Seven 'Principles' for Successful Return to Work

To provide a comprehensive summary of the most effective workplace-based return-to-work (RTW) interventions, the Institute for Work & Health conducted a systematic review in 2004 of the return-to-work literature published since 1990. The review, led by Dr. Renée-Louise Franche, included both quantitative (numbers-based) studies and qualitative (narrative-based) studies. Researchers sought to answer the following question: "What workplace-based return-to-work interventions are effective and under what conditions?"

The review focused on three outcomes: duration of work disability, costs of work disability, and quality of life of workers. Overall, the review found that workplace-based return-to-work interventions have positive impacts on duration and costs of work disability. However, only weak evidence was found to support that these interventions had a positive impact on workers' quality of life, suggesting the need for more research in this area.

Drawing on the findings of this systematic review (and other research that was current in the years after the review), the Institute developed seven 'principles' for successful return to work, originally published in 2007. These are included in the box on this page, and described in detail in the following pages.

These principles may change as new research evidence becomes available. Indeed, the Institute is currently partnering with the Institute for Safety, Compensation and Recovery Research (ISCRR) in Australia to update the 2004 systematic review on return to work. The findings from this newest systematic review may be ready to report as early as 2015. To ensure you don't miss the release of these findings, please sign up for *IWH News* at www.iwh.on.ca/e-alerts.

SEVEN PRINCIPLES FOR RTW

1. The workplace has a strong commitment to health and safety, which is demonstrated by the behaviours of the workplace parties.
2. The employer makes an offer of modified work (also known as work accommodation) to injured/ill workers so they can return early and safely to work activities suitable to their abilities.
3. RTW planners ensure that the plan supports the returning worker without disadvantaging co-workers and supervisors.
4. Supervisors are trained in work disability prevention and included in RTW planning.
5. The employer makes early and considerate contact with injured/ill workers.
6. Someone has the responsibility to coordinate RTW.
7. Employers and health-care providers communicate with each other about the workplace demands as needed, and with the worker's consent.

Principle 1

The workplace has a strong commitment to health and safety, which is demonstrated by the behaviours of the workplace parties.

People may talk about what they believe in or support, but as the old saying goes, "actions speak louder than words." Research evidence has shown that it is 'behaviours' in the workplace that are associated with good return-to-work outcomes. They include:

- top management investment of company resources and people's time to promote safety and coordinated RTW;
- labour support for safety policies and return-to-work programming (for example, demonstrated by inclusion of RTW job placement practices in policies/procedures and/or the collective agreement); and
- commitment to safety issues as the accepted norm across the organization.

The systematic review done at IWH by Franche et al (9,10,21) found evidence to support this in numerous studies (1,6,12,19,20,29). Studies of disability management interventions where there was strong union support (6,19,20,29) yielded positive results; i.e. reductions in work disability duration and cost. Results of qualitative studies (3,4,7,11) included in the review spoke directly to this; e.g. pointing out that a labour/management collaborative approach in planning/implementing a RTW program can ensure there is no conflict between the collective agreement and the RTW process. During a roundtable discussion about the relationship between return to work and healthy workplaces (14), Andy King (Department Leader for Health and Safety, United Steel Workers of America) suggested that creating a RTW strategy could be a natural point of collaboration for organized labour and management.

Principle 2

The employer makes an offer of modified work (also known as work accommodation) to injured/ill workers so they can return early and safely to work activities suitable to their abilities.

The Franche et al systematic review (9,10) categorized the offer of accommodated work as a core element of disability management, leading to favourable outcomes. However, arranging appropriate accommodated work requires many considerations (21). An awkward fit of the worker with a modified work environment can contribute to breakdown of the RTW process (7,8,17) and should be avoided. In a published guide for employers (28), the Montreal Public Health Department states that, where possible, it's ideal to return a worker to his/her own work area where the environment, people and practices are familiar. In some cases, it will be helpful to employ the services of someone with ergonomics expertise. The Franche et al systematic review (9,10) suggests that ergonomic worksite visits should also be considered a core disability management component. This would mean that when return-to-work planners are encountering difficulty in creating an appropriate modified job, ergonomics expertise should be made available.

Principle 3

RTW planners ensure that the plan supports the returning worker without disadvantaging co-workers and supervisors.

Return-to-work planning is more than matching the injured worker's physical restrictions to a job accommodation. Planning must acknowledge RTW as a 'socially fragile process' where co-workers and supervisors may be thrust into new relationships and routines (4,8,22). The qualitative component of the IWH review (9,21) indicated that, if others are disadvantaged by the RTW plan, it can lead to resentment towards the returning worker, rather than cooperation with the RTW process. Two examples illustrate where RTW plans may cause problems:

1. The injured worker may have to deal with co-workers who resent having to take over some of his/her work and, therefore, feel that the worker has managed to get an 'easier' job.
2. Supervisors may be required to fulfill production quotas in spite of accommodating a returning worker, and may not have the work that such accommodation requires fully acknowledged (3,4,8,12).

