

**HEADS OF WORKERS' COMPENSATION
AUTHORITIES**

HEADS OF COMPULSORY THIRD PARTY

**BIOPSYCHOSOCIAL INJURY
MANAGEMENT**

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1. INTRODUCTION

This paper outlines the HWCA and HCTP position on a biopsychosocial approach to injury management and recognises work undertaken by personal accident compensation authorities in this area. Also provided is a harmonised glossary of relevant biopsychosocial terms, and relevant risk assessment tools.

HWCA and HCTP recognise the World Health Organisation's generic biopsychosocial model of health, illness and disability as relevant to workers' compensation regulation, policy, and scheme administration. We accept this approach as critical to improving outcomes when managing injured people.

Injury management includes all the activities that ensure the safe and early return to usual activities of an injured person, including return to the workplace. It includes treatment, claims management, retraining of injured people, employment practices and occupational rehabilitation.

2. THE TRADITIONAL MEDICAL MODEL

The basis for conventional health care and rehabilitation in the personal injury domain is the traditional medical model which assumes a linear relationship between disease, symptoms and disability, and incapacity for work. The medical model includes the following elements:

- recognising patterns of symptoms and signs—medical history and examination
- understanding underlying pathology—diagnosis
- applying therapy to that pathology—treatment and rehabilitation
- expecting the patient to recover—cure or residual impairment.

However, this model is often inadequate as it can be too simplistic, over emphasizes impairment and incorrectly assumes a direct causal link between impairment and disability and fails to take sufficient account of the personal and social dimensions of disability. There is broad agreement that human illness and disability is best understood and managed according to a biopsychosocial model comprising biological, psychological and social dimensions. The biopsychosocial model of illness and disease proposes that biomedical explanations are often insufficient to fully explain ill health, or good health and wellbeing. Instead, biomedical, psychological and social factors all play a significant role in human responses to illness and disease¹.

3. THE BIOPSYCHOSOCIAL MODEL

Put simply, biopsychosocial injury management is an individual-centred model that considers the person, their health problem and their social context:

Biological—refers to the physical or mental health condition.

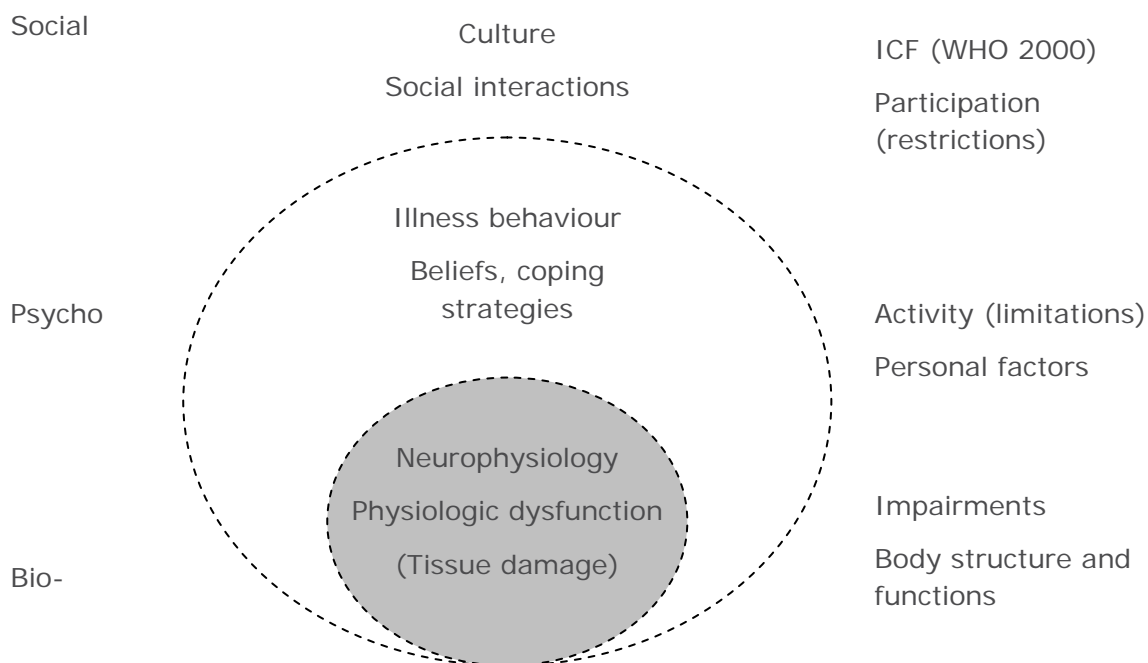
Psychological—recognizes that personal/psychological factors also influence functioning.

