Musculoskeletal disorders and return to work

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Work is what defines us:

“...... and what is it you do?”
The WORK ↔ HEALTH double act

I see my daddy walking through them factory gates in the rain

Factory takes his hearing, factory gives him life
The working, the working, just the working life

“Work is life, you know, and without it, there's nothing but fear and insecurity.”

Bruce Springsteen, 1978

John Lennon, 1969

But, is work healthy?
WORK ↔ HEALTH

• Review for DWP
  • *G Waddell, K Burton (2006)*

• Work is generally good for physical and mental health and well-being; prolonged sickness absence is not
  • Work can contribute to better health outcomes

• Proviso: good jobs are good for health
Work is an important health outcome

- Depends on who you are and where you are
  - Subjective reduction in symptoms
  - Improvement of functional limitation
  - Regain work participation
    - these are not equivalent and no linear path!
Huddersfield Dispensary and Infirmary

- model of charitable healthcare → OH
Traditional occupational health paradigm

Trauma → Hazard → Worker → Harm → Injury / disease

Focus on causal relationship

.... a reasonable concept, but over simplistic
Safety v Health – conflicting paradigms

- Reduce risks → primary prevention
  - paradigm works for safety
    - e.g. falls from height
  - paradigm works for occupational disease with clear cause-effect
    - e.g. hazardous substances
- But, the paradigm does not work for most common health problems
Common health problems

- Less severe illnesses and injuries
- Responsible for ~70% of absence and long-term incapacity
  - Musculoskeletal conditions
  - Mild/moderate mental health problems
  - ‘Stress’
Musculoskeletal problems

- High prevalence across population
- Characterised by symptoms more than disease or impairment
  - Coexisting symptoms common - physical and mental
- Untidy episodic pattern
  - Varying severity at irregular intervals over life course
- Care seeking for ~10% of episodes
  - Most episodes settle uneventfully
- Multifactorial causation
  - Work usually only one contributory factor
- Most people remain at work or return to work quite quickly
- Essentially whole people, with a manageable health problem
  - Given support, opportunities and encouragement
Prevailing paradox

- Increased disability
- Static prevalence rates
- Reduced work risks
- Enhanced treatment
CHP epidemiology – the key to understanding

- No Symptoms
  (all workers some of the time)

- Symptoms
  (most workers some of the time)

- Work-relevant symptoms
  (fewer workers less of the time)

- Healthcare or absence

- Extended absence

- Litigation
The elephant in the room

Symptoms exist irrespective of the nature of work

Symptoms ≠ care seeking, diagnosis or Rx
Work-relevant symptoms

- Symptoms can affect workability
  - symptoms may be more pronounced at work
  - work may be difficult because of symptoms
- How we deal with work-relevant symptoms can have major repercussions
The slide to disaster

social constructs → escalating obstacles

- Before symptoms
- At onset of symptoms
- At time of seeking healthcare
- If signed off work
- On failure to recover/participate

adapted from Hadler
The challenge: shifting the recovery curve

Standard recovery curve for musculoskeletal problems
The first part of the curve is quite steep, illustrating that many people recover or return to work within days or weeks. But, as time passes, the recovery curve flattens showing the mounting effect of obstacles – people then find it increasingly difficult to recover and get back to work.

Improved recovery curve
Effectively identifying Flags and tackling the obstacles will squash the curve. The effect will be increased recovery rates, leading to reduced sickness absence and less long-term disability.
Vocational rehabilitation

• A review for Vocational Rehabilitation Task Group (2008)
  • G Waddell, K Burton, N Kendall

• VR can be effective + has cost-benefits
  • sooner rather than later

www.tsoshop.co.uk/evidence-based
Integrated approach

- VR is whatever helps someone with a health problem to stay at, return to, and remain in work
- SAW and RTW don’t just happen – action needed!
- Healthcare alone not enough
  - voc rehab not something to try after healthcare has finished/failed
- Workplace must be involved
  - from day #1
  - working whilst recovering
The obstacles model
- overcoming obstacles to work participation
Why do some people become disabled?