Workplaces that create individual RTW plans that anticipate and avoid these pitfalls will probably have better outcomes.

Principle 4

Supervisors are trained in work disability prevention and included in RTW planning.

Both the quantitative (2, 6,15,19,20,25,29,30) and qualitative (3,4,8,12,26) studies in the IWH systematic review (9,10,21) support this principle. Supervisors were identified as important to the success of RTW due to their proximity to the worker and their ability to manage the immediate RTW work environment. Educating managers and supervisors in areas such as safety training or participatory ergonomics was also found to contribute to successful RTW (5,6,12,19,20,29,30). Discussions with workers and supervisors who participated in interactive workshops at an Ontario health and safety conference (26) reinforced that, when supervisors are left completely out of the RTW planning process, they feel ill equipped to accommodate returning workers. Dr. Glen Pransky (Director, U.S. Liberty Mutual Research Institute for Safety) reports positive results (23) from a program in which supervisors were given ergonomics and safety training, and taught how to be positive and empathetic in early contact with workers, as well as how to arrange accommodations, follow up and solve problems on a regular basis.

Principle 5

The employer makes early and considerate contact with injured/ill workers.

The Franche et al systematic review (9,10) states that 'early' contact is a core component of most disability management programs, and thus associated with better RTW results. Contact 'within the first week or two' should be seen as a guideline only, as the actual time-frame may vary depending on the worker's specific situation. Ideally the contact is made by the immediate supervisor as this helps the worker to feel connected to his/her workplace and colleagues. Pransky (21) maintains that the contact should signify that the employer cares about the worker's well-being, and should not involve issues such as discussing injury causation or blame. Also, if the worker feels that the contact is a reflection of the employer's concern about finances and not about his/her health, this can poison the RTW process. Finally, the worker's general perception about the workplace and its concern for workers (3,7,8,12,24,27) will influence how he/she responds to employer contact. The qualitative component of the systematic review (21) indicates that, in general, early contact is most successful when it builds on a workplace environment characterized by a shared sense of goodwill and confidence (4,8,16,21,24).

Principle 6

Someone has the responsibility to coordinate RTW.

Studies in the Franche et al systematic review (9,10,21) described successful RTW programs as involving a RTW coordinator whose responsibility it was to coordinate the RTW process (1,2,5,6,12,13,17,25,30). The coordination role may be performed by someone in the company or by someone external. In either case, this coordination role involves:

- providing individualized planning and coordination that is adapted to the worker's initial and on-going needs;
- ensuring that the necessary communication does not break down at any point; and
- ensuring that the worker and other RTW players understand what to expect and what is expected of them (12).

RTW players include workers, co-workers, supervisors/managers, health-care providers, disability managers and insurers. As noted in Principle 2, consideration of the needs of these various players will facilitate the RTW process and help to ensure its success.

Principle 7

Employers and health-care providers communicate with each other about the workplace demands, as needed, and with the worker's consent.

The Franche et al systematic review (9,10) showed that contact between workplaces and health-care providers reduced work disability duration. In these studies, contact ranged from a simple report sent back to the workplace, to a more extensive visit to the workstation by a health-care provider. On a case-by-case basis, the health-care providers involved might include one or multiple providers (such as physicians, chiropractors, ergonomists, kinesiologists, occupational therapists, physiotherapists and nurses). They can play a significant role in the RTW process as the injured worker is often looking to his/her health provider(s) for information about his/her condition and for return-to-work advice. It follows that the more these players understand the worker's job and the workplace's ability to provide accommodation, the better able they are to advise the worker and participate in informed RTW decision-making. In straightforward situations, where the worker's return is uncomplicated, contact may not be necessary; in other cases, it should happen. Permission from the worker needs to be given for this contact to proceed. The degree and nature of the contact between the workplace and health-care providers can vary depending on individual circumstances, including:

- a paper-based information exchange (e.g. information on job demands and/or work accommodation options sent to the family doctor by the employer);
- a telephone conversation about work and job demands (initiated by either party); and
- a workplace visit by a health-care provider to view the work activities and converse directly with the supervisor or employer.

In some cases, a health-care provider may be involved in delivering a fully integrated clinical and occupational approach to RTW, including medical assessment, follow-up and monitoring, plus jobsite evaluations and ergonomic interventions (5,6,18,28).

The qualitative study included in the Franche et al systematic review (8) showed that employers who have difficulty contacting physicians, or who feel that physicians delay RTW, may end up second-guessing the worker's doctor when making judgments about the worker's recovery and ability to RTW. For that reason, family physicians who do not have time to consult with the workplace or make a

workplace visit may benefit from having other rehabilitation and occupational health professionals act as a 'bridge' between the workplace and health-care system; i.e. provide the physician with succinct and essential information about the worker's job and workplace to assist with RTW planning.

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