¹ The Australasian Faculty of Occupational and Environmental Medicine (2010), 'Realising the health benefits of work: A position Statement', Sydney: Australia.

Social—recognizes the importance of the social context, pressures and constraints on functioning.

The biopsychosocial model is the basis of the World Health Organization International Classification of Functioning, Disability and Health (ICF), which is now widely accepted as the framework for disability and rehabilitation. Day to day functioning and disability is dependant on the dynamic interaction between the individual's health condition and related factors that include both personal/psychological and social/occupational factors. Understanding and preventing incapacity requires a framework that addresses all the physical, psychological and social factors involved in human illness and disability. Therefore rehabilitation needs to address biopsychosocial obstacles for recovery and return to work. These principles are fundamental in achieving better outcomes from clinical and occupational rehabilitation management.

4. VISUALISING THE BIOPSYCHOSOCIAL MODEL



A biopsychosocial model of low back pain and disability. ICF, International Classifications of Functioning, Disability and Health: WHO, World Health Organization. (refer to Waddell (2004))

5. IMPLEMENTING A BIOPSYCHOSOCIAL APPROACH

A biopsychosocial approach to injury management that provides programs tailored to the person's individual needs, has the best chance of maximising recovery and return to work, outcomes. The model (figure 1) illustrates the multivariate and interactive dimensions that are likely to impact on recovery, return to work including the legislative and regulatory context, and positions particular injury management issues within a broader health and disability context. For example. adopting this model recognises that a person's fears and beliefs about their injury and the impact on their return to work and health, should be included in injury management. Workplace variables influence an individual's motivation to return to work. Workplace factors

exert a strong influence on return to work such as support from managers and co-workers, flexible accommodation and the availability of suitable duties, and the organisation's willingness to invest in health and safety.

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

Figure 1: Biopsychosocial obstacles to return to work are classified, and the corresponding rehabilitation interventions are shown Waddell and Burton.²

The biopsychosocial approach provides an evidence-based framework for the prevention and management of ongoing pain and disability. It recognises that pain does not strictly correlate to damage to tissues, body structures and functions. Each individual's perception of pain differs according to the influence of psychosocial factors. Therefore, effective injury management is based on applying the biopsychosocial approach that considers the whole person - their physical, social, psychosocial & emotional needs of the worker, underpins effective injury management.

6. BIOPSYCHOSOCIAL INJURY MANAGEMENT PRINCIPLES

Personal injury Workers' compensation authorities are promoting the biopsychosocial model though their work in Australia and New Zealand. In particular the broad principles in:

- *Clinical Framework for the Delivery of Health Services*—WorkSafe Victoria/Transport Accident Commission, 8 September 2009
- *Improving Outcomes: Integrated, Active Management of Workers with Soft Tissue Injury*—WorkCover NSW, 19 August 2010
- *Pain Management Services*—Accident Compensation Commission, New Zealand, 8 June 2009
- *Nationally Consistent Approval Framework for Workplace Rehabilitation Providers*—Workplace rehabilitation principles being adopted by the Heads of Workers' Compensation Authority.

Each authority shares these common principles:

- early intervention and tailored programs
- a focus on a return to usual activities including work
- active engagement of injured person and working towards a common goal
- regular review of progress and management of risk factors
- evidence-based decisions.

² Waddell G, Burton AK. *Concepts of Rehabilitation for the Management of Common Health Problems*. London: The Stationery Office, 2004

6.1 Early intervention and tailored programs

- a person receives prompt attention and intervention appropriate to their needs.
- early identification of the psychosocial barriers to recovery and return to work to inform the most effective treatment and rehabilitation approach.
- return to work/lifestyle barriers are addressed in rehabilitation planning and strategies promptly implemented.
- injury management is actively coordinated between all players (the worker and their family and treatment providers), to achieve an integrated return to usual activities, including work.
- the workplace takes action to ensure further workplace injuries are prevented including assessment and management of the risks arising from the psychosocial working environment.

