Managing chronic pain in the workplace

MICHAEL K. NICHOLAS PhD

Despite the general agreement that work is good for mental and physical wellbeing, and that return to work as soon as possible after a work injury is important for a worker's long-term health and financial security, the means of achieving this outcome is not simply a matter of finding better treatments or better skilled healthcare providers.

For several years a key element of the generally recommended approach to managing injured workers with soft tissue injuries, such as nonspecific back pain, has been to encourage them to return to work (RTW) as soon as possible, even if symptoms (e.g. pain) are persisting.[1] A substantial body of evidence supports this approach, especially when it is facilitated by the employer.[2] This includes evidence of longer-lasting recovery, a more sustained RTW and greater physical and mental health benefits for those who are able to RTW and stay there, compared with being on a pension, for example.[3,4] This perspective is reflected in the consensus report by the Royal Australasian College of Physicians Australasian Faculty of Occupational and Environmental Medicine, which concluded that work is generally good for health and wellbeing, and that long-term work absence, work disability and unemployment generally have a negative impact on health and wellbeing.[5]

Key points

- **It is generally agreed that work is good for health and wellbeing, and that long-term work absence, work disability and unemployment generally have a negative impact on an individual's health and wellbeing.**
- **There is growing evidence that for a worker to sustain their return to work after injury, despite any persisting pain, a system-wide approach is required rather than just a clinical one.**
- **Helping an injured worker achieve a sustained return to work should encompass a biopsychosocial perspective to achieve the best outcomes possible.**
- **Interventions need to address the health issues (treatment), workplace modifications and service co-ordination between, for example, the injured worker, treatment providers, the insurer and the workplace.**

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In contrast to the documented health benefits of work, the potential financial and health penalties for staying off work and ultimately not returning to work can be substantial. It has been found that a major reason why middle-aged people leave the workforce early is back pain and the consequences for their personal finances are often severe, with much less retirement income available to them.[6] From a clinical management perspective, there is also good evidence that the longer an injured worker is away from work initially, the greater their chances of never returning to work.[7] Given that most of these people will consult their GP and the crucial role played by the GP in co-ordinating care, it is clearly important that the GP and others working in primary health care ensure they have a good appreciation of their role in facilitating RTW for recently injured workers.[8]

Although the evidence in favour of RTW as soon as possible has been compelling, its pursuit should not be oversimplified. Some researchers have asked questions such as: 'is it just any work, or only certain work?'.[9] This is important as it brings in the role of the workplace in RTW and indicates that RTW is not determined by medical treatment alone. This was a key outcome of a recent systematic review of the occupational rehabilitation literature that concluded the best RTW outcomes were associated with treatments that included engagement with the workplace.[2] In other words, RTW after injury and in the presence of persisting pain is less likely without addressing the steps that might bring this outcome about.

Examples of the problems confronting healthcare providers in achieving sustained RTW outcomes that are often outside the control of the treatment providers can be seen when there is an adversarial element present, not just on the part of the injured worker, but also when there is a disputed workers compensation claim or an uncooperative employer.[10-12] Further complicating matters, there can be quite different perceptions about the role of treatment providers held by the primary care providers and the insurance claims staff.[13]

There is growing evidence (and agreement) that for a worker to sustain their RTW after injury, despite any persisting pain, a system-wide approach is required rather than just a clinical one. If sustained RTW is a major goal for treatment, this means the healthcare providers involved must work in a collaborative way with other key stakeholders and should not expect their treatment and interactions with their patient to be sufficient.

A system-wide approach

An overarching perspective on a system-wide approach to RTW ranged from the macro (system level) to the micro (individual patient level) and it provides a useful framework for all those interested in this field, including government regulators, employers, clinicians and their patients, as well as researchers.[14] For the clinician, however, the challenge of helping an injured worker achieve a sustained RTW comes down to three broad domains:

- health focus (e.g. treatments)
- workplace modifications (e.g. arranging suitable duties, limiting work hours)
- service co-ordination (e.g. case management by the insurer or rehabilitation providers that provides the necessary linkages between the injured worker, treatment providers, insurer and workplace).[2]

This article considers each of these three categories, and assume that the primary focus is the most common of workplace injuries – musculoskeletal or soft tissue injuries such as back or neck pain – a large proportion of which often end up as chronic pain conditions.

Interventions need to address the physical aspects of an injury, the psychological aspects (according to assessed need) and the social (workplace) issues.

Health focus

In part, the approach to treatment will depend on the stage of injury. In the initial (acute) stage soon after the initiating event there will be more focus on diagnosis and treatments for the identified (or presumed) underlying cause of pain, whereas the pain will be managed with simple analgesics. A recent review of guidelines for acute low back pain included education (explaining the basis of the pain), reassurance and instruction on self-management options, encouragement to return to activity and possibly a trial of paracetamol, NSAIDs or spinal manipulation.[15]

But if the pain persists despite these initial treatments, and investigations have excluded serious pathology, the focus of treatment will soon shift to resuming function (including RTW) despite the pain. Thus, the guidelines for chronic back pain typically include activities such as exercise and multimodal rehabilitation (i.e. combined physical and psychological treatment).[15] The shift in focus to restoration of function is likely to require additional resources and one way of thinking about the evolving intervention process has been called a 'stepped-care' approach. It has been argued that the stepped-care approach, relative to offering all possible treatments initially, has potential advantages in that it involves the judicious use of resources and time given that most cases with musculoskeletal or soft tissue injuries will recover without incident.[16,17] In many ways this is a 'wait-and-see' approach, and although it has attractions for resource utilisation, there are also drawbacks.

