, the OHS professional may have a mentoring role.

6.2 Workplace rehabilitation providers

Workplace rehabilitation is defined as:

...a managed process involving timely intervention with appropriate and adequate services based on assessed need, and which is aimed at maintaining injured or ill employees in, or returning them to, suitable employment (HWCA, 2015, p.4).

In addition to workplace-based resources, rehabilitation may be supported by workplace rehabilitation providers, which are organisations that have been “approved by a workers’ compensation authority to provide workplace rehabilitation services to assist workers to recover at, or return to work following a workplace injury” (HWCA, 2015, p.37).

These organisations provide specialist expertise to the workplace by:

- facilitating the worker’s timely recovery at, or return to work
- identifying and designing duties for the worker to assist employers to meet their obligations in providing their workers with suitable employment
- identifying and coordinating rehabilitation strategies that ensure workers are able to safely perform their duties
- forging the link between the insurer, employer and treatment providers to ensure a focus on work

- arranging appropriate retraining and placement in alternative employment when the worker is unable to return to pre-injury employment (HWCA, 2015, p.4).

Workplace rehabilitation consultants working within approved workplace rehabilitation providers are required to have a qualification recognised, accredited or registered by one of the Australian Health Practitioner Regulation Agency (AHPRA) registration boards¹¹ and/or those listed below.

- Rehabilitation counsellor:
 - Australian Society of Rehabilitation Counsellors (recognised), or
 - Rehabilitation Counselling Association of Australasia (recognised)
- Occupational therapist (registered)
- Physiotherapist (registered)
- Exercise physiologist:
 - Exercise and Sports Science Australia (accredited as an Exercise physiologist)
- Psychologist (registered)
- Speech pathologist:
 - Speech Pathology Australia (recognised)
- Social worker:
 - Australian Association of Social Workers (recognised)
- Medical practitioner (registered)
- Nurse (registered) (HWCA, 2015, p. 10).

Workplace rehabilitation consultants with less than 12 months' experience delivering workplace rehabilitation services are required to complete a comprehensive induction program with 12 months of supervised professional practice (HWCA, 2015).

While the involvement of a workplace rehabilitation provider will contribute to the overall cost of a claim for compensation, their use is particularly recommended when:

- The organisation does not have in-house expertise in rehabilitation and RTW
- The workload does not allow the in-house professionals to provide the required level of attention to individual cases
- There are complex cases including psychological or mental health issues.

Role of the generalist OHS professional

Where there is no in-house health professional, an OHS professional may be required to work with the RTW Coordinator to select workplace rehabilitation providers. Selection will be made from the list of approved or accredited providers as determined by the relevant state workers' compensation body. Selection of a provider may be informed by reviewing their specialist expertise and by seeking the advice of others such as the insurer. Many organisations nominate up to three providers, allowing the injured worker choice in selecting a preferred provider.

The OHS professional may have a role in establishing systems to ensure involvement of the workplace rehabilitation provider early in the management of the injury or illness to ensure an optimum outcome. Ongoing engagement and liaison with a workplace rehabilitation

¹¹ See AHPRA website: <https://www.ahpra.gov.au>

provider is important; this may take the form of regular meetings to review progress and identify any barriers to effective return to pre-injury work.

6.3 Health professionals

6.3.1 General Medical Practitioner

General Practitioners (GPs) are seen as gatekeepers for the management of work-related injury and ill health (Mazza et al., 2015). GPs are responsible for overall management and coordination of care of the patient, including primary care, timely referrals, monitoring progress and outcomes, assessing capacity, and appropriately certifying and facilitating RTW (including communication with the employer and other parties). In Australia, an injured worker has the right to select their doctor so the treating GP may be the worker's own doctor or one nominated by the workplace.

As an authorised person for completion of fitness-for-work certificates (certificates of capacity), the GP effectively determines the period of absence from work due to injury and the scope of duties the injured worker may undertake during their staged return to full duties. While GPs recognise the importance of early RTW, they have reported significant barriers in carrying out this role, including:

- Reliance only on injured [and ill] workers' feedback on capacity to work
- Poor communication between GPs and employers and compensation agents
- Lack of availability of alternative/modified duties
- High administrative burden for low remuneration
- Conflicting medical opinions (Mazza et al., 2015).

6.3.2 Occupational and Environmental Physician

Occupational and environmental health physicians (OEPs)¹² are medical practitioners who complete specialised training through the Australasian Faculty of Occupational and Environmental Medicine (AFOEM). AFOEM training focuses on

...the ability to assess a person's fitness for work, facilitate return to work of a person after injury or illness, and identify ways in which work or environment harms health so as to negotiate effective prevention and to respond to the needs of courts and tribunals (Department of Health, 2010).

OEPs are the medical specialists in the interplay between work and health and health and work.

¹² In the workplace may be more often referred to as occupational health physician.

AFOEM describes the occupational physicians' role as follows:

OEPs are skilled in the investigation and diagnosis of work-related and environment-related conditions. They provide a multidimensional approach to the management and prevention of illness, injury and disease for individuals and the workforce. Referrals to OEPs can be made by GPs, medical specialists, allied health staff, employers, insurers, solicitors, unions, and statutory bodies. Referral may be for assessment and/or expert management advice and can include:

- Work-site and work-practice assessments and their effects.
- Multidimensional diagnoses, incorporating the scientific evidence relevant to the health impacts of the worker's employment and their work environment.
- Best practice management strategies for the injured worker.
- Specialist management of work-associated disability.
- [C]ase management for people with an injury, illness or disability and their health, work and social environments.
- Specialised skills in clinical decision-making and cost effective management of injured workers and sickness absence.

OEPs can focus on sub-specialties including: corporate health, health risk management, research, toxicology and military, musculo-skeletal, aviation, transport, underwater or medico-legal medicine. (AFOEM, 2014)

Role of the generalist OHS professional

The generalist OHS professional has a facilitator role in ensuring appropriate communication with a GP or occupational physician. This should include information on the nature of the organisation, the business and the work overall, as well as work specific to the injured worker, alternative duties and other support arrangements or limitations. Depending on the size and nature of the organisation, this facilitation may be directly with the doctor or through other professionals such as an occupational health nurse, RTW coordinator or rehabilitation provider.