6.2 A focus on increasing activity and return to work

- at the outset the injured person must be central to developing goals that focus on return to function and work
- treatment goals are developed that include relate to return to function and work.
- appropriate services are identified and delivered to maximise return to work and usual activities.
- initial return to work activities focus initially on return to the pre-injury employer or, if not possible, to another employer.
- design of treatment and rehabilitation promotes transition to independence and self management.
- workplaces promote positive health at work strategies, recognise and respond to early symptoms, are flexible in accommodating return to work by providing suitable duties and accommodating workers with persistent or recurring symptoms.

6.3 Active engagement of injured person and working towards a common goal

- adequate and consistent information is provided to an injured person about their injury and the return to usual activities and return to work process.
- effective communication between key parties establishes agreed goals and expectations of the support and assistance needed to achieve a safe and timely return to usual activities (including work). Agree on strategies to address barriers to recovery.
- a person is empowered to participate in their recovery through targeted education about their injury and relevant self management strategies as part of the treatment and rehabilitation program.

6.4 Regular review of progress and management of risk factors

- include and regularly review relevant outcome measures related to the functional goals of injury management.

- close management and monitoring of return to work/activity programs occurs in consultation with all parties.
- if recovery is delayed or risk factors are observed, use a standardised screening tool to identify/review risks of longer term incapacity.
- where recovery is delayed, all parties should proactively collaborate and collect additional relevant information to ensure the treatment and rehabilitation program addresses psychosocial factors to minimise the likelihood of persistent pain and functional loss.
- pain in excess of three months duration is referred to as persistent pain and is based on a complex relationship between physical and psychosocial factors. Multi-disciplinary programs are generally more effective in addressing persistent pain related disability.

7. FLAGS/FLAGS FRAMEWORK

The *Flags* concept originated as a practical framework for understanding and evaluating psychosocial influences in musculoskeletal problems³. *Flags* provide:

- an indicator that further attention is needed on a barrier to recovery.
- an aid to implement the biopsychosocial model into everyday practice.
- an understanding of why some people with musculoskeletal problems don't recover as expected. They offer a method to identify and tackle obstacles to recovery or return to work.

Flags are not diagnostic but can signal a specific obstacle to recovery, or to participation in productive activity.

Types of flags

Yellow Flags—Relate to the person and largely psychosocial factors associated with unfavourable clinical outcomes and the transition to persistent pain and disability. Yellow flags were developed from a clinical perspective plus include an occupational perspective of psychological and socio-occupational risk factors.

Blue Flags—Those perceived features of work, generally associated with higher rates of symptoms, ill-health and work loss, which may delay recovery from injury, or constitute a major obstacle to it, and for those at work may contribute to suboptimal performance or 'presenteeism'. Blue flags include issues related to the perception of job characteristics such as job demand, but also to the perception of social interactions (whether with management or fellow-workers).

Black Flags—The context in which the person functions, and includes relevant people, systems and policies such as at a societal level, or in the workplace, and the legislative framework of the compensation system. They may block the helpful actions of healthcare and the workplace. Contextual factors that cannot be changed need to be identified so that they can be navigated around. Black Flags indicate that others and/or other professionals might need to be involved in the process.

Red Flags—Risk factors for serious pathology or disease and were incorporated into screening tools recommended for use in primary care by clinicians.

³ Kendall & Burton (2009), 'Tackling musculoskeletal problems: a guide for clinic and workplace – identifying obstacles using the psychosocial flags framework, United Kingdom.

Orange flags—Yellow flags cover aspects of normal psychological processes, but they have sometimes been confused with psychiatric disorder, such as major mental illness or major personality disorder, including illicit drug use and ongoing forensic involvement. Orange flags require specialist assessment/referral and render the individual unsuitable (at that time) for a straightforward biopsychosocial approach.

Multiple flags—Psychosocial variables can have a cumulative effect as the *Flags* interact; people often have multiple obstacles across domains.

8. HARMONISING DEFINITIONS FOR BIOPSYCHOSOCIAL TERMS

The following terms refer to the World Health Organisation's (WHO) generic biopsychosocial model of health, illness and disability as applicable to personal injury management in respective schemes. The WHO's, the International Classification of Function publication *Towards a Common Language for Functioning, Disability and Health* is also particularly relevant; some terms from that publication have been incorporated into this glossary.

