Caring for Refugees: Chronic Pain and Employment

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Introduction

A frequent presentation to primary care doctors from any patient population is chronic pain. This can be debilitating, and in the case of the refugee, can add to job insecurity. At the same time, chronic pain can have unclear etiologies, presenting difficulty in treatment. This project aims to provide information to help providers best serve refugees with chronic pain and employment concerns.

A crucial step in integration of refugees into U.S. society is employment and self-sufficiency. Studies have demonstrated that employment is associated with better somatic and mental health (Jamil 2012). The nature of this relationship is complex and multifactorial, but there is certainly a role for the health care provider to promote health and the ability to work for his/her patients. This is particularly relevant in the first several years of entering the U.S.—studies have demonstrated that length of time in the U.S. is correlated with increased rate of employment (Jamil 2012, Capps & Newland 2015). The following sections will expand on some of the issues in the relationship between work, pain and health, examine the common presenting concerns of chronic, work-related pain, provide resources for counseling patients and outline resources available for patients who are struggling with entering the workforce due to poor health.

Work and chronic pain in refugee populations

A brief review of literature in OVID Medline was conducted, searching for "chronic pain" and "activities of daily living" as well as "chronic pain" and "refugee." Additional literature was found in relevant works cited or other works by these authors. The goal was to gain insight into the relationship of chronic pain, work and healthcare in the refugee experience. Where possible, statistics on prevalence are from U.S. refugee populations, but themes of refugee experience with employment and chronic pain are from studies in multiple countries.

Various studies have demonstrated that chronic medical conditions are more common than acute communicable disease in refugee populations. Of these chronic conditions, most are musculoskeletal complaints (Bischoff 2009). The most common musculoskeletal complaint is neck and lower back pain, others include chronic headaches and less well defined pain (Eckstein 2011). The prevalence of pain with activity limitation in one survey of over 4000 refugees was 11.8%, which is similar to the general U.S. population (Yun 2012; Hardt 2008). Taloyan et al found a higher incidence of depression in populations of immigrants with chronic pain. Further, after controlling for age and gender, the number of locations of pain had the highest correlation to depression (Taloyan 2014).

Several qualitative surveys collected interviews from refugee women living with chronic pain. Notably, controlling the pain was closely linked to regaining control in life (Zander 2013, Michaelis 2015, Martensson 2016). Healthcare appointments and extensive work ups were viewed as one method to be proactive about addressing pain (Michaelis 2015). This is an important observation, as the cause and effect relationship cannot be determined by these surveys—it is possible that helping refugees gain a sense of control in the rest of life will also help in gaining a sense of control over pain. This would indicate that multiple concurrent approaches could provide benefit, with both pharmacologic and non-pharmacologic treatments. At the same time, healthcare was considered frustrating when patients felt unheard, not taken seriously, or if there were dissimilar perceptions of the origin of the pain (Michaelis 2015). This highlights the need for thorough explanations of evaluations and therapies, with good patient involvement in care plans. For example, referrals to Family Stress Clinic could be promoted as a therapy for helping to manage pain acceptance and control, not an implication that stress is causing pain.

Another population in the IFMC clinic includes patients coming to the U.S. with Special Immigrant Visas (SIVs). These patients worked with the U.S. government, usually as translators. Their level of English proficiency is generally higher on arrival than other refugees, and possibly their level of education as well. The health and employment outcomes of this particular population are not well studied. However, one survey examined the employment satisfaction of professional Iraqis in the U.S., comparing refugees to immigrants with the same level of education and work experience (Jamil 2012). While not technically refugees, families here on SIVs might similarly be considered forced migrants, with the haste and uncertainty that accompanies departure from their home. This study reported that professional refugees were generally under-employed relative to professional immigrants, had lower job satisfaction and correlated lower self-reported health. Refugees are usually unable to provide documentation of higher education, and work history and references weren't prepared and do not transfer easily. Therefore they must build a resume, working at jobs that might be

more labor intensive than their previous work experiences. The switch from professional jobs to manual labor might be expected to take a toll on patient's physical health; this is an area that requires further research for prevalence and mitigating strategies.

