

The psychosocial flags framework: overcoming obstacles to work

Dr. Kim Burton

**The Psychosocial Flags Framework:
Overcoming Obstacles to Work**



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Work is what defines us:



“...and what is it you do?”

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Traditional occupational health paradigm

Trauma → Injury / disease

Hazard → Worker → Harm

→ Focus on causal relationship ←

...a reasonable concept,
but doesn't explain all we see



Bernardino Ramazzini
1533-1714




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Safety vs. Health – conflicting paradigms

Reduce risks → Prevent the harm

-  Paradigm works for safety
e.g. falls from height
-  Paradigm works for occupational disease
with clear cause-effect
e.g. hazardous substances exposure
-  Paradigm doesn't work for other purported work-related conditions


4 Actually impedes understanding health ↔ work

The work ↔ health double effect



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

John Lennon, 1969



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Uncomfortable tension at the clinic ↔ work interface



So, should we keep people off work?

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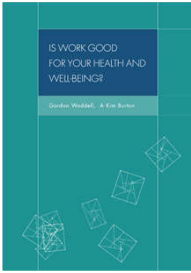
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Work ↔ Health

Is work actually good for your health and wellbeing?




UK Dept for Work & Pensions commissioned a review of the evidence to find out
G Waddell, K Burton (2006)



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Overview

-  Work is generally good for physical/mental health & well-being
-  Unemployment/unnecessarily prolonged sickness absence are generally bad for physical/mental health & well-being
-  Getting work can **reverse** the adverse health effects of unemployment
 - Proviso: depends on quality of work
 - **Work is essentially therapeutic** – helps promote recovery – leads to better health outcomes

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Focus: common health problems







- Less severe illnesses and injury
- Yet responsible for ⅓ of sickness absence and long-term incapacity
- **Low back pain** is a common health problem

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Common health problems

-  High prevalence across population
-  Characterised more by symptoms than disease or impairment
-  Coexisting symptoms common - physical and mental
-  Untidy episodic pattern: symptoms of 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

10 Most people remain at work or return to work quite quickly

Range of manifestations


It is important to distinguish between the different presentations:

Presence of symptoms

Reporting of symptoms

Attribution to work

- Work caused
- Work aggravated



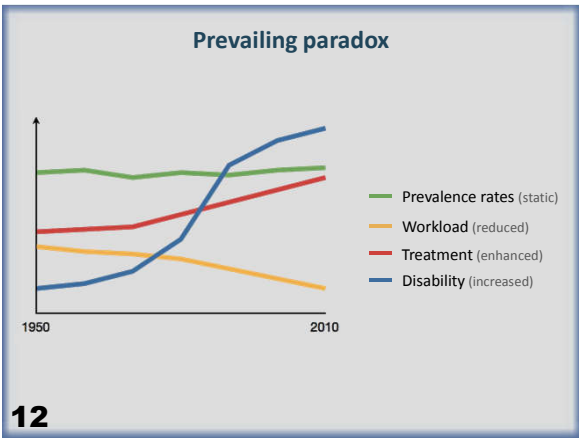
Objective injury/damage

Sickness absence

Long-term incapacity

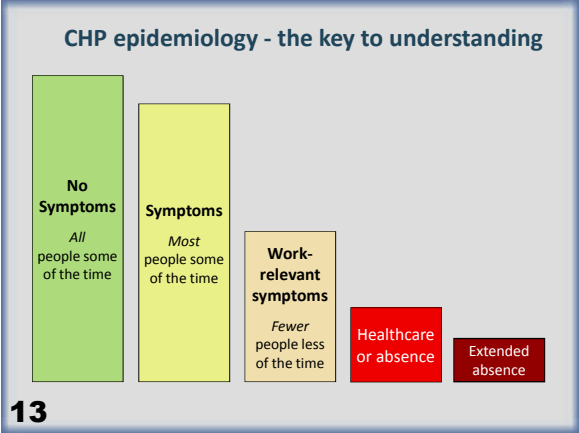
Disability

11 These have different determinants – role of work is inconsistent



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- Work-relevant symptoms
- Symptoms may affect workability
 - Symptoms may be more pronounced at work
 - Work may be difficult because of symptoms
 - Some cope - some struggle
 - Struggler → sick leave → disability
 - **Working while recovering**
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What is a health outcome?