6.3.3 Occupational Health Nurse

Occupational health nurses (OHNs) are registered nurses, often with postgraduate OHS qualifications and/or other relevant workplace qualifications, including rehabilitation, RTW and occupational hygiene. In their traditional role, they work closely with medical practitioners, including GPs and specialists, and support the position of the occupational physician. They contribute to the development of work-health-related policy and procedures and may manage a health or medical clinic. They often deliver workplace first aid or treatment for work-related illness or injuries, and provide rehabilitation and RTW programs. Other work-health-related activities undertaken by the OHN may include:

- Occupational immunisation
- Drug and alcohol screening
- Health assessments, including hearing and breathing tests
- Assessment of manual handling, chemical and biological hazards
- Psychological risk assessment
- Injury management

- Health promotion
- Workers compensation management, rehabilitation and return to work.

Role of the generalist OHS professional

The OHS focus of Occupational Health Nurses is usually on individuals while the OHS professional is primarily concerned with systems and management processes. Despite this difference in focus, the OHN and the OHS professional work to common goals and so should engage and collaborate to ensure they:

- Are aware of the objectives, strategies and activities of each other's roles
- Jointly identify opportunities for interaction and support to optimise outcomes
- Keep each other appraised of current developments, issues, barriers and how they may work together to achieve their separate and common goals.

6.4 Allied health professionals

There are overlaps in the roles of allied health professionals related to RTW. The contribution of the various roles is outlined below.

6.4.1 Physiotherapist

Physiotherapists aim to improve overall patient functioning through the restoration and enhancement of mobility, strength, resilience, endurance, physical capacity and neurological skills that have been lost or altered due to injury or illness. They do this through a variety of manual, exercise-based and education-based techniques. While physiotherapists take a holistic approach, they may focus on specific body systems such as cardiorespiratory, musculoskeletal, neurological and orthopaedic.

A physiotherapist may engage in the continuum of worker care in a range of roles, including as a:

- Nominated treating health professional
- On-site employer-funded treater
- Occupational rehabilitation provider
- Injury management advisor or RTW specialist in an insurance setting
- Independent injury management / RTW consultant
- Therapist in a work conditioning or pain-management program.

A physiotherapist will often be incorporated as part of a multidisciplinary team treating an individual patient. Physiotherapists will gather and refine information from other health practitioners (GPs, surgeons, medical specialists, exercise physiologists, occupational therapists and psychologists) to ensure treatment is correctly focused in relation to the care of the patient.

A physiotherapist may contribute to the mitigation of health impacts of workplace injury and ill health by:

- Working with the worker to improve their functional capacity to complete modified/suitable or pre-injury duties
- Assessing work tasks and providing advice on modifications to address reduced physical functional capacity or biomechanical issues and, where appropriate, to enable RTW
- Liaising and negotiating with the employer regarding identification of suitable duties and ensuring the needs of both client and employer are met
- Identifying barriers to RTW (medical, workplace and worker barriers) and assisting in identifying strategies to address these
- Working in partnership with the injured worker, employer and treatment team members to develop a RTW plan that includes, where appropriate, modified work duties and a graded approach in hours and duties to build endurance
- Monitoring the injured worker's progress and – in consultation with the injured worker, treatment team and employer – planning for ongoing suitable duties to support a sustainable RTW.

As part of this role, physiotherapists often undertake specific assessments such as:

- Physical capacity functional assessments
- Fitness for duties assessments
- Pre-employment functional assessments
- Physical task analysis
- Worksite ergonomic, risk and safety assessments.

6.4.2 Chiropractor

Chiropractors provide non-pharmacological management of musculoskeletal conditions as a first-line management approach to musculoskeletal injuries. They are regulated by the Australian Health Practitioner Regulation Agency (AHPRA), with registration requiring a five-year university qualification.

Chiropractic interventions may include spinal manipulative therapy (SMT), soft tissue procedures, mobilisation, electrotherapy, dry needling and other manual techniques. These treatments are delivered in conjunction with self-management strategies, including exercise-based rehabilitation and cognitive behavioural strategies, to assist injured workers in improving their level of function and returning to work.

Chiropractors can be an integral part of the management of musculoskeletal workplace injuries, often as part of a multimodal approach with other healthcare providers. As primary contact providers, chiropractors are able to:

- Assist in setting expectations regarding recovery at/return to work and the need for active participation in recovery, planning and treatment
- Conduct a detailed worker assessment and (where applicable) provide information to inform and/or confirm diagnosis and treatment strategies. Where a diagnosis is not clear, provide a provisional diagnosis and explain the reason(s)
- Liaise with stakeholders such as employers, rehabilitation providers and authorised insurance agents to assist with goal setting, tailoring of treatment interventions and RTW of injured worker
- Provide education on the health benefits of good work
- Support improvement in injured worker's independence and, if recovery at work is not possible, their participation in home and community activities.

Chiropractors with a special interest in OHS may provide ergonomic and worksite assessments, identify non-physical barriers to RTW and use their understanding of biopsychosocial issues to facilitate optimal outcomes.

6.4.3 Osteopath

Osteopaths are regulated health practitioners under the Australian Health Practitioner Regulation Agency (AHPRA). Many of the clinical functions and competencies of Osteopaths overlap with practitioners of other neuromusculoskeletal and rehabilitative professions such as physiotherapists and chiropractors. Osteopath key competencies include pathology, diagnostics, functional anatomy, physiology and biomechanics.

While osteopaths often work within primary practice, they may consult and liaise with workers' compensation scheme agents, insurers, employers and other health practitioners as part of an interconnected network. Osteopaths are approved providers of worker's compensation injury management services in all states and territories.

Services provided to injured workers include:

- Assessment of circumstances that led to injury, including factors that may have predisposed the worker to injury
- Assessment of rate of neuromusculoskeletal injury recovery and factors impacting recovery
- Assessment of impact of injury on physical capabilities for work tasks
- Development of treatment programs to improve functional limitations identified in the assessment; programs may include hands-on manual therapy, prescription of

aids, modifications or adjustments to the workplace, exercise prescription, lifestyle advice and/or education on appropriate movement and coordination

- Development of RTW plans based on applicable neural or musculoskeletal recovery timeframes and repeat injury risk.

Some osteopaths have further education, training and experience in areas beyond direct workplace-injury management. They may work across corporations and in consultancy roles to develop site-specific injury-management protocols, or deliver education on appropriate movement in specific work environments and for particular tasks.

6.4.4 Occupational Therapist

Occupational therapists (OTs) are client-centred health professionals who are

...concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to do, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement. (World Federation of Occupational Therapists as cited in OTA, 2018)

OTs have the knowledge and skill to understand a medical condition and the implications for functional restrictions and recovery rates.