The relationship between chronic pain and work is complicated in any population. Pain can sometimes be a somatic manifestation of social disruption, but it can also be worsened by the fact of pain changing social function and routine (Zander 2013, Sturgeon 2015, Andrews 2016). Recent trials in therapy for chronic pain have aimed at improving function in addition to including measures of pain. Many studies also measured comorbid depression and PTSD symptoms (Cederberg 2015, Jensen 2016, Norbrandt 2015). In studying coping mechanisms of chronic pain, Langens (2006) found an association between duration of unemployment, decrease of productive coping skills and increase in somatic concerns. These studies highlight the close relationship between pain, employment/social function, and mental health. The implication is that these concerns must be addressed together, not in isolation.

U.S. refugee resettlement policy prioritizes "victims of torture or violence, physically or mentally disabled persons; and persons in need of urgent medical treatment not available in the first asylum country" (Yun & Fuentes 2012). Conditions causing or associated with chronic pain are an important piece of the health of refugees, addressing the needs of chronic pain management will facilitate establishment of refugees in employment and community.

Physical and Evaluation

Physical exam and testing should focus on eliciting or ruling out underlying pathology, including:

- Musculoskeletal and neurologic examination: sensory and motor function
- Functional ability assessment
- Psychiatric screening/evaluation
- Age appropriate cancer screening

Plan

Setting expectations and goals is an essential part of the visit. Pain levels may be important for an internal, temporal measure of progress, however functional goals might be more feasible and more closely aligned with quality of life and ability to work. (Cederberg 2015, Jensen 2016). Equally important is coming to mutual understanding about sources of the pain, and how treatment will address the pain. The perception of pain as a purely physical symptom requiring physical treatments is a commonly held perception that should be addressed at each visit (Zander 2013, Louw 2011).

Chronic pain & work evaluation: general approach

Chronic, non-communicable diseases are more prevalent in refugee populations in the U.S. than communicable disease (Yun 2012) with musculoskeletal and chronic pain issues comprising the majority of disease of refugees in other countries (Bischoff 2009). The following is a brief overview of concepts to cover in the history, physical exam, evaluation and management of patients presenting with chronic pain and work concerns (Sokas 2015).

History

A thorough evaluation of work related pain includes a few extra elements to the standard history. It should include the onset and duration of pain, the quality, location and radiation of the pain. Review of systems should include ruling out signs of infection, malignancy and systemic inflammatory diseases. Chronic pain can be thought of in four categories: neuropathic, muscular, inflammatory, and mechanical or compressive (Lambert 2009).

From the initial to subsequent visits, the history is also time to establish a therapeutic relationship. Special elements of the history include:

- Occupational history, from prior to immigration, experience in primary asylum country, to current work;
- Impact of current pain on daily activities;
- Goals of function;
- Psychological and cultural beliefs of pain;
- Documentation of work related nature of pain

Pharmacologic Management: Pharmaceuticals can acutely control pain and allow rapid return to work while patients also use home exercises or other therapies. There are several options depending on the type of pain the patient is experiencing.

- Neuropathic Pain
    - First line: gabapentin, pregabalin (including diabetic neuropathy, fibromyalgia, post-herpetic neuralgia)
    - Anticonvulsants
    - Tricyclic antidepressants
    - Serotonin-Norepinephrine Reuptake Inhibitors (including diabetic neuropathy and fibromyalgia)
    - Short-term: steroids (neuropathic radicular pain due to mass effects)

