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The experiences and expectations of return-to-work input in people with chronic pain: are we progressing?

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Background

Work is good for us; for both our physical and mental health and well-being and there are significant economic costs associated with worklessness[1,2]. Therefore it has been long advocated that returning people to work, or retaining those that are still in work, should be a major outcome of healthcare[1,2]. However, this has traditionally not been the case and it remains questionable as to the ability of healthcare clinicians to provide appropriate return-to-work (RTW) input and support[3]. People with chronic pain, such as those presenting to pain clinics, may have accessed various aspects of healthcare over a significant period of time[4], but little is known about this population's previous RTW input and, as such, whether they expect such input as part of their pain management.

Methodology

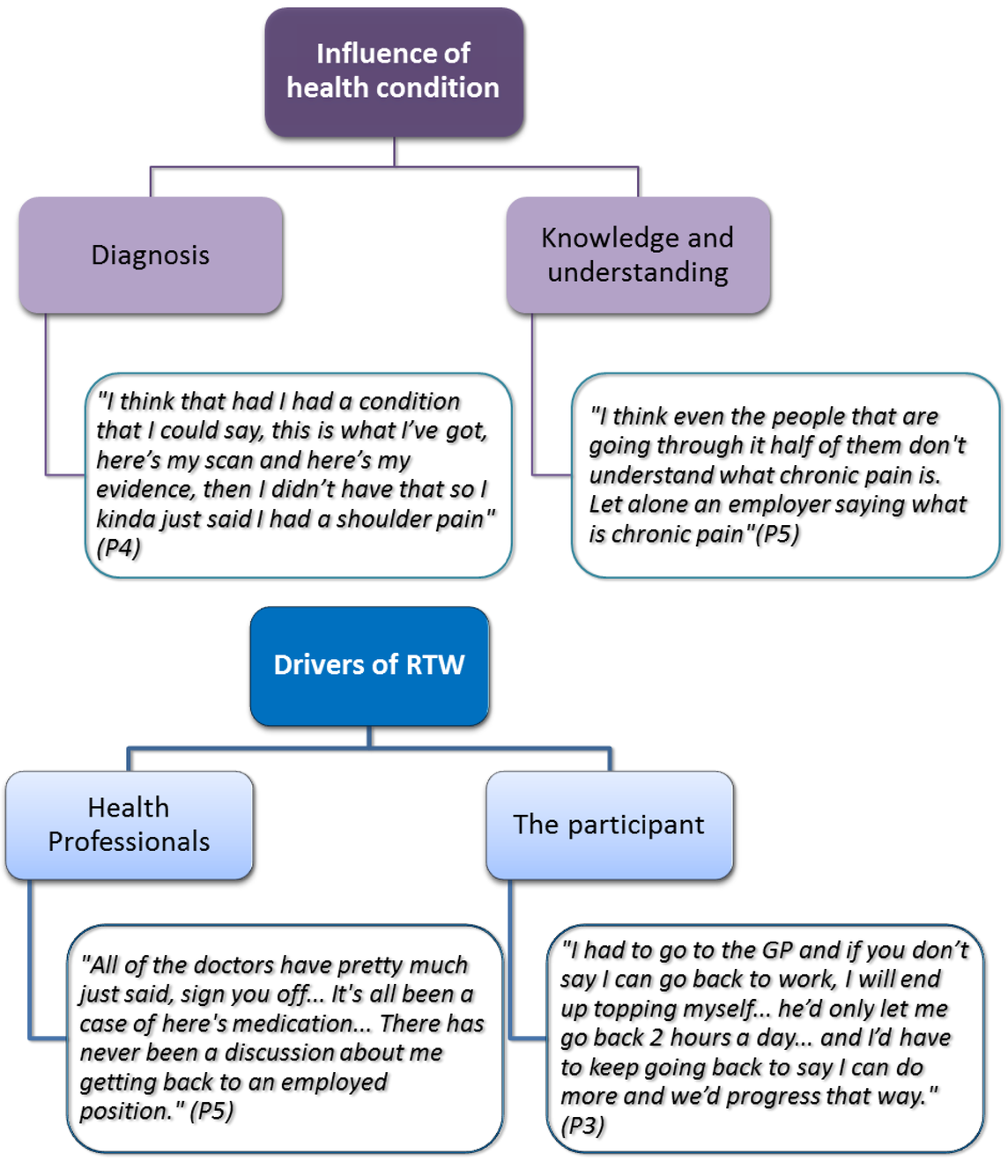
A qualitative approach using thematic analysis[5] via individual semi-structured interviews was most appropriate for the question. A purposive sample of 6 participants of adult working age were recruited from a hospital-based pain clinic, although only 5 were interviewed (see figure 1). The sample was deemed representative of a typical pain clinic[3,4].

Ethical approval was gained from Plymouth University's student ethics committee and the National Research Ethics Service (NRES) with the local NHS research and development (R & D) department.

Findings

Three emergent main themes, with relative sub-themes, were identified and are illustrated below. Generally participants reported little or no appropriate RTW input – or even discussion – from their GP or previous contact with physiotherapy. They did not also expect to receive RTW input from the pain clinic, although all subsequently received some form of RTW input.

