BACK TO WORK: A VOCATIONAL PLAN FOR CHRONIC PAIN

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Abstract

In the past two and one half years, there has been impetus to develop a vocational program to supplement chronic pain services. Through involvement with the pain management program, it was found the team had designed a plan which addressed medical issues. Little to no discussion of vocational outlets and opportunities were provided to clients. Referrals for vocational evaluation identified significant needs and insight had been gained into specific vocational issues of individuals with chronic pain. Vocational evaluation referrals appeared to be premature. Clients demonstrated needs to comprehend roles of rehabilitation professionals, to clarify vocational goals, explore work opportunities, and to understand Worker's Compensation issues. A vocational component was created to address deficit areas and to provide a more holistic approach to chronic pain management. The purpose of this paper is to elaborate on the implications of developing and implementing vocational services to this specific population. The paper will present history and development of program, eligibility criteria, program content, benefits and limitations of program, and issues to consider in development and administration of program. The program is designed to educate the individual of rights and benefits, community resources, and roles of individuals involved in the rehabilitation process. The structure of the learning process is client oriented. Promoting the vocational component was difficult as it was not necessarily a priority issue while clients were in the rehabilitation facility. Obtaining sufficient blocks of time to administer interest inventories, work hardening programs, and career exploration activities was a major barrier to program development. The structure was very haphazard and sporatic. Often, interaction with clients occurred during dinner hour or free time which decreased motivation to participate in the vocational component. The program has progressed to a four week in-house plan with a six week outpatient follow up. The vocational component has become recognized as a valuable entity, particularly as rehabilitation professionals and insurance carriers express primary needs of returning their clients to work. The vocational structure now offers both individual and group didactic sessions. Work hardening activities have been incorporated into the fourth and final week of their stay at the hospital. There is a constant review of the program components and structural changes are made on a continual basis. The team is continually attempting to design a program that best meets the needs of the individual clients.

History

Rural communities traditionally have had special problems in meeting medical and rehabilitation needs of individuals in their communities. Often these needs are met through referrals to facilities in larger metropolitan areas. Hilltop Rehabilitation Hospital of Western Colorado has recognized the need to provide rehabilitation services which meet the ever changing rehabilitation needs of individuals in this region. Increases in industrial injuries have led to the development of rehabilitation services for individuals suffering from chronic pain. One of the newer programs initiated by Hilltop Rehabilitation Hospital is a Chronic Pain Management Program (CPMP) designed to meet the needs of individuals in rural communities of Western Colorado and Eastern Utah.

The staff designing this program utilized a multidisciplinary medical model approach. Members of the Chronic Pain Team consisted of an occupational therapist, physical therapist, neuropsychologist, physiatrist, family service representative, nurse, recreational therapist, and music therapist.

The program was initially designed to change the way an individual responds to pain. Programmatic goals included, but were not limited to, increasing functional ability and decreasing or eliminating pain medication.

As the program took form, referral sources including insurance carriers saw the benefits of expediting the client's return to work. It became evident that vocational and avocational activities were needed to further enhance the effectiveness of the program. To address this need, the Pain Team began a referral process to Hilltop Independent Living Center Vocational Evaluation Program. The vocational evaluator became a member of the Pain Team. Through this individual, a vocational component was established to assess vocational strengths and limitations of each client.

Upon initial contact with clients, it became apparent that a vocational evaluation was premature. Clients showed a lack of understanding concerning the roles of rehabilitation professionals, Worker's Compensation issues and demonstrated the need to clarify their vocational goals. In order to provide a more holistic approach to chronic pain management, the Independent Living Center, in cooperation with the Chronic Pain Management Team, designed a vocational component to address these deficit areas.

Eligibility Criteria

Individuals have been referred to the Chronic Pain Management Program by rehabilitation counselors, physicians, and through self referral.

Prior to acceptance into the program, a thorough screening process has occurred.

Physical and psychological screenings by the hospital's physiatrist and neuropsychologist have been initiated prior to a pain staff meeting. In the first staffing, the team has discussed appropriateness of the client in a group setting and his/her level of adaptability to the program's structure. Prior to admittance to the program, potential clients have been presented with information about their responsibilities and the program's responsibilities and expectations. Individuals then were able to decide if the program met their needs.

The team accepted groups of approximately three to five individuals who were scheduled as inpatients for three weeks, with six weeks of outpatient follow up services.

During the first week of the in-house program, each client was further assessed by modalities provided by the Pain Team. The vocational evaluator assessed the individual's vocational needs utilizing information provided through medical records, client group discussion, and communication with the referral source.