- Opioids in certain patients: methadone, tramadol

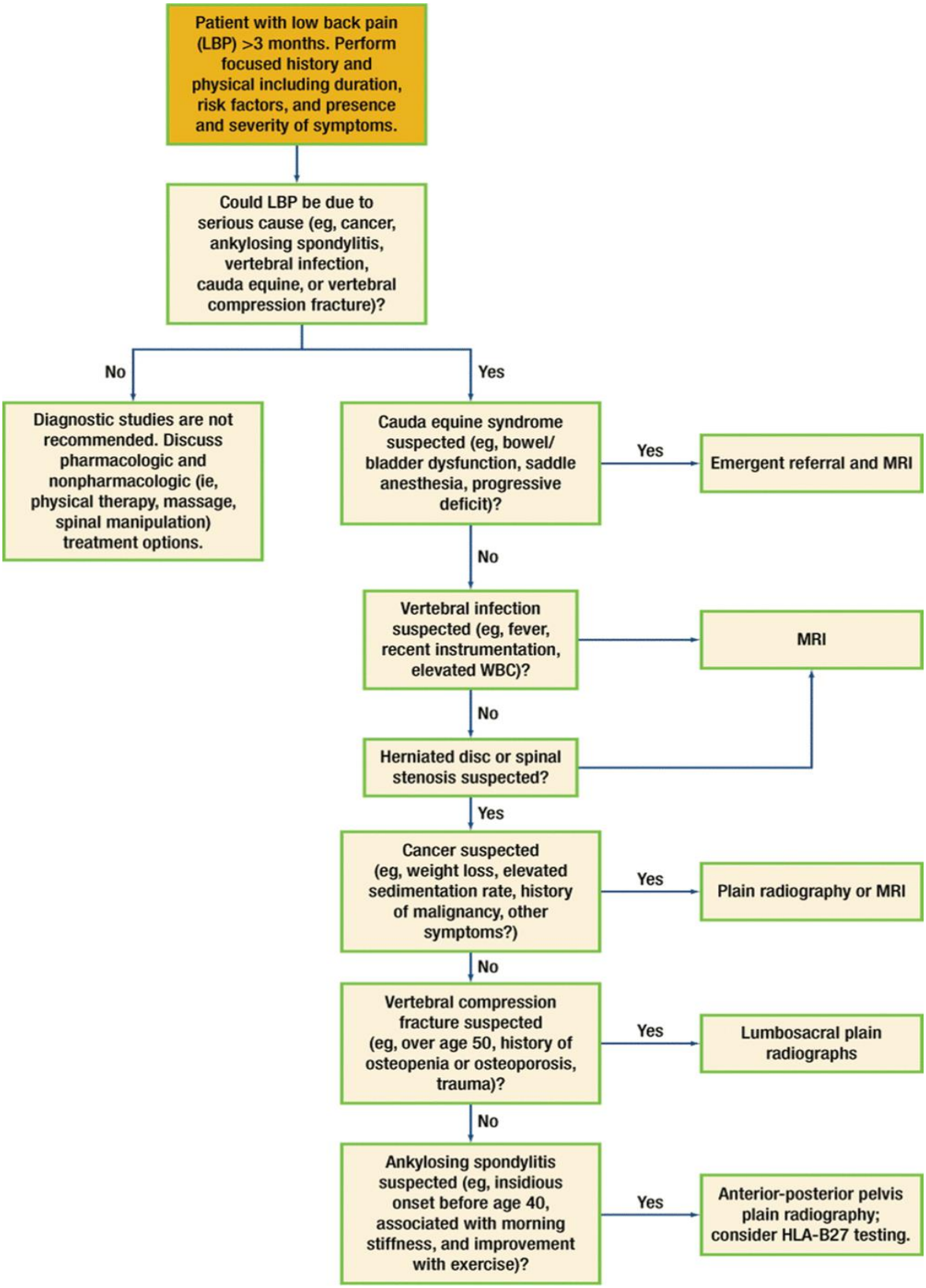

Figure1. Essential Evidence Plus: Approach to Patient with Low Back Pain

- Muscular, Inflammatory, Mechanical/Compressive Pain
    - Multidisciplinary approaches in addition to pharmacotherapy are most effective
    - NSAIDs and acetaminophen are first line pharmacotherapy
    - Tricyclic antidepressants
    - Opioids rarely needed

Non-pharmacological Management: It is important to keep in mind the schedule of refugees, particularly income sources. Hourly employees will not be able to earn income while receiving therapy. To the extent that patients are still able to work with pain, treatment plans must be formed around the work schedule if possible. A physician may be able to help with a note requesting a favorable shift schedule (Sokas 2016).