8.1 Glossary of terms

Absenteeism—The habitual failure to go to work due to personal injury, illness or psychosocial factors.

Activity—The execution of a task or action by an individual.

Activity limitations—Difficulties an individual may have in executing activities.

Assessment—The process of collecting evidence and making judgments on the nature and extent of performance. Involves the use of multiple data collection methods and sources, and a synthesis of data is drawn to reach conclusions.

Biomedical approach—The combination of design and problem solving skills of engineering with medical and biological sciences to improve healthcare diagnosis and treatment.

Body functions—Physiological functions of body systems (including psychological functions).

Body structure—The anatomical parts of the body such as organs, limbs and their components.

Catastrophising—The tendency to think the worst about situations. Such thoughts are usually extreme and negative (for example, 'I'll never be able to do this').

Clinical and psychosocial screening – is more interested in how and why some people develop long-term disability or poor health outcomes and what can be done about it. There has always been an interest in predicting likely progress and outcomes, but historically that was based on isolated items of information and general clinical judgement with little scientific basis. Modern clinical screening has a stronger scientific and statistical foundation but remains focused on clinical and psychosocial measures, clinical outcomes, and return to work.

Clinical framework—A set of guiding principles developed to assist medical and allied health providers in the management of injured workers.

Clinical guidelines—A set of systematically developed statements or recommendations about appropriate health care for specific clinical conditions.

Cognition—Thoughts, ways of thinking and perceptions.

Cognitive behavioural approach—A problem solving approach to facilitate achievement of defined goals by breaking tasks down into achievable steps. For example:

1. identify unhelpful beliefs
2. challenge unhelpful beliefs
3. introduce more helpful ways to think about/manage barriers (problem solving approach)
4. equip for self management (to apply problem solving approach independently).

Cognitive behavioural therapy—A type of psychological treatment where the patient examines the ways to think and respond to certain problem situations in their life. The treatment then focuses on helping them learn more helpful ways of thinking and responding to these situations and others that they might face.

Context—The variety of systems in which an individual exists: the family system; the social system; the workplace or company; the culture; and the political system of the country in which the person lives.

Disability—The definition of disability (as described by the World Health Organisation⁴) is:

An umbrella term, covering impairments, activity limitations and participation restrictions. An impairment is a problem in the body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives'.

Environmental Factors—These make up the physical, social and attitudinal environment in which people live and conduct their lives.

Evidence based intervention (practice/medicine)—The melding of individual clinical judgement and expertise with the best available external evidence to generate the kind of practice that is most likely to lead to a positive outcome for a patient.

Fear avoidance beliefs—A belief that certain activities should be avoided due to fear of causing pain or re-injury.

Goal setting—Establishing short- or long-term objectives, usually incorporating deadlines and quantifiable measures in order to achieve an outcome.

Impairment—The demonstrable deviation or loss of structure or function.

Incapacity—The inability to work or reduced functioning and performance in a particular role or work environment associated with sickness or disability.

Injury Management—encompasses all the activities associated with ensuring that a person sees an early, safe and durable return to activities including work as close as practicable

Medically required/discretionary/unnecessary certifying of incapacity or disability—Medical practitioner discretion in certifying incapacity to work. The three major causes of medically unnecessary disability days include⁵:

⁴ World Health Organisation (2011), <<http://www.who.int/classifications/en/>>

⁵ The Australasian Faculty of Occupational and Environmental Medicine (2010), 'Realising the health benefits of work: A position Statement', Sydney: Australia.

- physician skill in disability prevention, mitigation and management
- employer/insurer effectiveness at intervening on non-medical issues
- Quasi-medical communications between medical offices and employers/insurers

Modified duties/alternative duties/suitable duties- These recognise the individual's function and limitation, and reorganises job duties accordingly. Types of modified work include: alternate duties, modified duties, graded work exposure, work trial, and supported employment. This approach conveys a sense of understanding of the psychosocial aspects of work and disability for work, as well as the physical and financial aspects but also it may be a component of a phased RTW strategy required by the individual's employer.