Any RTW discussion was usually only associated with completing a sick note, which their GP appeared eager to do, but without an expectation or plan for them returning to work. This is despite a change in emphasis with the introduction of the so-called "fit note" in 2010 and the participants themselves were unaware of this change.



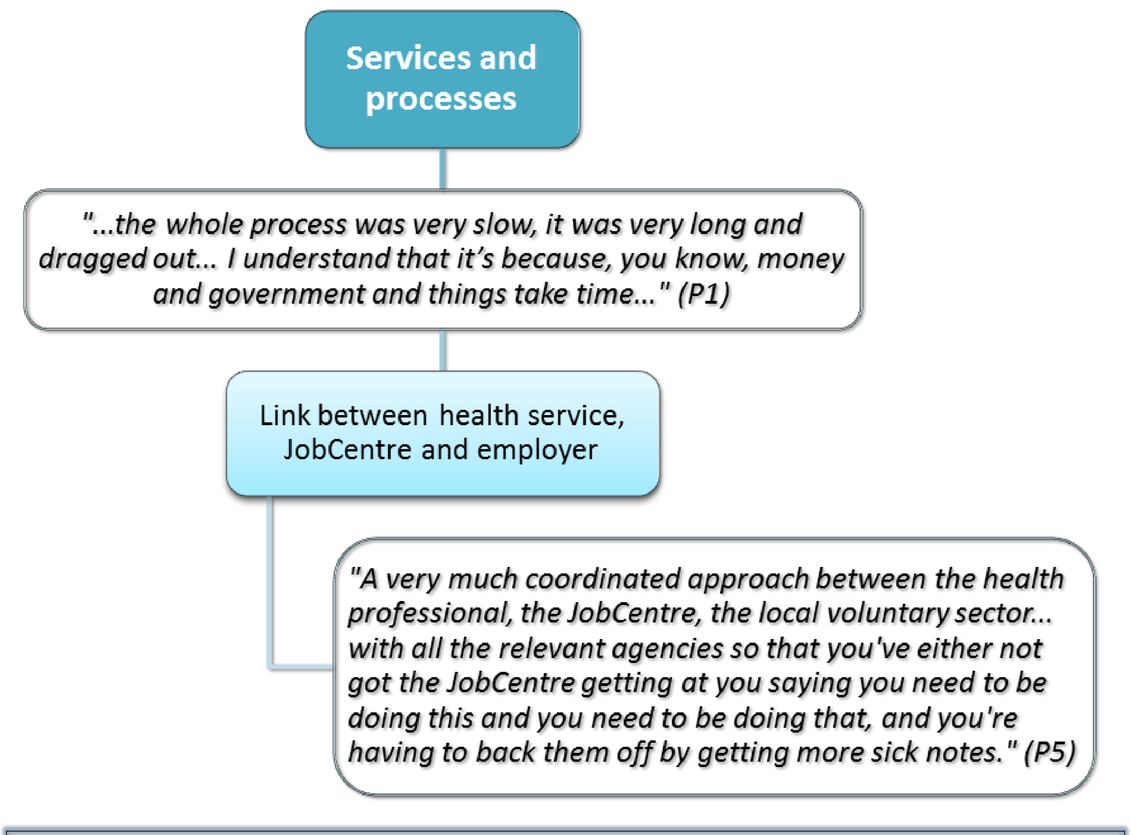
Aims and Objectives

The purpose of this study was to explore the experiences and expectations of RTW input in people, of working age, who have chronic pain. Specifically the objectives were:

- To explore the evaluated experiences of return-to-work input of users of a chronic pain service.
- To explore the expectations of receiving return-to-work input as part of a chronic pain service.

	Age and gender	Diagnosis and duration of condition	Stage of pain service management	Employment status and job type	State Benefit
1	22 Female	FMS >1 year	Completed pain management programme	Not employed (was in full time education 1 year ago)	JSA initially then ESA
2	43 Female	FMS >2.5 years	Recently assessed and started specialist pain physio and awaiting psychology	Not employed for years. Voluntary work – manager (flexible, part time)	None now was on IB, then ESA only 1 year
3	36 Female	CRPS (hands) 2.5 years	Recently assessed and started 1:1 specialist pain physio	Employed and at work full time. Call centre	None
4	37 Female	LBP (disc prolapse) 2 years	Recently assessed – to have 1:1 specialist pain physio	Employed. Off sick 3.5 months, planning to return in a few weeks. Office administrator.	None – occupation sick pay
5	49 Male	LBP 2 years	Currently undertaking pain management programme	Not employed. Last worked 2 years ago - public servant	ESA

Figure 1: Participant background data (ESA = Employment Support Allowance, JSA = Job Seekers Allowance, IB = Incapacity Benefit)



Conclusion

Any attempt to access RTW input and actually engage in it was nearly always initiated and driven by the individual with a sense of the system – itself slow and disjointed – working against them. Possibly as a result of these experiences, they were not expecting to receive RTW input through the pain clinic, despite expressing a desire to work and viewing it as a normal part of life.

Therefore, the evidence and associated policy/legislation changes advocating that RTW input should be a priority does not appear to have transitioned to practice. Further research to expand on this limited sample would be useful, particularly to see if the situation has improved with time and also to explore the reasons why RTW input does not appear to be a priority for health professionals like GPs.

References

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