- Physical Therapy, Occupational Therapy: There is not good evidence for PT/OT in preventing chronic pain, however as treatment these are well-supported. OT can help refugees build confidence with new and unfamiliar tasks. Physical therapy including body awareness and reduction of muscle tension is effective in reducing back pain (Essential Evidence Plus-Back Pain).
- Psychiatry Referral/Evaluation: PTSD and depression are often comorbid with chronic pain, and can affect how patients are able to handle therapy or pain acceptance. Comorbid psychosocial factors can delay healing (Lambert 2010).
- Family Stress Clinic: Can help with developing an individualized chronic pain treatment plan. Page FSC, a provider will either be able to come meet the patient and provide this service, meet the patient to schedule a future appointment, or have the patient call to set up a future appointment. Claudia Allen, PhD has developed handouts and visit scripts to help patients customize pain treatment: setting goals, choosing alternate treatment approaches with specific activities, and helping providers understand a patient's limitations to accessing care (finances, transport, child care, etc.) to better design plan.
- Cognitive Behavioral Therapy, Acceptance and Commitment Therapy: Cochrane Reviews have determined CBT is useful for the treatment of chronic pain (not just comorbid mental health concerns); Acceptance and Commitment Therapy trials have shown that acceptance of pain can be learned, resulting in improved function (Cederberg 2015). These therapies can require a great deal of time commitment to be effective, but should be considered for patients who might not otherwise work (Lambert 2009).
- Referrals: If conservative treatments fail to manage patient's pain, consider referral to orthopedics, multidisciplinary pain management clinics, or placement of spinal cord stimulator or intrathecal pump as appropriate.
- Patient Advocacy: Exploring employment and social services options—see the section below for brief outline of social services available to refugees. Additionally, document if the pain is work-related. Patients may be eligible for worker's compensation is pain results from a work injury. Doctors may also be able to advocate for healthy work practices for their patients: if there are conditions unfavorable to workers who do not feel comfortable voicing these concerns or suggestions. For example, suggesting stools for workers with back pain that stand most of the day, or short breaks for them to walk/sit. Social disruption is a major cause of distress secondary to chronic pain (Sturgeon 2015). Therapy to address the pain can be concurrent with empowering patient's options to maintain social functioning through continuing work and caring for family.

Specific symptoms: Back pain, knee pain

The following are common presenting concerns in both the general and refugee population. Included below are key points from Essential Evidence Topics on the work up of these symptoms as chronic complaints. Health information for patients in multiple languages is provided in Table 1.

Low Back Pain

- Differential: chronic soft-tissue strain, herniated disc, spinal stenosis, neoplasm, ankylosing spondylitis, cauda equine syndrome, vertebral compression fracture, vertebral infection
- Red flags: weight loss, fever, h/o malignancy, trauma, recent instrumentation, Age>55
- Most Common: Undiagnosed, chronic soft-tissue strain (85%)
- Diagnostic tests: See Figure 1
    - Acute episodes of low back pain without red flags resolve 90% of cases; work up should be performed for patients with 6 weeks of conservative management without pain improvement

Knee Pain

- Differential: crystal induced arthritis, osteoarthritis, patellofemoral pain syndrome, rheumatic arthritis, septic arthritis
- Most Common: Age<50 patellofemoral syndrome, Age>50 osteoarthritis
- Red flags: Nocturnal/unremitting pain, systemic symptoms, acute change
- Diagnostic tests: Guided by history and physical, see Figure 2

Healthcare providers and social services

The question of signing forms waiving participation in work programs, writing work excuses, and questions about disability come up often in conjunction with chronic pain concerns. In research and interviews for this project, a few themes emerged: employment is the best long-term solution for budget concerns of refugees. It is also important that refugees work on becoming citizens in order to continue to be able to access social services (Sokas 2016). The following section will outline some of the resources available to refugees during the transition to employment in the U.S. These are summaries from interviews with IRC and IFMC staff, as well as United States Committee for Refugees and Immigrants, *Resource Guide for Serving Refugees with Disabilities*.

Employment: International Rescue Committee, Charlottesville

Employment and job search assistance are available for refugees up to 5 years after arriving in the U.S. There *Temporary Assistance for Needy Families (TANF) Virginia Initiative for Employment on Welfare (VIEW)*

Refugees qualify for cash assistance (similar to TANF) for up to 8 months. Refugee families will continue to qualify if low income with dependent children, with assistance aimed at families becoming self-sufficient. If there are two parents in a household, both parents must be willing to work in order to receive TANF benefits. The total lifetime benefit is 5 years, and at any one time the benefit only lasts for 2 years, with a 1 year break in between. The goal of the program is to help parents towards employment and self-sufficiency—childcare is available while parents attend English classes and work training. If there are health restrictions preventing a patient from working, this can be indicated with a form brought in by the patient. Surveys have are certain funds for special cases. Monte Hackney is the current Employment Specialist. The main consideration when looking for a job for an individual refugee is their budget. Helpful information from healthcare providers includes:

- Functional ability,
- Positions that are better for pain/functioning (standing vs. walking vs. sitting)
- Will work cause tissue damage or is it pushing limits of pain?