Depends on who you are and where you are:



➔

- 1** Subjective reduction in symptoms - LESS
- 3** Work participation - SAW or RTW

- These are not equivalent
- No linear path!


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Work is an important health outcome

Work can be part of the recovery process

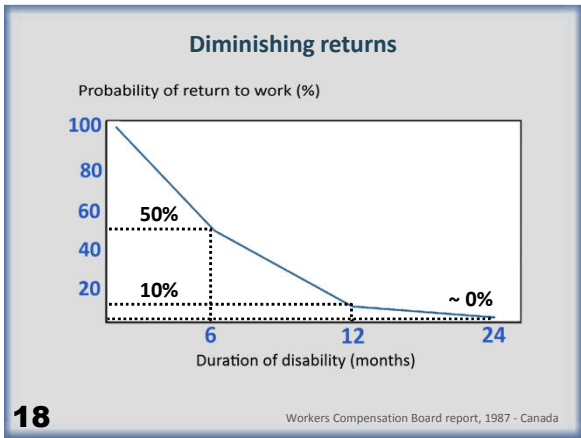
Provides protective factors

Timely return to work is crucial



- Structure to the day
- Social contacts
- Self-esteem

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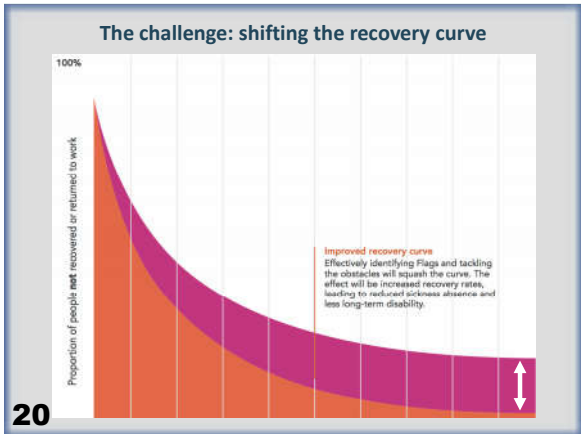
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The slide to disaster
Social constructs → escalating obstacles

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



19 Adapted from Hadler

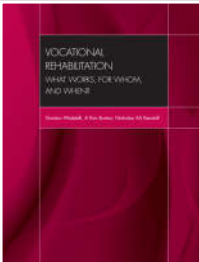


Vocational rehabilitation

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



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

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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 while recovering**



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So, why do some people become disabled?

! They **do not** have a more serious health condition or more severe injury

Not about **what** has happened to them; rather its about **why** they don't recover

🚶 They face **obstacles** to recovery and participation

→ **biopsychosocial approach**

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Biopsychosocial model of disability

SOCIAL	Context, systems, culture	Allows for interactions between person and environment
PSYCHO-	Illness behaviour, beliefs, coping strategies, emotions, distress	Addresses personal and psychological issues
BIO-	Neurophysiology, physiological dysfunction, tissue damage	Recognises biological factors

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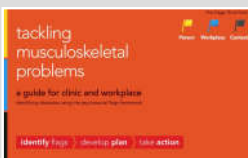
The Obstacles Model
Overcoming obstacles to work participation

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Tackling musculoskeletal problems

Psychosocial Flags Framework
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

- Flags are about identifying obstacles to being active and working
- Combining work-focused healthcare with an accommodating workplace:

