

# **Vocational rehabilitation and work resumption**

## **A review of the literature**



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# Stress Impact Project - Chapter 4

## Vocational rehabilitation and work resumption

### 1. Background

The aim of this chapter is to review the literature on vocational rehabilitation and work resumption as it applies to workers who experience stress related illnesses in the workplace. The main focus was on identifying literature which related to workplace responses to absenteeism due to stress related disorders.

There is increasing evidence which suggests that today more than ever before, employees are working in an atmosphere of anxiety and stress. A fundamental and dynamic shift is taking place in the world of work. Many have called this change the third revolution or 'tidal wave'. Most experts have agreed, however, that the situation is a transformation from an industrial economy to an information or knowledge based economy. Structural changes (downsizing, mergers, acquisitions and restructuring), changing social and working contexts and the introduction of new technology are all implicated in the stress process. The negative impact of stress can be observed in the wide range of conditions that are associated with it. Stress has been associated not only with a variety of psychological conditions including anxiety and depression, but also with a number of important physical conditions including heart attack, ulcers and stroke. It is also considered to be a contributing factor to low back pain and repetitive stress injuries.

The World Health Organization (2001) predicts that by 2020, mental illness will be the second leading cause of disability worldwide, after heart disease. The International Labour Organization (ILO), (2000) says mental illness affects more human lives and gives rise to a greater waste of human resources than all other forms of disability. Mental disorders are one of the three leading causes of disability. In the EU, for example, mental health disorders are a major reason for granting disability pensions. Five of the 10 leading causes of disability worldwide are mental health problems – major depression, schizophrenia, bipolar disorders, alcohol use and obsessive-compulsive disorders – and account for 25-35% of all disability (Cameron, 2000). Employers are greatly affected by their employees' mental health, and employers affect – positively or negatively – their employees' mental health.

The incidence of stress within European society is on the increase and accounts for over 30% of all absence from work (Paoli, 1997). Evidence for this is emerging from a number of sources including surveys, longitudinal studies and absence statistics (e.g. Van der Hek and Plomp, 1997; Jones et al, 1998). Estimations of the Health and Safety Executive (1998) are that between 30 – 60% of all Sickness Absence in the UK is related to a mental or emotional disturbance (i.e. stress, burnout). In The Netherlands long-term sickness absence due to 'mental disorders' has increased from 17 % in 1974 to 32 % in 1992 (Allegro & Veerman, 1998). This figure has increased over the past decade. Evidence from the literature suggests that Workers on long-term absence as a result of stress are less likely to return to work than those with physical injuries or illnesses (Watson Wyatt, 2000).

Watson Wyatt (1998), in their annual survey of integrated disability management programmes, found that incidents of disability are increasingly related to slowly developing, chronic conditions and work-induced stress. In this survey, musculoskeletal problems such as carpal tunnel syndrome and repetitive motion complaints (50 percent) exceeded injuries (44 percent) as the most common condition triggering an occupational disability expense. The

survey also found that mental health-related disabilities are on the rise. Forty-five and 58 percent of employers, respectively, expressed growing concern about mental illness as a source of occupational disabilities and non-occupational disabilities. Moreover, one-third of survey respondents characterized the management of mental illness in the workplace as very difficult.

The Canadian Mental Health Association (CMHA) says that emotional distress and mental illness account for 20-30% of all employee absenteeism and industrial accidents. Between 1990 and 1999, a 220-per-cent increase in stress cases was reported by employee assistance programs, according to the managing director of the Canadian Institute of Stress (Bauer, 2003). Seventy-nine percent of participants in Watson Wyatt's (2002/2003) 'Staying@Work Canada' survey indicated that psychological conditions (depression, anxiety, stress and other conditions that affect the psychological health of employees) were the leading cause of short-term disability (STD) claims, while 73 percent confirm that these conditions are also the leading cause of long-term disability (LTD) claims. The same survey estimated that most companies spend 2 to 3 per cent of their payroll on short-term disability claims, of which half may be stress-related. A recent report from Health Canada (2002) puts the costs associated with mental health disorders in the workplace at nearly 14 percent of the net annual profits of Canadian companies, with a price tag of up to \$16 billion annually. This report also suggested that employees who experience work stress (caused by interpersonal, job-control and management problems) are six times more likely than others to be absent from work for six or more days.