All individuals accepted to the CPMP were found to potentially benefit from information provided through the vocational component. Although not all individuals were found to be motivated or felt the need to return to work, it was the hypothesis of the staff that information regarding Worker's Compensation, work simplification, time management, rights and benefits, and counseling would assist client in developing an alternative lifestyle.

Design of the Vocational Program

The vocational component was designed to meet once a week for one hour discussions in group settings. The group explored their work history, work attitudes, motivation to return to work, financial status, present status in the rehabilitation process, knowledge of job seeking skills, and community resources. Depending upon each person's needs, a structure was designed to meet the individualized goals of each client. (Beck, 1985).

A great deal of discussion centered around issues of adjustment to disability. A filmstrip was presented to stimulate discussion regarding rights and benefits of individuals with disabilities, employment issues facing disabled workers, and ability versus disability.

Handouts were provided to clarify issues discussed within the group setting. Interest inventories were utilized to explore job families and identify transferrable skills for individuals considering job changes.

The vocational program also expanded into avocational areas and home management techniques. For example, homemakers were supplied information regarding adaptive cleaning tools. Those individuals opting to take an early retirement were able to explore adaptive equipment which aided in continued participation in hobbies.

After the first group completed the CPMP, it was discovered that the allotment of time for the vocational component was not sufficient to meet needs of clients. After discussing this problem with the Pain Team, an additional one hour lecture period was acquired.

Through program evaluation, it was found that group dynamics did not promote the most conducive environment for learning. Vocational staff felt individual one on one time would assist in building rapport and better support the client in active problem solving. One hour of four remained allocated for lecture and group discussion. Each client was seen on an individual basis approximately once a week.

Program Expansion

The program has been expanded to four weeks of structured inpatient activity with six weeks of continuing outpatient follow up.

During the first week, the vocational needs are assessed as in the original program. Particular emphasis of the client's overall status in the rehabilitation process is discerned. Basic explanations of rehabilitation professionals and their roles pertaining to the client's service needs are thoroughly explored.

A list of community resources describing service agencies and contact persons is disseminated. The opportunity is provided for clients to actively seek and make contact with community services if they feel it necessary. An interest inventory is presented for the client to complete during free time. At this point in the program, clients are contacted on a one to one basis and have had little to no involvement in a vocational group.

Upon completion of week one, pain patients gather for a one hour discussion of the interest inventory results. Job families, transferrable skills, and appropriate job goals are discussed in the group. (Matkin, 1983).

One to one client contact continues during the second week. Topics covered include advocacy issues, rights and benefits, 504 legislation, unemployment, civil rights issues, and employer attitudes as pertaining to people with disabilities. Client contact with professionals such as rehabilitation counselors and attorneys also takes place during this week.

During the third week, further exploration of job families takes place. A great deal of time is spent discussing adaptive equipment, funding sources, work simplification, and job modification. Concepts of job restructuring are introduced which allow the client to explore work alternatives such as flex time, job sharing, part time, and extended hours for work. Job seeking skills are reviewed with references given for interview skills and development of resumes and cover letters. Concerns and approaches for successful job interviews are presented. (Smith and Crisler, 1985).

The Work Hardening Program is introduced the fourth week to help clients increase physical and/or mental endurance necessary to participate in work activities. Work activities are provided and gradually increase in length of time and difficulty of task as the individual's tolerance increases. Clients are assigned separate job sites and are rotated in order to experience a variety of job demands. (Matheson, L.N., Ogden, L.D., Violette, K. and Schultz, K., 1985).

The follow up program for the vocational component is provided on an as needed basis. Vocational staff network with rehabilitation professionals and provide supportive services if necessary. Clients are encouraged to contact staff regarding additional information and services.

Program Limitations

When reviewing the structure of the vocational component, factors which enhanced or deterred client progress became apparent. With each client came special issues to consider in service delivery. Programmatic changes were made as limiting factors were recognized. Problem areas which were most apparent are discussed here.

Initially, the primary limitation in providing a vocational component revolved around scheduling problems and lack of time to disseminate adequate information. Of particular concern to both clients and vocational staff was the lack of time and available resources which could assist in explaining basic Worker's Compensation information clearly and concisely.

In addition, rehabilitation counselors occasionally expressed concerns that clients did not fully understand the role of the counselor. (Smith and Crisler, 1984). Services which explained roles of various professionals were requested. Conversely, other referral agencies simultaneously expressed concerns regarding duplication of services and reimbursement issues. Some rehabilitation professionals expressed concerns regarding compatability of vocational program plans provided by two separate agencies. Although the vocational component was designed to enhance and expedite meeting basic needs of clients, networking with a variety of referral sources was difficult and required an understanding of the individual philosophies of each agency. (Matkin, 1983).

