tackling
musculoskeletal problems

identifying obstacles using the psychosocial flags framework

Kim Burton
Centre for Health and Social Care Research
University of Huddersfield
kim@spineresearch.org.uk

Work is what defines us: "... and what do you do?"
So, it's what we do – but what does it do to us?

WORK HEALTH

DWP commissioned a review of the evidence to answer the question:
- Is work good for your health and wellbeing?

G Waddell, K Burton

workingforhealth.gov.uk | resources | downloads

IOM 40th Anniversary Seminar - From Coal to Carbon Nanotubes
19th June 2009
Overview

- Unemployment is bad for physical and mental health.
- Work can reverse the adverse health effects of unemployment.
- Clinical management of common health problems involves work as therapy.
- Beneficial effects of work greater than harmful effects of long term unemployment or prolonged sickness absence.
- Strong case that work is generally good for health.
  - True for people of working age generally, for many disabled people, for most people with common health problems, and for social security recipients.
  - Social and moral responsibility to help people with health problems stay in or get back to work.

Vocational rehabilitation

- A review for UK Vocational Rehabilitation Task Group.
- To provide an evidence-base for policy.
- G Waddell, K Burton, N Kendall.
- To assess the evidence on the effectiveness and cost-benefits of vocational rehabilitation interventions.

Timing determines the intervention

- Early (< 6 weeks absence): work-focused healthcare + workplace management.
- Later: more structured VR intervention needed.
- Long-term sick: focus on social obstacles, including help with re-employment.
- VR can be effective + cost benefits.
Dame Carol Black’s review

- Echoed those findings and developed ideas for implementation
- Fit for Work Service
- Gov’t’s response positive:
  - commitment to support local areas develop Fit for Work Services in a programme of piloting
- Remains to be seen precisely what the services will deliver, and how

Why do some people fail to RTW as expected?

- Whilst many people with episodes of musculoskeletal problems will RTW uneventfully, a large number do not
- Nothing different about their health condition.
- They face obstacles to recovery and participation:
  - bio-psycho-social factors that act to impede normal recovery and return to work.

The challenge: shifting the recovery curve
Shifting the curve is about overcoming obstacles

- Psychosocial Flags framework provides a way of thinking about obstacles
- The original Yellow Flags devised in 1997
  - Kendall, Main and Linton
  - Focus was on screening for people at risk
  - Personal and workplace variables not separated
- 2007: Flags Think Tank – Keele University
  - Looked at a decade of research, and moved ideas forward – conceptually and practically
  - Nick Kendall & Kim Burton charged with developing the Flags guide

Psychosocial Flags

Flags are:
- An aid to bringing the biopsychosocial model into everyday practice.
- An aid to understanding why some people don’t recover as expected.
- A method to identify and tackle obstacles to recovery or work.
- Signals: they point to the specific obstacles to recovery and 'Wt' in need of action.

N. Kendall, K. Burton, C. Main, P. Watson
www.tsoshop.co.uk/flags
3 domains:

- Psychosocial factors associated with unfavourable clinical outcomes and the transition to persistent pain and disability.
- Stem largely from perceptions about the relationship between work and health, and are associated with reduced ability to work and prolonged absence.
- Unhelpful systems, policies and people: may operate at a societal level, or in the workplace: they can block the helpful actions of healthcare and the workplace.

Andy’s predicament

“It all started when I woke up with severe neck pain. The doc gave me tablets and told me to rest and stay off work - but I didn’t get any better. I was sent for x-rays, which showed degeneration. Then I had to wait around to get treatment. The therapist said it was my job that caused it, so I shouldn’t go back till I was fully fit. By that stage I started to get really worried - and feeling down. The family won’t let me do anything, so I don’t get out much. The people at work haven’t been in touch, so I don’t know what's happening about me getting back. People are saying I should put in a claim. This whole saga has just taken over my life - all I wanted was a bit of help….”

What to do about it?

Identify flags, develop plan, take action.
### Important flags to identify

#### Person

- **Thoughts**
  - Catastrophising
  - Unhelpful beliefs and expectations about pain, work and healthcare
  - Negative expectation of recovery
  - Preoccupation with health
- **Feelings**
  - Worry, distress, low mood
  - Fear of re-injury
  - Uncertainty (about what's happened, what's to be done, and what the future holds)
- **Behaviours**
  - Extreme symptom report
  - Passive coping strategies
  - Serial ineffective therapy

#### Workplace

- **Employee**
  - Fear of re-injury
  - High physical job demand (perceived or actual)
  - Low expectation of resuming work
  - Low job satisfaction
  - Low social support
- **Workplace**
  - Lack of job accommodations/modified work
  - Lack of employer communication with employees
  - Social dysfunction in workplace

#### Context

- Misunderstandings and disagreements between key players (e.g., employee and employer, or with healthcare).
- Financial and compensation problems.
- Process delays (due to mistakes, waiting lists etc).
- Sensationalist media reports.
- Family member with negative expectations, fears or beliefs.
- Social isolation, social dysfunction.
- Unhelpful company policies/procedures
Obscured by clouds

- Beliefs are central to our responses to a health problem
- Beliefs → behaviour
- Urban myths and legends abound
  - major obstacles to successful rehabilitation and return to work.