26 — All players onside - consistency, coordination and collaboration

Important flags to identify - Person /

- **Thoughts**
 - Catastrophising (focus on worst possible outcome, or interpretation that uncomfortable experiences are unbearable)
 - Unhelpful beliefs and expectations about pain, work and healthcare
 - Negative expectation of recovery
 - Preoccupation with health
- **Feelings**
 - Worry, distress, low mood (may or may not be diagnosable anxiety or depression)
 - Uncertainty (about what's happened, what's to be done, and what future holds)
- **Behaviours**
 - Extreme symptom report
 - Passive coping strategies
 - Serial ineffective therapy

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identify flags → develop plan → take action

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Important flags to identify - Workplace /

- **Employee**
 - Fear of re-injury
 - Low expectation of resuming work
 - High physical job demand
 - o Perceived or actual
 - High mental job demand
 - o Feeling of being 'stressed'
 - Low job satisfaction
- **Workplace**
 - Lack of job accommodations/modified work
 - o Perceived or actual
 - Lack of employer communication with employees
 - Low social support or social dysfunction in workplace


28 identify flags → develop plan → take action

Important flags to identify - Context /

- Significant others with negative expectations or beliefs
 - Family
 - Line manager
 - Healthcare
- Unhelpful policies/procedures used by company
 - Discourage early return, require medical report
- Process delays
 - Waiting lists, claim acceptance etc.
- Role ambiguity or disagreements between key players
 - Employee <> employer <> healthcare
- Financial, compensation or legal issues

29 identify flags → develop plan → take action

Identification of flags



Ask the right questions

- Common sense
- Integrate with clinical consultation

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**Identifying flags:
Useful stem questions**

- 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?

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Work ability screening

Work Ability House

Work ability index: measure of how people feel they are coping with work & health

Helps detect possible work-relevant health problems

Clinically, it can be estimated with one question.....

Ilmarinen J. Work ability - editorial. *Scand J Work Environ Health* 2009;35:1-5

Finnish Institute of Occupational Health

Work ability question

“Assume that your work ability at its best has a value of 10 points. How many points would you give your current work ability?”

Completely unable to work **0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10** Work ability at its best

Scores 8 to 10: probably able to stay at work (or return) with little help

Scores 3 to 7: diminished ability to work - at risk - you need to identify obstacles/flags

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Andy's predicament

"It all started when I woke up with severe back 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 said I should put in a claim: the solicitor sent me to a specialist so it must be serious. This whole ongoing saga has just taken over my life - all I wanted was a bit of help...."

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develop plan → **take action**

Smarter management

Agree RTW plan with the person

Early intervention

- Identify & address obstacles
- Myth busting info

Coordination

Healthcare: work-focused

- Deal with bio issues whilst supporting early RTW
- Psychosocial problem-solving

Workplace: accommodating

- Transitional work arrangements

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develop plan → **take action**



- ✓ Communication
- ✓ All players onside and acting!

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The role of healthcare



- Complex and difficult
 - Focus is on clinical care
 - Not well integrated with work

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Observational study of people seeing doc with LBP




What patients want...

85%	81%	1/3
How to manage the back pain problem	How to resume usual activities	Time off work, referral for diagnostic test, or physiotherapy

38 LeRiche et al. 1996

What docs did...



None inquired into the patient's goals for the visit!

6-32%	85%	40%
Asked about pain-related limitations in work or leisure	Given a medical diagnosis	Received explanations of disc disorders, muscle disorders or both
Usually volunteered by the patient not elicited by the clinician		

39 LeRiche et al. 1996


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Words that do harm

- What is said can be a major obstacle to early RTW (or SAW)
- The words the clinician uses are very powerful

“It probably happened because of your work”



“You really need some time off”

“These things don’t really get better you know”

“If it doesn’t improve, I’ll have to send you for tests”

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Therapy



- It’s possible to deliver
 - Useless treatments efficiently
 - Effective treatments inefficiently
- ☹️ both will have negative impact
 - Individual with the problem
 - Waste of resources

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**Over servicing:
What ‘messages’ does the worker get?**

-  There is a problem needing treatment
-  The treatment will cure the problem
-  Pain reduction is necessary before rehab
-  The clinician is responsible for getting you better (patient has passive role)
-  The problem should have been prevented