Recent evidence suggests that the common risk factors for delayed recovery can be present around the time of injury or soon afterwards and delays in dealing with those that are modifiable may provide time for them to 'fester', to the long-term detriment of the patient.[18] Chief among these risk factors are what have been called psychosocial factors, commonly referred to as 'yellow flags'.[19] These include depressed mood, anxiety, fears, beliefs/expectations of delayed recovery and the belief that activities that might aggravate pain should be avoided. It is not difficult to see that if these issues are left undetected and unaddressed they could easily pose a risk to speedy recovery and RTW, especially as pain, for example, can persist in 20 to 30% of musculoskeletal injury cases for up to one year or more.[17] From this perspective, a stepped-care approach could miss the

opportunity for early intervention. This concern has led to attempts to triage and stratify or match care according to the nature or degree of presenting problems.[20,21]

Fortunately, these psychosocial risk factors can be detected within days of the injury by brief self-report screening scales, such as the 10-item Orebro Musculoskeletal Pain Screening Questionnaire (OMPSQ).[22,18] It has been concluded from multiple randomised controlled trials that, in general, when psychosocial risk factors are minimal, usual care will be sufficient, but when these risk factors are prominent, additional measures will be required to evaluate and treat these risk factors.[19,23] This means engaging practitioners with skills in psychological interventions to address these psychosocial problems. But this should not be a stand-alone intervention either, as the next section will illustrate.

Workplace modifications

Examples of workplace modifications identified include modified duties and working hours, supernumerary replacements and ergonomic adjustments.[2] Changes in equipment, work design and organisation, working environment (e.g. reduced noise, vibration), work conditions (e.g. financial/contractual arrangements) and case management with the worker and their employer have also been included.[24]

Changes can also be made to the ways in which a job is performed. For example, activity pacing is a commonly used self-management strategy in pain management programs to help patients with chronic pain gradually upgrade their activity levels despite pain, and this can be translated to the workplace with the co-operation of the worker's employer.[25] It allows for the gradual upgrading of work duties (e.g. sitting, standing, carrying, typing) in a sustainable way and it means that initial activity limitations on a medical certificate can be seen as a starting point and not a permanent limitation. This is also reflected in the thinking behind the UK initiative known as the 'fit note' (as opposed to the 'unfit note').[26]

Other researchers have identified relationships and communications within the workplace as important contributors to poor outcomes as well. Failure to RTW, especially to stay at work, is quite predictable if the injured worker experiences or senses a degree of hostility or lack of acceptance and support by workplace management or their peers.[27] But these obstacles can also be modified. A recent trial found that when the supervisors of workers with back pain (and high scores for psychosocial risk factors on the OMPSQ) were assigned to either usual management or a composite intervention that included training in problem-solving and communication skills for both the injured workers and their supervisors, the composite intervention had significantly better outcomes over the following six months. The better outcomes included fewer days off work, improved perceived health and less healthcare utilisation.[22]

Not surprisingly, there can be opposition to these types of changes within the workplace. The employer, for example, may have concerns about costs, lack of modified duties, fear of re-injury or morale among other workers if one worker seems to be getting favourable treatment.[28] There are also counter arguments (e.g. cost and productivity, legal requirements, employee wellbeing), but regardless of the different arguments, it means that treatment for injured workers and their sustained RTW requires investigation of ways of developing collaborative relationships between the treatment providers, injured workers and the workplace to solve the identified obstacles. How this might be brought about is addressed next.

Service co-ordination

Co-ordinating treatments and workplace modifications is clearly crucial, lest the interventions lose their synchrony, thereby risking failure – to the detriment of all.

The need for case management (either by the insurer or rehabilitation providers) to provide the necessary linkages between the injured worker, treatment providers, insurer and workplace was identified.[2] Different health and injury management systems will likely use different providers in this role, and larger employers may have an in-house RTW co-ordinator, but the focus here is on the principles and tasks involved rather than who should do it. In this context, the need for improving communication both within the workplace and between the workplace and treatment providers was identified.[2] These might include the development of RTW plans (negotiated between the treatment providers, workplace and injured worker), as well as overall case management combined with the provision of education and training for the different stakeholders. An example of this can be seen in a recent study cited earlier.[22] But an integrated perspective on how this work might be performed via liaison between the injured worker, their workplace and primary care physiotherapist has been provided.[29]

Conclusion

Although an injured worker and their healthcare practitioner may prefer to see the worker's injury and its management within a purely patho-anatomical framework, the evidence summarised in this article has highlighted the importance of moving to a more biopsychosocial perspective to achieve the best outcomes possible. This means that if sustained RTW is a goal, interventions need to address the physical aspects of an injury, the psychological aspects (according to assessed need) and the social (workplace) issues (as relevant). Dealing with this range of tasks is likely to be beyond the capacity of a single practitioner or any single treatment in isolation. Accordingly, when all these risk factors are present, achieving sustained RTW after a work injury and the development of chronic pain is now recognised as a multifaceted series of tasks that range from the clinic to the workplace and encompassing the broader health care and insurance systems operating within any country. PMT

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A list of references is included in the online version of this article (www.painmanagementtoday.com.au).

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