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?"

Traditional occupational health paradigm

Trauma --- Injury / disease
Hazard --- Worker --- Harm
Focus on causal relationship

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

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Safety vs. Health – conflicting paradigms

- 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
  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

Uncomfortable tension at the clinic ↔ work interface

So, should we keep people off work?

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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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Work ↔ Health

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

Focus: common health problems
• Less severe illnesses and injury
• Yet responsible for ½ 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
- 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

These have different determinants – role of work is inconsistent

Prevailing paradox
- Prevalence rates (static)
- Workload (reduced)
- Treatment (enhanced)
- Disability (increased)

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CHP epidemiology - the key to understanding

The elephant in the room

Symptoms exist irrespective of the nature of work!

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:

- These are not equivalent
- No linear path!

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What is a health outcome?

1 Subjective reduction in symptoms
2 Work participation – SAW or RTW

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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Diminishing returns

Probability of return to work (%)

50% 10% ~ 0%

Duration of disability (months)

6 12 24

Workers Compensation Board report, 1987 - Canada

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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

Adapted from Hadler

The challenge: shifting the recovery curve

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.toshop.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

So, why do some people become disabled?

- \underline{They do not have a more serious health condition or more severe injury}
- \underline{Not about what has happened to them; rather it’s about why they don’t recover}
- \underline{They face obstacles to recovery and participation}
  ➔ biopsychosocial approach

Biopsychosocial model of disability

- **SOCIAL**
  - Context, systems, culture

- **PSYCHO-**
  - Illness behaviour, beliefs, coping strategies, emotions, distress

- **BIO-**
  - Neuropsychology, physiological dysfunction, tissue damage

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The Obstacles Model
Overcoming obstacles to work participation

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

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

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

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?

Work ability screening

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

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
Andy’s predicament

“It all started when I woke up with severe back pain. The doctor 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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Hyena Stewart Talks

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Coordination

Smarter management

Agree RTW plan with the person

Healthcare: work-focused

– Deal with bio issues whilst supporting early RTW

– Psychosocial problem-solving

Early intervention

Workplace: accommodating

– Transitional work arrangements

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✓ 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

Observational study of people seeing doc with LBP

What patients want...

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

What docs did...

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

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

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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”

Therapy
• It’s possible to deliver
  – Useless treatments efficiently
  – Effective treatments inefficiently
  ☒ both will have negative impact
  – Individual with the problem
  – Waste of resources

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

- Rest
- Seek treatment
- Work

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

**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
- Contacting absent worker is intrusive
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Dispelling myths and shifting the culture
- Condition-specific evidence-informed educational booklets
- Simple information and self-management advice
- 3 evidence-informed leaflets: Workplace, Worker, Healthcare

Who is involved in RTW
- Person
  - Struggles
- Line Manager
  - Struggles
- Clinician
  - Can help or sabotage

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

Altered hours
- ↓ work hours/days
- + 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
- ↓ reaching
- Provide seating
- ↓ weights
- Different department
- Achievable goals, scheduled at start of day
- ↓ pace of work
- ↓ task frequency
- ↑ task variety
- Co-worker as buddy

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

We need to shift the culture

Working while recovering

‘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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