A second issue in developing a vocational component was that of combining varied philosophies of Pain Team members. Philosophically, Pain Team members possessed two diverse ideas; medical model versus the community based model. The integration of these models became essential in order to build a successful vocational component for the program. (Margolis and Fiorelli, 1984).

Initially, the vocational component was considered an ancillary service for clients. Time sharing, inappropriate time slots, and general lack of time to schedule clients portrayed low priority for the vocational program. This appeared to influence the level of commitment clients expended in completing tasks.

Frequently, vocational information was presented during the client's free time and dinner hour. Sessions were rushed and clients had difficulty staying on task. Educating the Pain Team as to the extent of clients vocational needs became a factor in further expanding and establishing the vocational component as a viable service.

Additional limitations in developing effective programming for industrial injured individuals included lack of vocational opportunities for high salaried, blue collar workers. Often clients had obtained minimal education or possessed knowledge in one specialty area. If avenues for returning to previous occupations were blocked, clients frequently lacked vocational goals, motivation, or community resources to obtain training in an area which could employ them in their community.

To date, some of the earlier difficulties have been resolved. Through the growth of the program, new issues have surfaced. Transportation between residential and work hardening sites and lack of adequate job sites which provide the clients with meaningful work situations are examples of problems in rural and economically depressed areas at this time.

Program Benefits

Although problems were recognized while developing this program, benefits surfaced which staff feel enhance the clients rehabilitation process. Not only do clients demonstrate increased knowledge of the rehabilitation process, they also actively begin to take steps in problem solving, and express basic knowledge of local resources. Clients increase interactions with their rehabilitation counselors and/or attorney. This demonstrates how the client takes more control and responsibility in the rehabilitation process. (Smith and Crisler, 1985; Beck, 1985).

The vocational component emphasizes the need to broaden the CPMP from a strictly medical model to an integrated approach utilizing community and medical resources. This has led to a more cost effective program.

Individuals in the CPMP are no longer housed within the hospital, but reside in an apartment setting. A community setting is also available for work hardening programs which primarily take place in a modified industrial setting. Utilizing community resources, along with medical facilities, demonstrates how medical and community based models might function cooperatively.

Issues To Consider in Development of Vocational Programs

In our discussion of the vocational component thus far, we have considered such issues as team philosophy, concern over duplication of services, and increasing the number of professionals involved in a client's case, to name a few.

With program development and expansion, issues recur which are often difficult to resolve. This influences program effectiveness and demands attention from the Pain Team staff. Some of these issues are viewed as more universal, while others reflect programmatic problems in rural areas.

Programs in rural areas typically deal with additional burdens associated with the lack of an efficient transportation system. Frequently, clients must utilize professional services in larger neighboring towns. Networking with agencies in neighboring towns becomes more difficult in provision of services and follow up. Clients frequently have to rely on others to transport them to larger cities for

the screening process. This often contributes to postponing the client's involvement in an inpatient program. Thus, clients tend to meet less frequently with service providers which often delays progress in the rehabilitation process.

Job availability is frequently an issue in smaller towns having few, if any, nearby industries. This may necessitate clients to consider changing jobs or relocating for employment which again, creates networking, follow up problems, and social implications.

Delays in referring clients to rehabilitation services often create disincentives to work. (Huneke, 1982). Without knowledge of the rehabilitation process, the motivation and desire to return to work is often dampened. This may be compounded by compensation benefits which outweigh what most clients perceive they could make at a modified or unfamiliar job. (Huneke, 1982).

The client's readiness must be carefully considered throughout the program. Individuals who appear least enthusiastic often benefit greatly from information provided. Occasionally, individuals have not considered their vocational status and need encouragement to begin taking more responsibility in their rehabilitation process. Information presented during the first week of the inpatient program may not be significant until the second or third week when awareness increases and clients adjust to the program.

Issues of when to initiate work hardening programs and vocational evaluation need to be considered. Transportation, available staff, and simulated work sites appropriate to the client's situation all affect how these components can provide information and be utilized within the CPMP.

Motivating the client to return for the follow up Work Hardening Program needs to be further addressed by the Pain Team in conjunction with the insurance carrier. This will further enhance the client's progress obtained during the inpatient program. (Huneke, 1982).

Finally, means of evaluating, reviewing, and modifying the program should be considered early in the program development stage. Whether through follow up services, interagency communication, surveys, statistics, team meetings, or other methods, staff, client, and other agency satisfaction needs constant review.

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