An OT may provide direct support to an injured worker or act as a case manager overseeing the injury management and RTW process. The nature of the role will depend on whether the OT is employed:

- Within the employer's business
- As an occupational rehabilitation or vocational provider
- As an injury management advisor or RTW specialist in an insurance setting
- As an independent injury-management/RTW consultant
- As a therapist in a work-conditioning or pain-management program.

An OT evaluation of an injured worker's current capabilities will include exploring:

- Their capacity and challenges in the work and home environment
- Social and community access capacities
- Physical and cognitive function.

Specific assessments commonly undertaken by an OT include:

- Task analysis

- Worksite assessment
- Ergonomic/workstation/workplace assessments
- Physical and functional capacity assessments.

Assessments will be conducted in association with other practitioners or informed by comprehensive assessments conducted by specialists (e.g. occupational physicians, neurosurgeons, orthopaedic surgeons and psychologists). Information gathered collectively informs the OT of the injured worker's capacities, supports that may be needed to promote recovery, and strategies that may be helpful in achieving an efficient and sustainable RTW.

An OT may contribute to mitigating the health impacts of workplace injury or ill health by:

- Undertaking additional assessments (i.e. functional capacity evaluations) to clarify functional strengths and limitations to inform RTW planning
- Assessing work duties, and the physical and cognitive demands of work tasks, to identify duties that are within an injured worker's capacity and those that may require modification
- Identifying barriers to RTW (medical, workplace and worker barriers) and assisting in identifying strategies to address these
- Liaising with the medical/health treatment team regarding the medical condition, treatment needs and prognosis, and ensuring that treatment team members are aware of job demands and requirements for a sustainable RTW
- Determining any practical modifications to pre-injury work to enable RTW
- Liaising and negotiating with the employer regarding identification of suitable duties and ensuring the needs of both client and employer are met
- Working in partnership with the injured worker, employer and treatment team to develop a RTW plan that includes, where appropriate, modified work duties and a graded approach in hours and duties to build endurance
- Monitoring the injured worker's progress and – in consultation with the injured worker, treatment team and employer – planning for ongoing suitable duties to support a sustainable RTW.

OTs whose focus is on the workplace and injured workers will often undertake further qualifications in areas such as:

- Occupational health and safety
- Workplace ergonomics
- Functional capacity evaluations
- Mediation and conflict management.

6.4.5 Exercise Physiologist

Exercise physiologists accredited with Exercise and Sports Science Australia are approved as workplace rehabilitation consultants (HWCA, 2015). Exercise Physiologists contribute to RTW of an injured worker by assessing and prescribing functional exercise related to their injury, work tasks and work demands. Such exercise programs should provide the worker with supervision and education to undertake home-based exercise programs to develop work capacity and facilitate RTW (RTWSA, 2017b).

6.4.6 Psychologist

While psychologists traditionally work at the tertiary end of the workplace health and safety spectrum, they are increasingly involved in primary¹³ and secondary interventions in the workplace.

In terms of secondary or early intervention, it is important that workers who experience mental health difficulties are supported. Companies usually provide such support through employee assistance programs (EAPs), which offer short-term employer-sponsored counselling services that are predominantly provided by contract psychological services (see section 7.6). The principle of workplace support for those with mental health issues has gained a profile through the Mentally Healthy Workplace Alliance, which is a national approach by business, community and government (National Mental Health Commission, 2014). A range of tools has been developed by *beyondblue*, and the focus on mental health has led to increasing involvement of clinical and organisational psychologists in advising workplaces on the creation of a supportive and psychologically healthy environment.

Psychologists also provide treatment services for workers with compensable psychological injuries. The 2006 introduction of the Medicare rebate for psychology services has led to many GP clinics having access to a psychologist for referral of mild-to-moderate mental health issues under a Medicare Mental Health Care Plan. GPs may also refer compensable cases to an in-house psychologist.¹⁴

In addition to mental health issues, clinical psychologists and health psychologists are increasingly employed in pain-management programs, providing training for persistent pain sufferers in psychological pain-management techniques such as mindfulness, pacing and other cognitive-behavioural-based interventions.

¹³ A future *OHS BoK* chapter will address the primary aspects of designing work for psychological health.

¹⁴ As noted in section 1, the management of psychological and mental health issues in the workplace is a complex topic beyond the scope of this chapter.

Role of the generalist OHS professional

Effective RTW requires liaison between the workplace and the treating allied health professionals. This will be through the workplace rehabilitation consultant where they are involved or the in-house health professional or RTW coordinator. Alternatively, it will be the role of the OHS professional to maintain contact with the allied health professionals.

The OHS professional should ensure that treating allied health professionals are aware of the nature of the pre-injury work and the availability of alternative duties. The OHS professional may liaise with treating allied health professionals to identify the timeline for RTW and any barriers inhibiting effective RTW.

7 Strategies

Key concepts of early intervention, RTW and social support underpin a range of strategies available to the employer to mitigate the health impact of work-related injury and illness. This section briefly examines these strategies and the potential role of the OHS professional in their implementation.

Pre-event

1. Health risk assessment
2. Exposure and health monitoring
3. Early notification of 'near misses,' injury or disease

Intervention

4. Early provision of skilled first aid
5. Early provision of medical care
6. Employee assistance programs
7. Implementing SAW/RTW
8. Managing a critical incident
9. Response to a workplace fatality.

While not strictly sequential, it is useful to consider these strategies in terms of a timeline (Figure 3) that builds on Viner's (2015) Generalised Time Sequence Model.¹⁵

Implementation of these strategies should be considered in the context of the work environment and the elements of the environment that may support or detract from effective injury management and RTW. Such contextual factors may include the workplace culture, workforce demographics, and organisation of work such as length of shift and fly-in-fly-out arrangements.

¹⁵ See also Figure 1 which introduced mitigation in terms of time sequence.