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Stepped approach “just what’s needed when it’s needed”

- In the early stages most people do not require much intervention
- For most people after two or more weeks only light intervention is necessary

0-2 WEEKS
provide support
- evidence-based advice
- myth busting
- symptom control

2 TO 6 WEEKS
Light intervention
- reassurance + workplace accommodation
- identify psychosocial obstacles
- develop plan for early return/activity

6 TO 12 WEEKS
shift up another gear
check for ongoing obstacles
- avoid vocational rehabilitation approach
- once ineffective reassurance

>12 WEEKS
Multi-disciplinary approach
- consider return to work goals
- monitor return to work performance
- increase return/activity efforts by all players

>26 WEEKS
need to make decisions
- provide counselling + emotional support
- workplace return
- avoid unnecessary medical intervention

initial early persistent

These frames - progressively fewer people remain as time passes - step times are approximate
www.tsoshop.co.uk/flags

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Beliefs

Are central to what we do about injury and disease
Beliefs drive uncertainty

- Health myths abound
 - Held by clinicians as well as by the public
- Uncertainty and myths are major obstacles to work participation

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Myths:

- Rest always needed until pain goes
- It's a health problem, so there must be a cure...
- Working whilst ill or 'injured' will just make matters worse
- It hurts at work, so I was damaged by my work
- No return to work until 100% fit
- Contacting absent worker is intrusive


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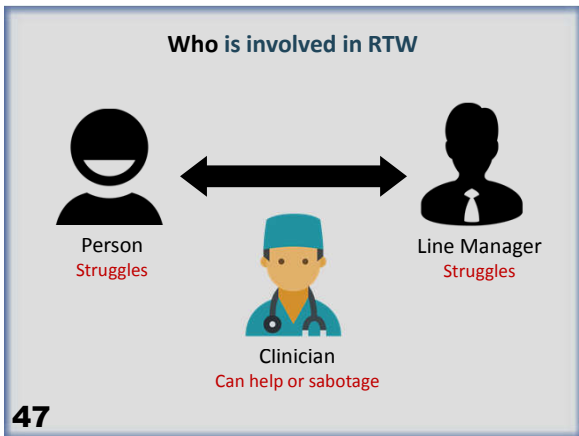
Dispelling myths and shifting the culture
HEALTH WORK WELLBEING

- Condition-specific evidence-informed educational booklets
 - Simple information and self-management advice
- 3 evidence-informed leaflets: Workplace, Worker, Healthcare

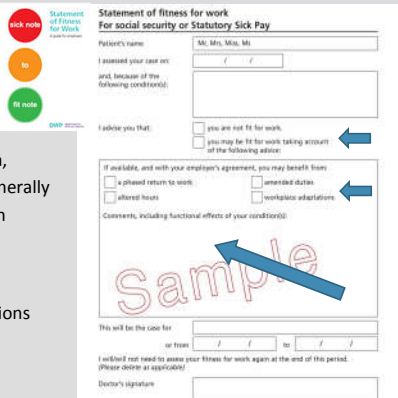


Consistent messages for all the players

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



Fit Note



It's a great idea, **but** the doc generally has little notion of the work or workplace

Recommendations will need to be interpreted...

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The line manager's predicament

- Interpretation of medical advice can be tricky
- Need confidence and knowledge
- Clear advice from clinician

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- ↓ work hours/days
- + rest breaks
- Allow work at home

- ↓ reaching
- Provide seating
- ↓ weights
- Different department

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

- Achievable goals, scheduled at start of day
- ↓ pace of work
- ↓ task frequency
- ↑ task variety
- Co-worker as buddy

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The nature of workplace accommodation

- **Temporary** modifications
 - To facilitate RTW or SAW
 - Goal is return to usual work
 - *Not* an indictment of the job
- Worker knows best
 - About work difficulties
 - About suitable modifications

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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:
 - Work-focused healthcare
 - Liaise with employer and worker
 - Working while recovering

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We need to shift the culture

Working while recovering

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‘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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