Multidisciplinary rehabilitation—The necessary involvement of two or more disciplines in assessing and treating the physical, psychological, medical, vocational and social aspects aimed to rehabilitate the injured worker.

Occupational Rehabilitation—A managed process involving timely intervention with appropriate and adequate services based on assessed need aimed at maintaining injured or ill employees in, or returning them to, suitable employment.

Outcome measure—A test or scale that has been shown to measure a patient characteristic of interest. Outcome measures are used to evaluate change from one point in time (before treatment) to another (after treatment). It is also used to assess whether goals have been achieved.

Pain—A normal and time-limited response to trauma, as a general guide:

Acute pain – A type of pain that typically lasts a period of less than three months. Acute pain is distinct from chronic pain and is relatively more sharp and having severe symptoms.

Chronic pain – Pain lasting longer than a period of three months can be referred to as chronic or persistent pain and is usually the result of a complex relationship between physical and psychosocial factors. Personality traits, mental health issues, counterproductive beliefs and past experience can affect and reinforce the pain experience.⁶ Chronic pain can persist after injuries heal for no apparent biological cause and can lead to significant psychological and emotional trauma which often limits an individual's ability to function.

Participation Restrictions—Problems an individual may experience in involvement in life situations.

Presenteeism— Is the opposite of absenteeism whereby employees come to work in spite of illness with similar negative repercussions on business performance.

Psychosocial factors—Factors more relevant to behavioural outcomes (including activity level, participation, productive activity, and work) than to symptoms (such as pain). Sometimes the choice is between getting on and enjoying life or withdrawing from activity; either way, the amount of pain may well be the same. Effective, timely identification and management of psychosocial factors facilitates recovery and reduces the risk of longer term disability (and work loss).

⁶ Motor Accidents Authority & WorkCover NSW (2009), 'Treatment Principles for the provision of psychological and counselling services'.

Return-to-work (RTW)—Under accident compensation schemes, return to work is when the worker actually returns to their usual place of employment (full-time or part-time) or to a new employer. That process can be:

Graduated RTW the person gradually increases their hours/duties at work. This is often in a structured way to match/enhance rate of recovery

Sustainable/durable RTW a time period that confirms the likelihood that a worker is able to sustain a return to their work situation

Measurement of RTW outcome Describes a measurable characteristic of the worker's RTW status or experience. Outcomes can occur through the process and include such variables as employment status, productivity, job satisfaction and promotion.

Risk factors—Should be used to refer to factors associated with the future development or occurrence of an event such as disease of some sort. They may or may not be implicated causally in the development of the disease, but the disease is not present at the time of risk estimation.

Secondary psychological condition – The psychological consequences of the injury or the effects of that injury.

Self-efficacy—A personal belief about how successfully one can cope with difficult situations; the degree of confidence a patient has in performing normal activities and tasks despite their pain.

Standardised outcome measure—A measurement tool that has undergone testing to establish its validity, reliability and sensitivity to change in relation to a specific variable of interest.

Vocational rehabilitation—See occupational rehabilitation.

Workplace rehabilitation—See occupational rehabilitation.

Work disability—The impact on a person's ability to perform paid work from all kinds of impairment from birth or acquired through illness, accident or the ageing process including cognitive impairment as well as physical, sensory and psycho-social disability.

Workplace assessment—An on-site assessment of the worker performing pre-injury duties, potential suitable duties, and/or equivalent, with the same or a different employer.

9. RISK ASSESSMENT TOOLS

The following list of HWCA endorsed validated biopsychosocial risk assessment tools include screening tools that have been applied in the Australian accident compensation environment. Information about the tool includes: what the tool measures; when it is most useful; and any limitations to its use. Additional tools will be included after testing in the Australian context.

9.1 Validated biopsychosocial risk assessment tools

NAME OF VALIDATED TOOL	Pain self-efficacy questionnaire (PSEQ)
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	General
WHAT THE TOOL IS DESIGNED TO MEASURE	A person's coping skills with pain; general function; global expectations of recovery; some workplace and compensation issues
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Nicholas M.K. Self-efficacy and chronic pain. Paper presented at the annual conference of the British Psychological Society. St. Andrews, 1989.