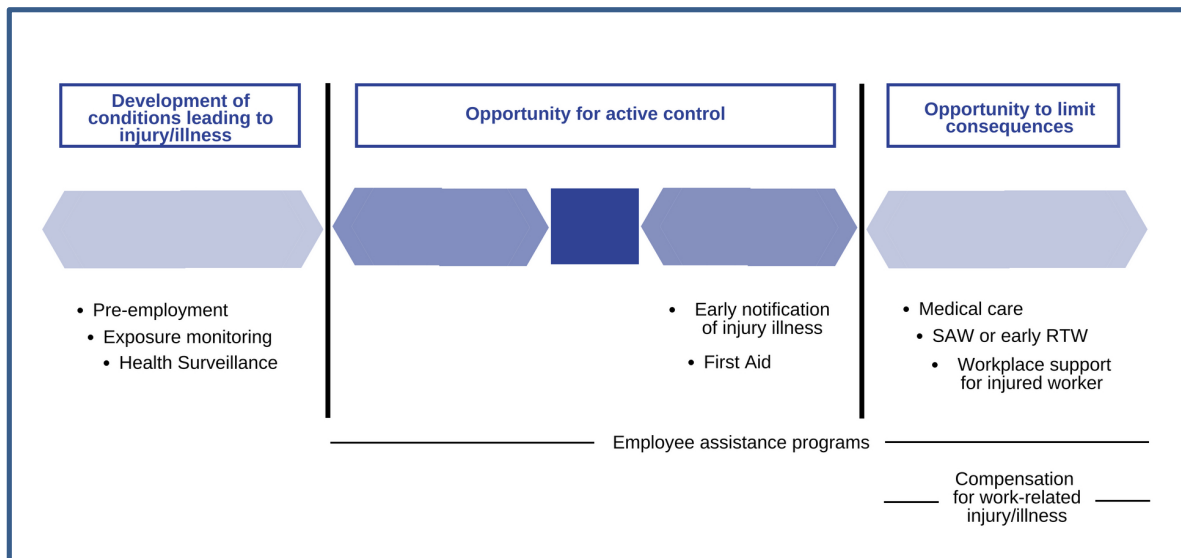


Figure 3: Strategies for mitigation of health impacts

7.1 Pre-placement health assessments

Previously termed ‘pre-employment assessments,’ pre-placement health assessments may be carried out before employment, before placement in a new job or work environment, or following a period of absence (AFOM, 1998). Historically, these assessments were based on a standard questionnaire and health checks, and were often used as a basis for exclusion from employment. As such, their value as a health and safety management tool has been questioned. Offering a more positive view, in 1998 the Australasian Faculty of Occupational Medicine listed three objectives of pre-placement health assessments:

1. To determine appropriately the capability to work safely in the internal and external environment of the workplace.
2. To assess the physical and mental capability for a particular job or work tasks, including development and advancement in that job.
3. To provide a baseline for health so those subsequent assessments can be compared and interpreted. (AFOM, 1998, p. 3)

From an equal opportunity and anti-discrimination perspective, the health assessment is about the person’s ability to do the work considering the safety of the worker and others. To achieve these objectives, the assessment should take account of the nature and risk of the particular job for the individual worker. This can only occur if the health professional is appropriately informed about the nature and demands of the job and the work environment (AFOM, 1998).

Ideally, the assessing health professional will have visited the workplace and have some familiarity with the work, however information relative to specific jobs should still be provided. Such information may include:

- General position description
- Task analysis for the jobs undertaken, addressing physical and cognitive demands
- Hazards to which the worker may be exposed
- Safety critical factors with implications for the worker and/or others.

Where an employee is assessed as having an impairment or disability, the employer should be prepared to discuss accommodations or adjustments to the workplace with the assessing health professional.

Information collected by the health professional in pre-placement assessments is covered by the usual confidentiality and privacy conditions attached to all medical records. Only results relevant to the performance of the job are communicated to the employer (AFOM, 1998).

Some industries where sudden incapacity presents a considerable risk to workers or the public (e.g. rail, aviation and maritime) have legislated requirements for health assessments as part of an integrated health risk assessment system (NTC, 2017). These highly developed health risk assessment processes provide useful examples for other industries and workplaces. Figure 4 summarises the steps in a risk assessment process, the key elements of which should inform all health assessments.

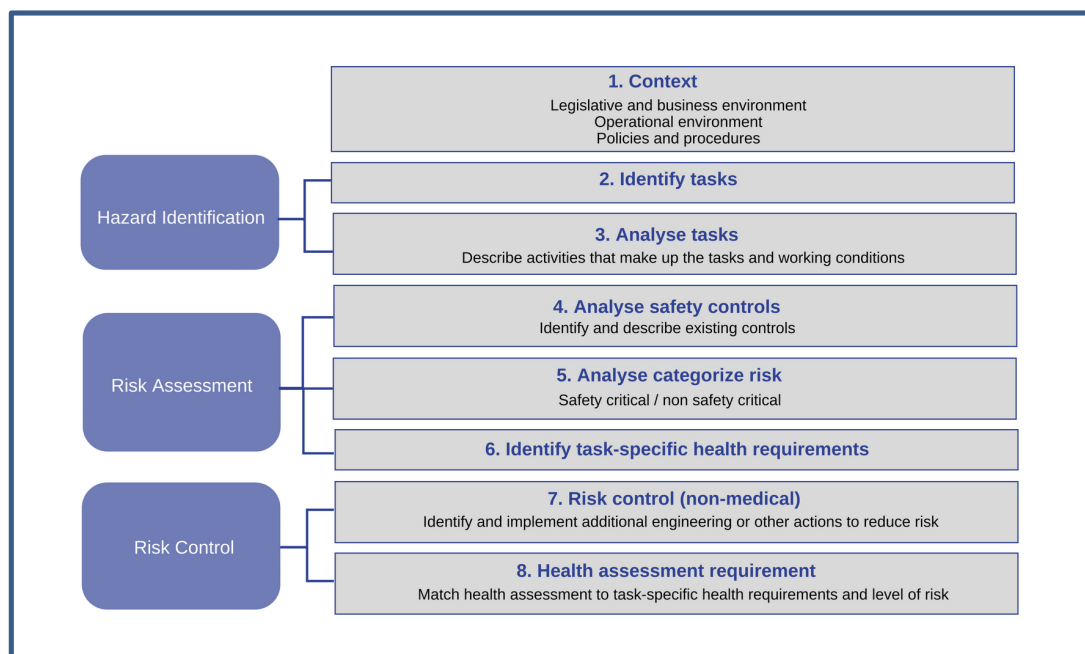


Figure 4: Health risk assessment process (modified from NTC, 2017, p.40)

Role of the generalist OHS professional

The OHS professional has a vital role in ensuring that:

- Appropriate task analysis and risk assessments are undertaken so that information is available to inform pre-placement health assessments
- The information is communicated to the assessing health professional.

The OHS professional should ensure that any limitations or conditions imposed as an outcome of the assessment are addressed in the workplace.