Unfortunately, there are no short-term disability benefits available to refugees. Applying for disability is a permanent, distinct process. Work notes are helpful if allowing for taking a break or sitting during work or possibly allowing for time off for physical therapy. However it is important to remember that most of the jobs held by refugees are hourly, any excuse from work or time spent in therapy results in decreased income.

If seeking alternate employment, note that examples of employers when starting out include restaurants, hotel services (Omni), Wegman's, Kroger, UVA housekeeping, maintenance, and security. Another resource for employment is the Virginia Employment Commission.

Disability

The International Rescue Committee also has a specialist in assisting refugees who are eligible in applying for disability through Social Security Income benefits. In the most general terms, an individual must not be able to hold any job in the U.S. economy in order to qualify. If a patient is eligible for SSI, coordinate with Kelly Ann Fredgren to work with IRC to apply.

demonstrated that time to learning English/host country language predicts better employment and integration into host country societies (Capps & Newland 2015). While temporary reprieve can be necessary in some cases, it might not always be beneficial to place work restrictions.

Department for Aging and Rehabilitation (DARS) Vocational Rehabilitation Services
Services for Persons with Disabilities

DARS vocational rehabilitation provides services for individuals who are having trouble finding or holding a job due to a range of medical conditions. This does not require the level of disability that would warrant SSI benefits.