NAME OF VALIDATED TOOL	Depression and anxiety Scale Survey (DASS)
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	General usage
WHAT THE TOOL IS DESIGNED TO MEASURE	Clinical measures of mood and distress
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Depression Anxiety Stress Scales (DASS), <<http://www2.psy.unsw.edu.au/groups/dass//>>

NAME OF VALIDATED TOOL	Fear and avoidance Beliefs questionnaire (FABQ)
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	Can be applied at any time after injury
WHAT THE TOOL IS DESIGNED TO MEASURE	Detect avoidance behaviour related to general activities and activities related to work
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Gordon Waddell, Mary Newton, Iain Henderson, Douglas Somerville and Chris J. Main, A Fear-Avoidance Beliefs Questionnaire (FABQ) and the role of fear-avoidance beliefs in chronic low back pain and disability, *Pain*, 52 (1993) 157 – 168, 166.

NAME OF VALIDATED TOOL	Shaw Back pain Disability Risk Questionnaire
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	Acute risk screening and medical questionnaire
WHAT THE TOOL IS DESIGNED TO MEASURE	Specific for those with back injury and is a shorter version of the Orebro but includes questions on worker's perception of workplace relationships
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Shaw, W. , Pransky, G. , & Winters, T. . (2009). The Back Disability Risk Questionnaire for work-related, acute back pain: prediction of unresolved problems at 3-month follow-up. *Journal of occupational and environmental medicine American College of Occupational and Environmental Medicine*, 51(2), 185-194.

NAME OF VALIDATED TOOL	Pain Catastrophising Scale (PCS)
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	Can be applied at any time after injury
WHAT THE TOOL IS DESIGNED TO MEASURE	If the person has a pain focussed and catastrophising personality that could impact on their recovery and return to work
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Sullivan MJL, Bishop S, Pivik J. The pain catastrophising scale: development and validation. *Psychol Assess*, 1995, 7: 524-532

NAME OF VALIDATED TOOL	Kessler's Psychological Distress Scale (K-10)
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	Can be applied at any time after injury
WHAT THE TOOL IS DESIGNED TO MEASURE	Global measure of distress over the past 4 weeks; used in populations studies and by general practitioners
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Kessler and Mroczek (1994). School of Survey Research Center of the Institute for Social Research. University of Michigan.

NAME OF VALIDATED TOOL	Oswestry Disability Questionnaire
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	Specific for low back pain

WHAT THE TOOL IS DESIGNED TO MEASURE	Function and disability, impact of pain and quality of pain
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. Spine, 25(22):2940-2953. Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. Physical Therapy 2002;82:8-24.

NAME OF VALIDATED TOOL	Pain Disability Index (PDI)
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	for those experiencing pain
WHAT THE TOOL IS DESIGNED TO MEASURE	Function and disability, impact of pain and quality of pain
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Tait RC Chibnall JT Krause S. The pain disability index: psychometric properties. Pain. 1990; 40: 171-182.

NAME OF VALIDATED TOOL	Positive and Negative Affect Scales (PANAS)
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	To measure general mood
WHAT THE TOOL IS DESIGNED TO MEASURE	Affective states – general measure of positive and negative affective states
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. Journal of Personality and Social Psychology, 54(6), 1063-1070.

NAME OF VALIDATED TOOL	Tampa Scale of Kinesophobia
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	Developed for use with chronic pain patients
WHAT THE TOOL IS DESIGNED TO MEASURE	Fear of pain and catastrophising
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Pain, Fear of movement/(re) injury in chronic low back pain and its relation to behavioural performance, 62, Vlaeyen, J., Kole-Snijders A., Boeren R., van Eek H., 371.

NAME OF VALIDATED TOOL	Örebro Musculoskeletal Pain Questionnaire (various versions)
WHEN IN THE COURSE OF RECOVERY IS MOST USEFUL	Useful at all stages but mainly validated for acute and subacute populations
WHAT THE TOOL IS DESIGNED TO MEASURE	Composite psychosocial risks such as function, long term disability, activities of daily living, pain
ANY LIMITATIONS AND RESTRICTIONS IN USE	

Source: Linton SJ, Boersma K. Early identification of patients at risk of developing a persistent back problem: the predictive validity of the Örebro Musculoskeletal Pain Questionnaire. Clin J Pain 2003; 19: 80-86

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WorkCover NSW

World Health Organisation (2011), <<http://www.who.int/classifications/en/>>