7.2 Monitoring as part of mitigating health impacts

Information is a key requirement for identifying hazards and their impact on workers, and for monitoring the effect of controls. Two key sources of information to assist in identifying the potential and actual health impacts of hazards are exposure monitoring and health monitoring.

7.2.1 Exposure monitoring

Safety systems exist to protect workers from hazards, which by definition are situations or things that may cause harm if there is exposure to them (SWA, 2011).¹⁶ Exposure is essential for harm to occur; this may be an acute exposure or more long-term exposure. Exposure monitoring is often considered in the traditional ‘occupational hygiene’ context such as in a chemical or radiation leak, explosion, or prolonged or repeated exposures to hazardous substances. There are many examples of such incidences in the history of occupational medicine such as exposure to heavy metals (lead, cadmium and mercury); to chemicals such as trichloroethylene, vinyl chloride monomer and aromatic solvents; and to noise, dusts and asbestos. However, exposure monitoring should be considered in the broadest context and include physical and psychosocial hazards.

Role of the generalist OHS professional

Although exposure monitoring of hazardous agents is usually conducted by occupational hygienists, the OHS professional has a key role in ensuring such monitoring is carried out when required and that the information is shared with occupational and environmental physicians and treating doctors as appropriate. Also, the OHS professional has a key role in instigating and managing exposure-monitoring activities in the broader context, which may include workplace inspections, surveys and audits, and hazard and incident reporting.

¹⁶ See also *OHS BoK Hazard as a Concept*.

7.2.2 Health monitoring

One way of assessing whether a safety system is working to prevent a workplace exposure is to undertake workforce health monitoring.

The *Model Work Health and Safety Regulations* (SWA, 2016) define health monitoring¹⁷ as “monitoring the person to identify changes in the person's health status because of exposure to certain substances” (*WHSR* s 1.1). The regulations specify that when there is exposure to certain chemicals, health monitoring must be carried out by registered medical practitioners with relevant competencies. While not an alternative to reliable control measures, health monitoring provides information on the efficacy of controls and may indicate the need to review control measures. Health monitoring is common in the mining industry where workers exposed to various dusts are regularly screened by structured questionnaires, lung-function testing and chest x-rays for early signs of lung disease. The regulations mandate health monitoring for a range of chemicals considered high risk (*WHSR* Schedule 14).

Biological monitoring is also a useful tool employed to measure the exposure of individuals to certain workplace hazardous substances. As defined by Safe Work Australia (2016), biological monitoring is “the measurement and evaluation of hazardous substances or their metabolites in the body tissues, fluids or exhaled air of an exposed person” (*WHSR* s 1.1). Biological monitoring is conducted as part of health monitoring programs. While biological monitoring is mandated for people working with lead, it may also be used to confirm immunity or presence of diseases such as hepatitis.

On a wider scale, governments and industry sectors record the incidence of occupational disease to monitor compliance with safety regulations (and systems). While arguably outside the parameters of the legislated definition, the most common example of health monitoring in industry today is the regular performance of audiometry screening in a noise-exposed workforce to check for early signs of noise-induced hearing loss. If the tested workforce demonstrates hearing loss consistent with noise exposure, a failure of the hazard control system is exposed, enabling rectification.

Role of the generalist OHS professional

Health monitoring can only be carried out by registered medical practitioners. The generalist OHS professional should be aware of the substances being used in the workplace and whether any of them have mandated requirements for health monitoring. Where a health monitoring program is required or in place, the OHS professional may have a role in coordination, maintenance of records and communication of information. In such a coordination role, the OHS professional must ensure that records are managed according to legislated requirements and provided to appropriate personnel and authorities as legislated (section 7.5.4). The OHS professional may engage an occupational physician and ensure that

¹⁷ Referred to as ‘health surveillance’ in earlier legislation.

they are provided with the required information. The OHS professional should have an understanding sufficient to interpret the results and, together with the occupational physician, be able to explain the significance of the collated results.

7.3 Early notification of injury, ill health and ‘near misses’

Workplace injury, ill health and near misses can be viewed as failures of the safety system. A robust reporting system that emphasises early reporting is essential to, firstly, activate a review of the system as it relates to the failure and correct it and, secondly, facilitate early detection, diagnosis and treatment of any injury or ill health and so support a faster recovery and better outcome.

Reporting processes are of two types:

- Reporting to external bodies as part of regulatory requirements (e.g. reporting as part of a claims process, reporting of serious injury or fatality)
- Internal reporting processes to support early intervention, to initiate investigation for the purposes of future prevention and for trend analysis.

Only the latter reporting type is addressed here.

Internal reporting arrangements will be part of the safety management system.¹⁸ Reporting arrangements must be easily accessible to all who may observe a system failure, easily completed, and overseen by personnel who have the power and authority to investigate, correct the failure and communicate to all within the safety system. Sanctions for violations of the system must be clearly thought through otherwise reporting will be discouraged.

Industry/sector-specific reporting systems provide further information to enable early response to prevent or mitigate injury or ill health. The importance of such systems in early detection of emerging health issues was highlighted in investigations into the re-emergence of coal workers’ pneumoconiosis (Monash University, 2016).

Role of the generalist OHS professional

The design, implementation, use and monitoring of an effective near-miss, incident and injury reporting system is a core function of the OHS professional. It is also the role of the OHS professional to interrogate the reporting system to identify trends and the need for hazard alerts, and to respond to individual reports. The OHS professional should be aware of industry-specific systems of hazard and health assessment and reporting, and have current knowledge of the outputs of such systems.

¹⁸ A future chapter of *OHS BoK* will address OHS management systems.

7.4 Early provision of first aid

At least since the time of the Roman Legions, the concept of battlefield ‘medics’ has been recognised and utilised by armies. Although their medical treatment was primitive by modern standards, the Romans recognised that early provision of first aid for the injured improved survival of battlefield casualties (Efsthatis, 1999). In the civilian world, it was not until the 1870s in England that first aid classes were made available for the public, with workplace first aid initially established in the coal mining and railway industries (Efsthatis, 1999).

