Return to Work after Brain Injury

This section talks about return to work after head injury and what kind of difficulties people experience. It moves onto talking about what kind of help and support is needed and suggests that this can often mean very simple, highly cost-effective changes in the process which occurs when a person returns to work after head injury. For others there may need to be a more formal, intensive, or longer intervention or period of support. Either way BrainCurve stresses that both are preferable to the current scenario and the common lack of a coherent approach.

Examples of typical problems on returning to work are:

1. Vulnerability towards fatigue
2. Difficulty in planning, organising and executing tasks at work
3. Memory problems - especially when given a lot of information
4. Attentional problems - difficulty in sustaining concentration or difficulty processing new information, i.e. making sense of it and integrating it.
5. Sudden, unpredictable point in day or week when ability will drop markedly and cannot be found again despite best efforts, until rest and often sleep restore functioning.
6. Relationship problems, sometimes due to inappropriate social behaviour, sometimes secondary to the injury, e.g. withdrawal due to depression, or anger at feeling not understood. People can often be sensitive about changes in how they appear to others, e.g. a stutter. This can cause a kind of defensive, hypervigilant reaction where the person overestimates how much others notice this and can misinterpret things others say or do.
Most people who suffer a mild-moderate head injury will receive little or probably no advice on returning to work, yet most will experience symptoms which are predictable.

Approximately 1.4 million people in Britain attend accident and emergency (A&E) departments each year with a head injury, constituting 11% of all A & E presentations. Most of these head injuries are classified as mild, the majority of patients being discharged home within a few hours, and of those admitted to hospital the majority will be kept in for less than 48 hours. Patients are often discharged with little or no follow-up, even less formal, planned follow-up, with rehabilitation focusing primarily on the severely injured. Yet approximately 63% of all brain injuries occur in people aged 15–64 years, i.e. the working population.

As a clinician who has worked in the NHS as a neuropsychologist for over ten years I am aware that many of those patients who were referred to me at least a year or more after sustaining a mild-moderate head injury and had been employed prior to the injury, had had experience often of making an unsuccessful return to work. Very often they were referred years later. This often was the reason for their referral for assessment and rehabilitation. Yet experience and research shows that these people had similar difficulties on their return to work, that they received little or no advice at all before returning, little or no planned support in the workplace and therefore some were forced to leave work again or endure significant problems.

**Definitions of severity**

<table>
<thead>
<tr>
<th>Mild head injury</th>
<th>Moderate head injury</th>
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<tr>
<td>GCS - 13-15</td>
<td>GCS - 9-12</td>
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<tr>
<td>(14-15)</td>
<td>(9-13)</td>
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<tr>
<td>PTA - up to 1 hour</td>
<td>PTA - &gt; 1 hr - 1 day</td>
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The Glasgow Coma Scale score ranges from 3 to 15 and is based on the person’s best verbal response, ability to follow commands, and eye opening. A person with a score of 15 has their eyes open, is following commands, and is talking and may or may not have full orientation. By definition a GCS score of 8 or below reflects a
severe TBI, a score of 9-12 a moderate TBI, and a score of 13-15 a mild TBI. This is a very common method of measuring severity, although in those with mild head injuries it may not even be conducted.

Another way of estimating severity of a brain injury is the extent of post-traumatic amnesia (PTA). Someone who has had a significant head injury will have amnesia for the event thus they do not remember the injury and possibly events for sometime afterwards. This is the period of post-traumatic amnesia. The longer the duration of amnesia, the more severe the brain dysfunction. Up to a week of amnesia after the injury is considered a severe injury. Beyond a week of amnesia, the injury is considered very severe. Despite the fact that length of PTA is a fairly reliable measure of severity there are problems with this method too. Firstly, again people with mild injuries may not even be asked what they remember. For both groups another problem even if PTA is measured it is rarely measured correctly. A person ends the period of PTA when they are demonstrated to show a continuous stream of memory for events, tested repeatedly over a period of time. Before that they may show intermittent recall of events, e.g. remembering the doctor’s name. This is sometimes taken as the end of PTA when in fact it may be days later or longer before their memory for events and new information is reliable. In busy, acute hospitals, PTA may often not even be measured. If I see a person for a medico-legal report I will ask them or preferably a person who was around them then, when they began to remember things properly after the injury, but by then this is far from reliable. Hospital notes typically do not mention end of PTA or do not say how it was assessed, or fail to highlight where the information is.