- They do not have a more serious health condition or more severe injury
  - So, it’s not about what has happened to them; rather it’s about why they don’t recover
- They face obstacles to recovery and participation

→ biopsychosocial approach
Tackling Musculoskeletal Problems

A GUIDE FOR CLINIC AND WORKPLACE
identifying obstacles using the psychosocial flags framework

Kendall, Burton, Main, & Watson: TSO Books, 2009

www.tsoshop.co.uk/flags
Psychosocial flags framework

- Flags are things we can observe that indicate problems ahead
- They flag up obstacles to being active and working
- They point to what needs to be done
Important flags to identify - **Person**

Psychological factors are associated with poor clinical recovery

**Thoughts**
- Catastrophising (focus on worst scenarios)
- Unhelpful beliefs and expectations about pain, work, and healthcare
- Low expectations of *recovery*
- Preoccupation with health

**Feelings**
- Worry, distress, low mood  (± diagnosable anxiety or depression)
- Fear of movement
- Uncertainty (about the health problem)

**Behaviours**
- Extreme symptom report
- Passive coping strategies
- Serial care seeking
Psychosocial workplace factors associated with persisting absence

• **Employee**
  - Fear of re-injury
  - Low expectation of *resuming work*
  - High physical job demand (perceived or actual)
  - Perception of high mental job demand (‘stress’)
  - Low job satisfaction

• **Workplace**
  - Lack of employer communication with employees
  - Lack of job accommodations/modified work
  - Low social support or social dysfunction in workplace
Important flags to identify - **Context**

- Significant others with negative expectations or beliefs
- Ineffective management
  - (lack of involvement/investment: poor line management)
- Unhelpful policies/procedures used by company
- Process delays
  - (e.g. waiting lists, claim acceptance)
- Role ambiguity or disagreements between key players
  - (employee <> employer <> healthcare)
- Financial, compensation or legal issues
Useful questions to ask

- What do you think has caused your problem?
- What do you expect is going to happen?
- When do you think you’ll get back to work?
- How are you coping with things?
- Is it getting you down?
- What can be done at work to help?
Develop a plan with the person

Key Players Communicate:

- agree the specific obstacles and actions
- agree timeframe and communication channels
- use (conditional) confidentiality waivers
- emphasise ability rather than disability
- all players sign up to the plan
- key players work together to ensure accommodating workplace
Action:

- Stepped care approach
  - just what’s needed when it’s needed
- Identify and tackle obstacles
- Myth-busting info/advice
- Work-focused healthcare:
  - deal with biomedical issues whilst supporting early return to work
  - psychosocial problem-solving
- Workplace accommodation
  - ease the worker back to usual duties
- Communication between the players to interweave the actions
Who is involved in RTW

Person  ↔  Line Manager

Clinician Ergonomist can facilitate or sabotage
Question of balance

- Enough of what’s good
- Minimise what’s not

- Stepped care is optimal
  - recognising the limitations of medical/clinical intervention
    - not all health problems are medical issues
Stepped approach “just what’s needed when it’s needed”

1. **< 2 WEEKS**
   - Provide support
   - Evidence-based advice
   - Myth busting
   - Symptom control

2. **2 TO 6 WEEKS**
   - Light intervention
   - Healthcare + workplace accommodation
   - Identify psychosocial obstacles
   - Develop plan for early RTW/activity

3. **6 TO 12 WEEKS**
   - Shift up another gear
   - Check for ongoing obstacles
   - Expand vocational rehabilitation approach
   - Cease ineffective healthcare

4. **> 12 WEEKS**
   - Multidisciplinary approach
   - Revisit plan and goals
   - Consider cognitive behavioural programme
   - Maximise RTW/activity efforts by all players

5. **> 26 WEEKS**
   - Move to social solutions
   - Provide signposting + ongoing support
   - All players maintain communication
   - Avoid unnecessary medical intervention

Timeframes - progressively fewer people remain as time passes - step times are approximate
Beliefs

- Beliefs are central to what we do about injury and disease
  - about whether to rest
  - about whether to seek treatment
  - about whether to work
  - about what it means for the future
- People don’t cope too well when they are uncertain

- Health myths abound
  - held by clinicians as well as by the public
- Myths are major obstacles to work participation
Popular myths:

- Rest always needed until pain goes
- It's a health problem, so there must be a cure....
- It hurts at work, so I was damaged by my work
- Working whilst ill or ‘injured’ will just make matters worse
- No return to work until 100% fit
- Modified work means work was unsafe
We need to shift the culture