Today in Australia, workplace first aid is governed by codes of practice or guidance notes under the relevant state, territory and Commonwealth OHS laws. For example, the *Model Work Health and Safety Regulations* (SWA, 2016) stipulate that:

- conducting a business or undertaking at a workplace must ensure:
 - (a) the provision of first aid equipment for the workplace; and
 - (b) that each worker at the workplace has access to the equipment; and
 - (c) access to facilities for the administration of first aid. ...
- (2) A person conducting a business or undertaking at a workplace must ensure that:
 - (a) an adequate number of workers are trained to administer first aid at the workplace; or
 - (b) workers have access to an adequate number of other persons who have been trained to administer first aid. (*WHSR* s 42)

The determination of adequacy of first aid training and facilities should be risk-based taking account of the hazard and risk profile of the workplace, the characteristics of the workforce and proximity to primary medical care.

In some circumstances, well-trained and well-equipped first aiders in a workplace can make the difference between life and death. Also, well-trained first aiders will be able to identify whether they can effectively treat an injury or whether the injured worker requires more advanced care and should be transported to a clinic or hospital.

Role of the generalist OHS professional

The OHS professional should undertake a first aid needs assessment taking account of the risk profile, the workforce and availability of medical support. The OHS professional should seek specialist input to the assessment as appropriate.

The OHS professional may also be required to coordinate first aid training, including identifying and contracting a provider, and ensuring availability of appropriate equipment and personnel across shifts.

7.5 Early provision of care

For serious injuries, medical care by a nurse or doctor may be required. Caring for a workplace injury requires a degree of understanding of the dynamics of workplace injury as well as the appropriate medical expertise. As in other spheres of medicine, timeliness of diagnosis and treatment is paramount. At the heart of medical care of workplace injury or disease are the prime principles of early diagnosis and formulation of the best (evidence-based) treatment plan and early resumption of suitable work. The initial treating doctor plays an important role in planning for an injured worker's early RTW.

7.5.1 Diagnosis and treatment

Initial medical treatment may occur at an on-site medical facility or, as is more common in Australia, at a local medical clinic or hospital. The advantage of the on-site clinic is the speed with which an injury can be treated by nursing or medical staff who are familiar with the workplace. If referral is required, treatment can be expedited with a phone call to ensure timely assessment at the local clinic or hospital. However, only a small proportion of Australian workplaces have on-site medical facilities; more commonly, an injured worker attends their GP, if they have one, or the casualty department of the local hospital. As with first aid, the decision regarding any on-site medical facility should be informed by a risk assessment taking account of the hazard and risk profile of the workplace, the characteristics of the workforce, and proximity to primary and specialist medical care.

In the absence of an on-site medical facility, the best arrangement for treatment of an injured worker is for an organisation to have a relationship with an interested local GP who knows the workplace and its personnel, or with a dedicated off-site occupational health clinic. Such arrangements facilitate timely access to medical care and ensure that the impacts of the work on the illness or injury are considered in both the diagnosis and the treatment. It is generally considered appropriate for a first aider or line supervisor to accompany an injured worker to a medical centre and, where hospital care is required, the injured worker may be accompanied by a member of management staff. However, this would depend on the wishes of the injured worker.

The role of the treating doctor is pivotal in this process and early RTW may depend on the treating doctor being committed to it, and engaging with the employer and worker in a three-way communication about RTW.

As outlined in section 6, allied health professionals have an important role in the treatment of work-related injuries and ill health. This may be through referral by the treating doctor or by direct arrangement with the workplace. For example, larger companies are increasingly contracting on-site physiotherapy services and may have similar arrangements with other allied health services such as psychologists.

7.5.2 Protocols and appropriate practice in liaison with health and allied health professionals

Sections 5 and 6 emphasised the importance of three-way communication between the worker, treating health professionals and the workplace. In a 2015 webinar, presented by the Queensland Workers' Compensation Regulator, Dr Matt Brand provided the following tips:

- [Prepare an] Injured worker pack for worker and treating health practitioner:
 - Employer contact details
 - List of modified/suitable duties and task demands
 - Authority to release and obtain information signed by the injured worker
 - Company policy of commitment to provide suitable duties to injured worker
 - Information on the workers' compensation process including workers' rights and employer's rights and responsibilities
- Establish contact with the TMP [treating medical practitioner] as early as possible
- Don't wait for the TMP to call you!
- Face-to-face would be the preferred mode of contact with the TMP ...
- Offer to attend appointment with worker to advise TMP of accommodations and duties available to support return to work ...
- Potential barriers [to communication] and solutions...
 - Geographical factors – consider alternative modes of communication e.g. telemedicine, videoconferencing, skype
 - 'Gatekeeper' (clinic reception staff) – [build relationships; make an appointment to] speak to the doctor; [advise] that TMP can charge for any phone calls (item number) for the time spent on the phone discussing the injured worker's return to work (Brand, 2015).

In such communications there are protocols that must be followed relating to confidentiality, permission from the injured worker and scope of discussions with the treating health professional.

Confidentiality

Health professionals owe a duty of confidentiality to their patients, and will generally require the consent of their patients to discuss details with the OHS professional. This does not prevent the OHS professional providing the treating health professional with information about the workplace and possible alternative duties, where appropriate.

Permission from the injured worker

A written authority from the injured worker is required to facilitate communication with treating health professionals. This is usually via a signature on the claim form or other formally structured consent form.

Limited scope of discussions with treating health practitioner

Even with the consent of the injured worker, any discussions between the treating health professional and the OHS professional or other workplace representative must be limited to the specific injury/condition and the implications for work and cannot stray into other matters such as general health.

Role of the generalist OHS professional

In the absence of an occupational health nurse, RTW coordinator or rehabilitation provider, the OHS professional may be required to liaise with a treating doctor and allied health professionals regarding an injured worker's work fitness and RTW arrangements. In such situations, the OHS professional should be aware of appropriate privacy and confidentiality protocols.

7.5.4 Retention and management of medical records

Records relating to workers' health must be maintained in accordance with Australian Privacy Principles (APPs) contained in privacy legislation (Office of the Australian Information Commissioner, 2015),¹⁹ and managed and stored in line with relevant health records legislation.

There should be a policy defining the arrangements for management of worker health records that addresses as a minimum:

- Notification to the worker as to the nature of records being held (APP 5) and how the worker may access their information (APP 12)
- Methods of ensuring the accuracy and currency of the information (APP 10 and APP 13)
- Arrangements for ensuring security of information, including protection from unauthorised access, misuse, modification or disclosure (APP 11)
 - Only registered health professionals should have access to health records
 - Others such as managers, supervisors, and human resources and OHS personnel should only have access to summary information relevant to the work
 - Persons with authorised access should be specified by name and title to ensure clarity
- Methods of ensuring durability and availability of records, including:
 - Protection of paper-based records from environmental damage such as water and fire
 - Accessibility and retrievability of electronic records, including archiving
 - Additional protection for records stored via cloud computing.
- Retention periods
- Methods of disposal.

