

EFFECTIVENESS OF COMMUNITY AND WORKPLACE-BASED INTERVENTIONS FOR MSD ABSENCE

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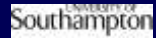


BACKGROUND

- MSDs are a major cause of sickness absence in western countries
- NICE has reviewed effectiveness of community- and workplace-based interventions to limit sickness absence and published advice on workers with MSDs
- But no quantitative estimates of benefit or assessment of possible publication bias

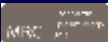


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AIMS

To assess the effectiveness of non-pharmacological interventions in workplace or community settings in reducing sickness absence and job loss and promoting return to work among workers with established MSDs

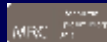


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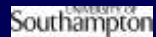


METHODS

- Extended NICE literature search to later date with additional terms, and checked citations in other relevant reviews
- Included RCTs and cohort studies from 1990 in which subjects were workers with MSDs
- Limited to studies which quantified relevant outcomes in relation to interventions delivered in primary care or workplace
- Data abstracted, checked and studies scored for quality

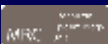


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SCOPE OF DATA

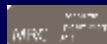
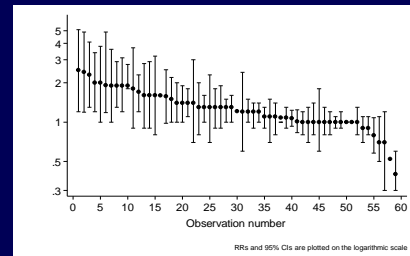
- 54 reports identified from 2156 screened
- 34 RCTs and 8 cohort studies
- Half on low back disorders and only two on upper limb disorders
- 30 prescribed exercises, 37 promoted behavioural change, 17 at workplace, 10 provided additional services
- Follow-up for 1 week to 5 years
- Median sample size 107 (IQR 77-148)



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RELATIVE RISK OF RETURN TO WORK FOR INTERVENTION V CONTROL

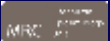


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ESTIMATED BENEFITS FROM INTERVENTIONS

| Outcome | Number of | | Median | (IQR) |
|---|-----------|-------------|--------|---------------|
| | Studies | Comparisons | | |
| RR of return to work | 25 | 59 | 1.21 | (1.00 – 1.60) |
| RR of avoiding job loss | 5 | 15 | 1.25 | (1.06 – 1.71) |
| Mean days/month of sick leave prevented | 21 | 41 | 1.11 | (0.32 – 3.20) |

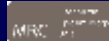


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ESTIMATED BENEFITS FROM INTERVENTIONS BY QUALITY AND SIZE OF STUDY

| Quality Score | RR to return to work | | Mean days/month of sick leave prevented | |
|----------------------|----------------------|-------------|---|-------------|
| | Median | (IQR) | Median | (IQR) |
| Low | 1.30 | (1.30-1.90) | 3.20 | (1.25-3.52) |
| Intermediate | 1.20 | (1.00-1.59) | 0.33 | (0.09-0.95) |
| High | 1.10 | (1.00-1.40) | 1.01 | (0.35-2.26) |
| High and large study | 1.00 | (0.85-1.20) | 0.30 | (0.20-0.40) |

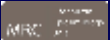


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ESTIMATED RR OF RETURN TO WORK BY INTENSITY OF INTERVENTION

| Estimated total hours of intervention | Number of | | RR of return to work | |
|---------------------------------------|-----------|-------------|----------------------|-------------|
| | Studies | Comparisons | Median | (IQR) |
| ≤6 | 6 | 11 | 1.30 | (1.20-1.35) |
| >6 – 12 | 2 | 6 | 1.80 | (1.33-2.08) |
| 12 – 32 | 8 | 14 | 1.45 | (1.10-1.85) |
| 33 – 70 | 3 | 6 | 1.09 | (1.08-1.18) |
| >70 | 2 | 5 | 1.00 | (1.00-1.00) |

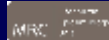


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CONCLUSIONS

- Benefits are generally small and of uncertain cost-effectiveness
- Expensive interventions should be implemented only with carefully planned evaluation of costs and benefits
- Future research should focus on cost-effectiveness of simple, low cost interventions, and impacts on job retention



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