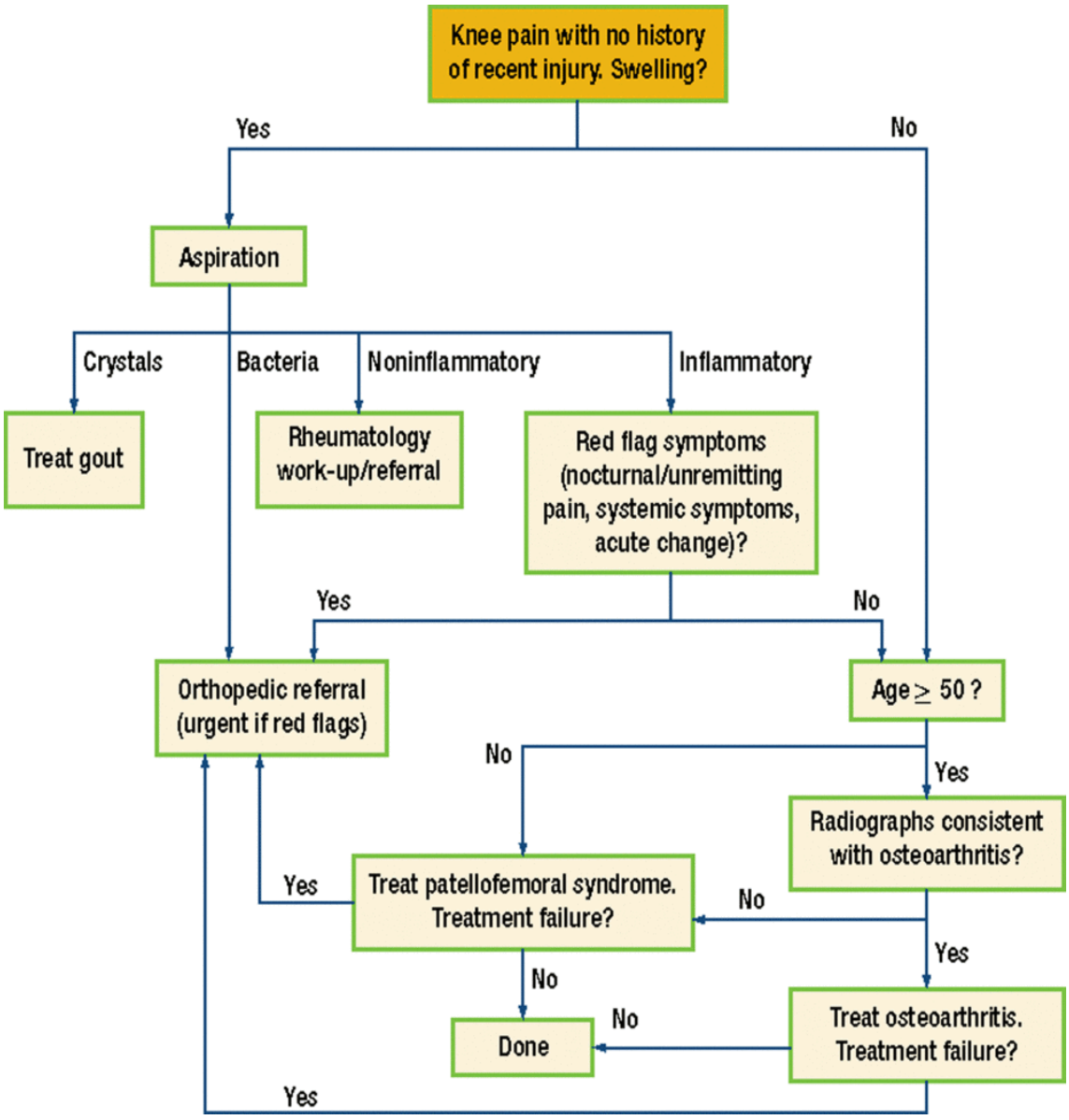

Figure 2. Essential Evidence Plus – Approach to Patient with Knee Pain

Wilson Workforce and Rehabilitation Center
Residential Program

DARS vocation rehabilitation in Virginia includes this residential program to help individuals with disabilities regain skills for employment. Includes driving services, PT, OT and speech therapy in addition to vocational training and rehabilitation counseling.

Caretaker Employment

If a member of a family requires assistance with activities of daily living, such that they might normally require nursing home level assistance, one of the family members (non-spouse) might be eligible to receive payments for acting as the caretaker. This is determined by a joint evaluation by the Health Department and Department of Social Services. A letter from the doctor does not influence this determination.

Health Insurance

All refugees have Medicaid for the first 8 months after arriving in the U.S. Like other benefits, this is temporary and it is important to encourage refugees to plan for losing this benefit. Purchasing insurance through work is a foreign concept, but important to introduce. Refugees are significantly more likely to have chronic health problems than other immigrants, with 46.5% of refugees with chronic conditions lacking insurance (Yun & Fuentes 2012). UVA financial

screening is an important process to start, however this is not a substitute for health insurance.

Table 1. Health Resources for Patients
Health Information Translations from Ohio State University

Resource	Languages
Exercises for your back	English; Arabic; Chinese, Simplified (Mandarin dialect); Chinese, Traditional (Cantonese dialect); French; Hindi; Japanese; Korean; Nepali; Russian; Spanish; Somali; Ukrainian
Back Health	Arabic, Chinese Simplified, Traditional, English, French, Hindi, Japanese, Korean, Nepali, Russian, Somali, Spanish, Ukrainian
Active Leg Range of Motion	Arabic; Chinese, Simplified (Mandarin dialect); Chinese, Traditional (Cantonese dialect); French; Hindi; Japanese; Korean; Nepali; Russian; Somali; Spanish
Active Range of Motion Exercises: Wrists, Elbows, Forearms, Shoulders	English; Arabic; Chinese, Simplified (Mandarin dialect); Chinese, Traditional (Cantonese dialect); French; Hindi; Japanese; Korean; Nepali; Russian; Somali; Spanish
Headaches (Sinus, Tension, Migraine, Cluster, Red flags)	English; Arabic; Chinese, Simplified (Mandarin dialect); Chinese, Traditional (Cantonese dialect); French; Hindi; Japanese; Korean; Russian; Somali; Ukrainian
About Your Pain (guide to help patients describe pain)	Arabic, Bosnian, Chinese Simplified, Traditional, English, French, Hindi, Japanese, Korean, Marshallese, Portuguese, Russian, Somali, Spanish, Tagalog, Ukrainian, Vietnamese
Health Information Translations by Topic	Various topics and languages

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