¹⁹ The Office of the Australian Information Commissioner website includes an APP Quick Reference Tool (<https://www.oaic.gov.au/agencies-and-organisations/guides/app-quick-reference-tool>)

In the absence of an occupational health nurse or other health professional, the OHS professional may have a role in establishing procedures for management of health records. It should be noted that where the OHS professional is not a registered health professional they do not have access to the original health records, only the summary information relevant to their role.

7.6 Employee assistance programs

Workers on a RTW program have their RTW coordinator, rehabilitation provider and other health professionals to provide psychological support during the RTW process. However, workers who have not registered a claim or formally reported a workplace injury or ill health may also require support.

Many workplaces have an employee assistance program (EAP) that offers employees a way of accessing professional support to communicate, process and work through personal and work-related issues (Joseph, Walker & Fuller-Tyszkiewicz, 2018). The aim of such programs is “to provide preventive and proactive interventions for the early detection, identification and/or resolution of both work and personal problems that may adversely affect performance and wellbeing” (EAPAA, 2009).

EAPs are usually delivered by providers external to the organisation and may incorporate proactive and reactive aspects with both secondary and tertiary interventions. While the core intervention is usually short-term psychological counselling, other services may include support such as management coaching and crisis support. These services are offered through a range of modalities, including face-to-face, web-based and telephone. (Joseph et al., 2018).

Growth in the use of EAPs by medium-to-large companies has been rapid as has the scope of services offered; this may represent a significant investment by organisations. While there has been little systematic research assessing overall impact, effectiveness of specific interventions or delivery of interventions, anecdotal evidence strongly supports the benefits of EAPs. Also, in a review of EAP literature, Joseph et al. (2018, p. 12) found that “utilizing EAPs enhanced individual and organizational outcomes...in particular reduction in presenteeism rates and improvements in levels of functioning at work and at home were evident post-EAP.” Joseph et al. (2018) found mixed results from studies investigating impact of EAPs on absenteeism.

The general view regarding EAPs is that they focus on the emotional, mental and psychological wellbeing of employees and, as such, have a role in mitigating the health impact of workplace injury or illness. They proactively provide workers at all levels of the

organisation with access to external trained resources with whom they can discuss workplace issues and strategies for addressing such issues before they escalate into psychological ill health.

Role of the generalist OHS professional

The OHS professional may be required to select an EAP provider, establish the contractual arrangements and provide information to the workplace on the EAP program, the rights of workers and how workers are able to access the program.

7.7 Planning and implementing return to suitable work

The key concepts and importance of RTW were discussed in section 5.2. Establishing RTW arrangements is a legislated duty under the workers' compensation legislation in all Australian states. Each workers' compensation regulator provides guidance for employers on establishing and managing RTW programs (e.g. WorkSafe Victoria, n.d.). Workers' compensation insurance agencies are also a source of information on establishing RTW programs.

As discussed in sections 6.1 and 6.2, RTW coordinators and workplace rehabilitation providers have key roles in managing and facilitating RTW.

Role of the generalist OHS professional

The OHS professional should be aware of sources of information on establishing and managing a RTW program. They should be able to advise on the basic principles of engagement between the workplace and the injured worker, and actively promote such engagement. Where they have a 'hands-on' role in managing RTW they should undertake an approved RTW coordinators' course as a minimum.

7.8 Managing a critical incident

There are many definitions of critical incidents. In this discussion:

A critical incident is an event, often unexpected, that poses an actual or perceived threat to an employee's wellbeing or someone close to that employee. It may also be an event that produces a strong emotional response that temporarily overwhelms an employee's ability to cope.

The most common critical incidents with which employees request assistance are:

- Employee death or disability
- Suicide attempt by employee or employee's family member
- Violence in or near the workplace, such as robbery
- Workplace accidents
- Natural disaster... (Optum, 2015, p.2)

Some writers on the topic include downsizing and redundancy as critical incidents.

Critical incidents can severely impact those involved directly or indirectly.

Individuals impacted by critical incidents can experience strong emotional reactions that have the potential to interfere with their ability to function either at the scene or later. The severity of distress is influenced by length of exposure, perceptions, the cumulative effect of incidents over time, pre-existing coping strategies and available social support. (Mitchell, Sakraida, & Kameg 2003, p. 46).

Critical incident stress management (CISM) as a response to crisis events was developed in the 1980s by Professor Jeffrey Mitchell as a pre- and post- intervention for high-risk personnel (military, emergency services and disaster workers) who were continually exposed to critical incidents and trauma in their work. The aims of CISM were to help individuals verbalise their distress, to normalise and validate their stress and psychological reactions, and to provide them with support to facilitate a return to 'normal' functioning.

Elements of CSIM as envisaged by Mitchell include:

- Pre-incident education and training
- On-scene support services
- Defusing and demobilisations
- Debriefing (CISD)
- Community outreach programs
- Support services for significant others
- Individual consultations
- Referrals for follow-up services (Mitchell et al., 2003, p.47).

These elements have been encapsulated in many examples of generic guidance for workplaces (e.g. Better Health Channel, 2011). However, much of the literature on management of critical incidents challenges the value of debriefing in response to critical incidents and suggests that there may be negative outcomes (e.g. Devilly & Cotton, 2004; Devilly, Gist & Cotton, 2006; Jahnke, Gist, Poston & Haddock, 2014; Paterson, Whittle & Kemp, 2015; Rose, Bisson & Wessley, 2003). Where there is support for debriefing it is recommended that debriefing should, as described by Mitchell, (Mitchell et al., 2003; Mitchell, 2014), be:

- Part of an integrated approach
- Conducted with groups rather than individuals
- Used with professional peer groups with similar background and experience.

Notwithstanding these mediating findings, the literature on the effectiveness of formal debriefing as part of management of critical incidents suggests that debriefing is not a useful intervention for all participants as it may trigger vicarious re-exposure, resulting in

intensifying, compounding or expanding the original trauma derived from the critical incident.

Alternative approaches focus on:

- Peer support – preparing personnel to be attentive, responsive and supportive to one another in the context of their working groups
- The role of managers in the preparation for critical incidents and support for affected workers (Devilly & Cotton, 2004; Halpern, Gurevich, Schwartz & Brazeau, 2009; Jahnke et al., 2014)
- Emphasising occupational health rather than the worker as a victim (Tuckey & Scott, 2014).