Working while recovering
Key players must be onside and acting

- Poor communication is a major obstacle
Dispelling myths and shifting the culture

Set of guidance material developed
- 3 leaflets
- common set of messages
- focus on how players interact
- evidence-based
- believable and doable
- wide stakeholder support
- target the key players
Workplace

- Players in and around the workplace
  - senior management • line managers • human resources • small employers • unions • health & safety advisers • occupational health professionals • rehabilitation providers • employment advisers • claims handlers • lawyers
- 6 pages of information + practical advice on RTW procedures
  - PDF downloads

www.tsoshop.co.uk/evidence-based
Workers-patients

- Leaflet for patients/workers
  - straightforward language
  - distribution by healthcare and employers
  - information, practical advice + stories
    - PDF downloads
    - Also 20 page booklet in style of The Back Book

www.tsoshop.co.uk/evidence-based
Healthcare

- Leaflet for health professionals
  - discusses evidence on work and health
  - practical advice on how to tackle this difficult topic
- 6 pages
  - + 1-page e-summary
  - PDF downloads

www.tsoshop.co.uk/evidence-based
Downloadable resources
sick note

Statement of Fitness for Work
A guide for General Practitioners and other doctors

to

fit note

This guide has been developed in partnership with the Royal College of General Practitioners and the British Medical Association.

DWP Department for Work and Pensions
Fit note

It’s a great idea, but the doc generally has limited understanding of the work or workplace.

Recommendations will need to be interpreted.......

### Statement of fitness for work

For social security or Statutory Sick Pay

<table>
<thead>
<tr>
<th>Patient’s name</th>
<th>Mr, Mrs, Miss, Ms</th>
</tr>
</thead>
</table>
| I assessed your case on: | /
| and, because of the following condition(s): | |
| I advise you that: |  |
|  | you are not fit for work. |
|  | you may be fit for work taking account of the following advice: |
| If available, and with your employer’s agreement, you may benefit from: | |
|  | a phased return to work |
|  | amended duties |
|  | altered hours |
|  | workplace adaptations |
| Comments, including functional effects of your condition(s): | |
| This will be the case for | |
| or from | / / to / /
| I will/will not need to assess your fitness for work again at the end of this period. |
| (Please delete as applicable) | |
| Doctor’s signature | |
| Date of statement | / /
| Doctor’s address | |

[Sample Form]

Med3 04/10
Interpreting the work modification boxes

- **Altered hours**
  - Reduced work hours/days
  - Additional rest breaks
  - Allow work at home

- **Phased return to work**
  - Flexible start-finish times
  - Graded return to work
  - Start work on a Wednesday
  - Selected duties

- **Workplace adaptations**
  - Reduce reaching
  - Provide seating
  - Reduce weights
  - Different department

- **Amended duties**
  - Achievable goals, scheduled at start of day
  - Reduce pace of work
  - Reduce task frequency
  - Increase task variety
  - Co-worker as buddy
The nature of workplace accommodation

- Temporality is key
- Transitional work arrangements
  - Temporary facilitation of SAW or RTW
  - Goal is return to usual work
  - Not an indictment of the job

DON’T SIT DOWN CAUSE I'VE MOVED YOUR CHAIR
  - Arctic Monkeys 2011
Worker knows best

- Participatory ergonomics
  - Involve person:
    - identifying the obstacles
    - selecting the solutions

- Communication
  - person
  - line manager
  - clinician
Whither healthcare?

- Treatment may be needed, but
  - beware iatrogenesis:
    - what is said can undo what is done
- More and better health care alone is not the answer!
- Health care needs to work to a new integrated paradigm:
  - recovering while working
  - work with employer and worker
Whither prevention?

- Preventive intervention alone will have little impact on common health problems among workers.
  - Undue emphasis on ergonomic solutions may engender counterproductive beliefs

- More and better ergonomics alone is not the answer!

- Yet, ergonomics does have a major role in return-to-work and work-retention programs.
  - Workplace accommodation
  - Implementing fit note recommendations
‘work should be comfortable when we are well, and accommodating when we are ill or injured’

Nortin Hadler (1997)

Thanks for letting me talk with you

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