Myths

**Myth: My health problem was caused by work.**

- Usually not!
  - CFTR have similar prevalence in non-workers and in adolescents.
  - Work may exacerbate symptoms, but that does not mean work caused the problem in the first place.

- False! In most cases, sick leave is not required:
  - most people stay at work, and come to no harm
  - In fact, working often helps people feel better

**Myth: Working whilst you are ill or injured will just make matters worse.**

- Usually not!
  - driven by the prevalence of long-term sick leave.

**Myth: A sick certificate means that you MUST NOT work.**

- Wrong! A sick note is not a medical order to stay off work.
  - It just says that you can’t do (all) your ‘usual’ job + eligibility for sick pay
  - you can arrange to get back to work at any time
  - ‘Fit notes’ are a better idea
  - can work with adjustments
Myths

Myth: Diagnostic tests are needed, followed by specific therapy.
- Actually, for most episodes, people with CHPs don’t seek healthcare
- Investigations are generally unhelpful
- Most treatments have a rather small effect size!

Myth: Modified work must be permanent
- No - most people return to their full usual job quite quickly
- Modified work should be seen as a transitional arrangement
  - a tool for helping early return

Overcoming obstacles to recovery and RTW

Beyond therapy

- Therapy alone can address symptoms but does not impact on participation (RTW)
- Tackling psychosocial factors is not a replacement for appropriate treatment
- It is a fundamentally important enhancement
  - can make the difference between effective and ineffective management
- Tackling psychosocial factors needs to be intertwined with therapy
Develop Plan – Key Players Communicate

- Key players combine information on obstacles
  - Use written confidentiality waivers
- Develop a plan for the person
  - Agree timeframe
  - Agree appropriate treatment
  - Agree workplace accommodation
- If lack of progress
  - Re-evaluate flags and identify new or changing obstacles
- Allocate key player: ‘case manager’

Healthcare intervention

- Timely delivery of effective healthcare
- Symptomatic relief + work focus
- Problem solving behavioural input is essential supplement
- A can-do approach
  - Avoid iatrogenesis
  - Cautious certification

Workplace intervention

- Involvement of employer critical
  - Maintain contact
  - Social support
  - Positive organisational attitudes and practice
  - Temporary modified work - if required
Transitional work arrangements

- Temporary modifications simply to gradually ease into usual work by getting over pertinent obstacles:
  - Alter the work:
    - reduce pertinent physical demands
  - Alter the work organisation:
    - reduce work pace/intensity
  - Flexibility
    - allow time for healthcare; home work

Stepped care

- only what’s needed when it’s needed

Stepped care approach

- < 2 weeks:
  - Provide support
    - evidence-based advice
    - myth busting
    - symptom control
  - 2-6 weeks:
    - Light intervention:
      - Healthcare + workplace accommodation
      - Identify psychosocial obstacles
      - Develop and implement plan for early RTW/activity
**Stepped care approach**

- **6-12 weeks**
  - Shift up another gear:
    - Check for ongoing obstacles
    - Expand vocational rehabilitation approach
    - Cease ineffective healthcare

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

**All players onside**

- believing the same things
- talking common language
- having a shared goal
- coordinating their actions…….

**Kamala’s role**

“We’re a small company with a simple protocol for managing pain and injury. It’s my job to put it into action. Basically, I act as a case manager with support from professionals, to coordinate things. I get informed at day one of absence, and stay in contact. I liaise with the doc, but also send our people to a local clinic. They tell me what my colleague can do (we use a confidentiality waiver), which helps me figure out how best to help my colleague back to work. They point out the obstacles and what needs to be done to overcome them, as well as giving treatment. I devise the Plan with my colleague and we sort out any work modifications as a team. I also use information leaflets to bust the myths. It works well!”
Shifting the culture

- Evidence-based information material has been developed:
  - common set of messages
  - myth-busting guidance
  - practical advice
  - separate material for the different players
    - evidence-based and evaluated
    - wide stakeholder support

Workplace

- Leaflet (+PDF) for professionals in and around the workplace
  - senior management • line managers • human resources • small employers • union reps • health & safety advisers • occupational health • rehabilitation providers • claims handlers • lawyers

Workers-patients

- Booklet
  - 22 pages - in style of The Back Book
  - also PDF leaflet
  - straightforward language
  - distribution by healthcare or employers

www.tsoshop.co.uk
spineresearch.org.uk
Healthcare

- Leaflet (PDF)
  - GPs and other healthcare practitioners
  - discusses evidence on work and health and what to advise for patients
  - can-do approach \(\rightarrow\) fit notes

www.tsoshop.co.uk
spinneresearch.org.uk

Implementation

- We know a lot of what to do:
- Most MSDs can be accommodated at work if:
  - all players work together
  - a flexible approach
  - communication communication communication

- Case management:
  - coordinate the process
  - negotiate between players
  - focus on overcoming obstacles

Hanson et al. HSE Research Report 493, 2006

Thanks for letting me talk with you

kim@spinneresearch.org.uk