Organisations should clearly define what constitutes a critical incident and the organisational response to such incidents.²⁰ The response should highlight the commitment of the organisation and the visible, demonstrated support by managers. It should address the following aspects:

- Ensuring immediate physical needs are met, including an immediate time-out period
- Provision of factual information about the critical incident and normalisation of reactions (not symptoms)
- Connection with familiar supportive groups such as peer groups
- Promotion of proactive problem solving and coping responses
- Monitoring to identify at-risk individuals
- Availability of and access to early intervention clinical support as required, perhaps through an EAP
- Promotion of being a survivor, rather than a victim, and ongoing recovery
- Ongoing monitoring of the response and needs of the group and individuals (Devilly & Cotton, 2004; Halpern et al., 2009; VandePol, Gist, Braverman & Labardee, 2006).

Role of the generalist OHS professional

The OHS professional has a role in ensuring that the potential for a critical incident is identified, and that appropriate procedures are defined and resources allocated. The OHS professional should be aware of current thinking challenging the value of formal debriefing and be able to discuss the range of approaches suggested by research.

²⁰ See also *OHS BoK Mitigation: Emergency Management*.

7.9 Responding to a workplace fatality

The worst outcome from the failure of a safety system is the death of a worker or member of the public. When a death occurs in the workplace it may result in a Coroner's inquest and, depending on the circumstances, a crime scene. Appropriate management of such an event is paramount to satisfy regulation and law, and to minimise health impacts on workers, witnesses and others who may be affected.

Regrettably, many Australian workers die in the course of their employment each year. "In the 14 years from 2003 to 2016, 3414 workers lost their lives in work-related incidents" with 182 killed in 2016, a fatality rate of 1.5 fatalities per 100 000 workers (SWA, 2018b).²¹ It is estimated that for every worker killed on the job there are 12 to 20 immediate family members, close friends and colleagues who will be affected (Matthews et al., 2016). Based on survey responses, Matthews et al. (2016, p. 2) identified that "notwithstanding some recent efforts to improve institutional responses to workplace death, these incidents have a significant and prolonged economic, social and psychological impact on families."

WorkSafe Victoria produced a useful booklet covering the essential elements of dealing with a workplace death (WorkSafe Victoria, 2000). Its recommendations include:

- Leave the site untouched, but secure it and make it safe; if possible screen it from open view to facilitate investigation while preserving respect for the deceased
- Have a senior manager present
- Clarify with police the process for the removal of the deceased
- Have appropriate employee records available to enable police notification of next of kin
- Ensure a senior company representative and a volunteer workmate visit the family as soon as is practicable after they have been notified by police
- Ensure a senior manager informs the workforce and allows workmates to form a guard of honour as the deceased is carried from the workplace
- Make trauma counselling available to workmates
- Offer grief counselling to the family
- Ensure all company officials cooperate fully with any investigation
- Review the failures of the safety system that led to the death
- Ensure the system is rectified to prevent recurrence.

Matthews et al. (2016) identifies a number of actions within the control of the workplace that could assist in addressing the needs of families affected by a workplace death. These actions include:

²¹ These figures exclude deaths arising from work-related disease and ill health.

- Providing timely and accurate information, particularly regarding the required formalities and legal decisions as well as guidance in navigating support services; communications should go beyond the legal next of kin to include, as appropriate, parents and siblings
- Facilitating the involvement of families, or their representative, in formal processes, to have their voice heard and to influence decisions about their loved ones
- Providing information and explanation to assure families of the rigour of the investigative processes and to give a clear account of how and why the death occurred
- Providing timely information to give families confidence that actions have been implemented to prevent any future loss of life due to similar events
- Ensuring families have appropriate ongoing emotional and financial support, especially as the workers' compensation process is perceived by many to be complex, unfair and lacking in transparency.

Role of the generalist OHS professional

In addition to ensuring compliance with regulatory requirements for reporting the fatal event and liaising with relevant authorities, the OHS professional may have a vital role in coordinating and facilitating communication with family members and colleagues of the deceased worker. This communication and engagement should go beyond the minimum legal and organisational requirements to identify the needs of the workers and family members, and to take action where possible to minimise emotional and other impacts.

8 Implications for OHS practice

The role of the generalist OHS professional in the mitigation of health impacts from work-related injury and illness will be influenced by a number of factors, including the availability of in-house health professionals and the organisational level at which the OHS professional is employed. Also, the extent of involvement will vary across the different strategies described in this chapter as is highlighted in the role-specific comments at the end of each section.

In summary, the OHS professional has a role in:

- Advising employers of the legal obligation for providing reasonable RTW and espousing the benefits of RTW for the individual and the organisation
- Ensuring that the focus of mitigation strategies is on early intervention and SAW/RTW where appropriate

- Promoting an organisational and workplace culture that supports procedures for management of workplace injury and ill health
- Engaging with the organisational RTW coordinator, rehabilitation provider and health professionals to ensure appropriate communication between the workplace, health professionals and the worker
- Ensuring pre-placement health assessments are informed by appropriate task analysis and risk assessments
- Ensuring exposure monitoring appropriate to workplace hazards is carried out and acted upon
- Identifying any legislative requirements for health monitoring relevant to the workplace
- Ensuring effective processes for identifying, recording and analysing near misses, incidents and injury/illness
- Ensuring that a risk-based needs assessment is undertaken for first aid and medical response
- Implementing appropriate protocols for communicating with health professionals and maintaining medical health records
- Advising on the legal requirements for, and basic principles of, RTW programs
- Advising on the need and appropriate arrangements for EAPs
- Advising on responses to critical incidents and workplace fatalities.

If the delivery of these processes is part of an OHS professional's core activity, then it is likely that additional knowledge and skills would be required.

9 Summary

Using the role of the generalist OHS professional as a lens, this chapter provided a brief overview of key concepts relevant to the mitigation of the health impacts of work-related injury and illness. It identified key actors and their roles, and mitigation strategies available to the organisation. Such strategies apply across the time sequence of the incident or development of ill health and address:

Pre-event

- Pre-placement health assessments
- Exposure and health monitoring
- Early notification of near misses, injury or disease

Intervention

- Early provision of skilled first aid

- Early provision of medical care
- Employee assistance programs
- Implementing SAW/RTW
- Managing a critical incident
- Responding to a workplace fatality.

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