From a therapist’s viewpoint it is all too obvious how vulnerable a person feels after brain injury, physically, psychologically, in every way possible. People describe it as feeling like walking on unsafe ground. Some clients describe experiences such as not wanting to even leave the house alone, feeling safe at night only by returning to childhood and clutching a teddy bear. I used to wonder why people felt ashamed after a brain injury, yet with experience, I came to realise the feeling is common, although it may seem irrational to others. People often dislike or don’t recognise the person they feel they have become. Imagine then the sense of dislocation on returning to work, the success or failure it symbolises. Imagine the return to normality which is craved, which work is seen as a huge step in having reached. Yet imagine the threat of failure it also represents. Yet every time someone affected by brain injury is forced to make often clumsy, unsupported steps towards returning to work, society lets that person down. It could so easily be you or I. It could be different, sometimes without much cost or effort, at a huge gain to that person making 'baby steps' towards the life he or she had before.
As will be discussed next week, sometimes return to work, or to that job, is not the right way for the person in the end. Yet when the person tries he or she has a huge amount of emotional investment in a successful return. Thus finding that this route to normality is actually blocked, is like finding no way through in a maze, or like finding yourself alien in a world you once felt part of. In many cases people could be successful with the right support and advice. Equally, if it is too early to return or no longer the right kind of job, support and advice to employers about how to manage this situation when the person is very vulnerable could help prevent lasting psychological damage.

Research

Few studies have looked at the experiences of people returning to the same job after a head injury and even fewer have looked at it from the perspective of the people themselves. A study in Leeds by Gilworth and others in 2008 examined the experiences of a total of 33 people who had experienced mild or moderate head injury were interviewed 4-6 months after their injury. Eight had either not returned to work at all or had returned and subsequently had to leave. The definitions of severity used in the study are shown in blue in italics above.

<table>
<thead>
<tr>
<th>Psychological problems</th>
<th>Cognitive Problems</th>
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<td>perceived changes to identity by self and others</td>
<td>memory</td>
</tr>
<tr>
<td>mood problems</td>
<td>concentration</td>
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<tr>
<td>fears (about the future)</td>
<td>planning/ organising</td>
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Typical Experiences or Feelings

- having to prove oneself
- struggling to cope
- feeling their problems 'invisible' to others
- perceived lack of support and unrealistic expectations of others at work
- perception of point in the day when skill level would suddenly plummet, unable to recover it, ensuing loss of confidence
- feeling of being dazed or distanced from what was going on around them
- feeling colleagues didn't see problems as genuine
- fear of having to take (more) sick leave
Two people reported trying to return and finding the experience changed their perception of the importance of work in their life, e.g. not being worth the perceived stress involved, e.g. not really caring about it, not feeling motivated, in the wrong job.

**What could be done to support Return to Work (RTW) more effectively?**

The study suggests a number of things could be done to increase support and actually some are small and probably low-cost.

1. Many of those in the study, especially in the mild group had received no medical follow-up at all
2. Even those who had received follow-up from GP or actual rehabilitation could not recall detailed discussion about return to work. Although some may have conceivably had actual discussions but forgotten this indicates a failure of therapists, etc. to effectively present or record the information in such a way as to make it useful when needed.
3. Lack of guidance/advice about when to return meant some felt they had returned to work too soon
4. Lack of support/poor support systems on return meant poor planning and common sense approaches did not occur, e.g. ensuring/advising a phased return
5. Lack of advice on coping strategies, although some people developed their own.
6. Lack of formal information giving process to employer (although people did report deliberate withholding of information through fear of what might occur). Employer thus in most cases had no idea what problems to expect or how to give support.
7. Failure, though sometimes because of (6) to inform colleagues, increasing pressure on those with head injuries (and probably the colleagues), no agreement about which colleagues needed to know

The study highlights the approach taken by Ponsford et al (2002), who provided a simple information booklet incorporating components mentioned above. This kind of approach benefits the person affected by brain injury, both by alerting them to possible problems, stressing the normality of these if experienced, so providing reassurance, suggesting coping strategies, emphasising that symptoms can be synonymous with a successful return to work with support (avoiding the possibility of person assuming symptoms are a signal to quit) and reduce the 'invisibility' of symptoms and the expectations of others.

Such an approach would therefore benefit those affected directly, the employer and managers, but also colleagues, both by increasing their empathy and ability to provide
support and by reducing the extra workload which may fall on them if one person in the team is struggling to cope. Thus resentment on both sides could be minimised, along with misunderstanding.

Naturally for some people, perhaps those with more severe injury, more persistent problems, and/or more challenging jobs, a more structured approach involving professional support/intervention might be necessary. It is my belief however that providing both simple and more costly formal approaches in a timely, planned fashion, would have a number of benefits.

1. Increasing the probability of successful RTW
2. Avoiding the damaging effects of too early a return, possibly by identifying through assessment when a person is 'ready'.
3. Avoiding damaging secondary psychological consequences of persistent difficulty and possible failure, such as loss of self-esteem and depression
4. Minimising skill loss by enabling people to return at the right time, i.e. early enough so that skills are not lost but not so early that the person is unlikely to succeed
5. Increasing the benefits to society, through enabling people to contribute and be productive, increasing awareness of others about head injury, and reducing effects upon families and crucially, children.