The United Kingdom Department of Health and the Confederation of British Industry have estimated that 15 to 30 percent of workers will experience some form of mental health problems during their working lives. The most recent research from the HSE (2002) suggests that since 1995 the number of working days lost to stress, anxiety and depression in the UK has more than doubled. In 2001, more than 13 million days were lost because of stress, which affects one in five of all employees at a cost of up to £3.8 billion.

In the USA in 2000, on any given day 3.9% of employees in US workforce are absent from work (Bureau of Labour Statistics, 2002). In 1998 costs associated with 8.3 million work related injuries and 5,100 work deaths resulted in 125 million lost work days and cost American business \$125 billion in wage and productivity losses, health care costs and administrative expenses (Di Guida, 1995). These are the direct quantifiable costs, however, they represent only a portion of the costs. The indirect costs, which include the cost of hiring and training replacement employees, lost profits, loss of customers, decreased employee morale and efficiency, time lost by supervisors and other employees at the accident; are estimated to be about 5 to 15 times higher (Kalina, 1998). Estimates of the national cost of depression (USA 1990) range from \$30-\$44 billion of which close to \$12 billion is in lost work days each year. A further \$11 billion in costs accrue from decreased productivity due to problems with concentration, memory, decision-making.

Studies released by the ILO (2000) on mental health policies and programs affecting the workforces of Finland, Germany, Poland, United Kingdom and United States showed that the incidence of mental health problems is increasing. It reported that as many as one in 10 workers suffer from depression, anxiety, stress or burnout. In some cases, these problems lead to unemployment and hospitalization. The findings of the report included:

Clinical depression has become one of the most common illnesses in the U.S., affecting one in 10 working-age adults, resulting in a loss of approximately 200 million working days per year

More than 50 percent of the Finnish workforce experiences some kind of stress-related symptoms, such as anxiety, depressive feelings, physical pain, social

exclusion and sleep disorders. Seven percent of Finnish workers suffer from severe burnout, leading to exhaustion, cynicism and sharply reduced professional capacity. Mental health disorders are the leading cause of disability pensions in Finland.

Depressive disorders in Germany account for almost seven percent of premature retirements, and depression-related work incapacity lasts about two-and-a-half times longer than incapacity due to other illnesses. The annual volume of production lost due to absenteeism related to mental health disorders is an estimated 5 billion DM annually.

Nearly three out of 10 employees experience mental health problems in the United Kingdom each year, and numerous studies show that work-related stress and the illnesses it causes are common. One in every 20 working-age Britons is experiencing major depression.

In Poland, a growing number of people, especially those suffering from depressive disorders, are receiving mental health care, a trend related to the country's socio-economic transformation and resulting increases in unemployment, job insecurity and declining living standards.

Wyatt-Watson (2002), in their annual survey identified that mental health disorders can also put employees at greater risk of other illnesses, or increase the gravity, duration and likelihood of recurrence of chronic illnesses. For example, individuals who suffer from depression and/or anxiety are at greater risk of developing cardiovascular disease.

A CBI (1999) survey looking at long-term absence suggests that diagnosing illness may become more important (and more difficult) as psychiatric claims become more common. Psychiatric illness can be: stress related to work or family; anxiety; depression; or even more extreme conditions of the psyche. Unum, a large insurer of long-term illness claims, has reported an 88% growth in these types of claims over the last several years. With the psychiatric diagnosis more susceptible to fraudulent claims and little rehabilitation available, it is viewed as a potential worry for employers. Interestingly, only 7% of employers viewed stress or psychiatric claims as a serious concern. The reasons for their growing concern included: having personally experienced an increasing number of stress induced claims in their company; the pressures of past (and anticipated) mergers have increased levels of stress within their organisation; and the lack of training and programmes to equip line managers to adequately handle claims of this nature (cited in [www.watsonwyatt.com](http://www.watsonwyatt.com)).

The issue of disability or illness which prevents workers from participating in the workplace is of major concern to both corporations and individuals. From an organisational perspective, unscheduled worker absence, whether it is due to incidental sick leave, disability or illness, reduces productivity, profits, organisational competitiveness and employee satisfaction. For the individual the costs of absence from work due to disability or illness include personal, career, financial and family costs.

The remainder of this chapter provides a brief review of the literature on return to work. Since there is very literature specifically addressing the issue of the return to work of workers with stress related, mental health problems or other psychological difficulties, the main themes are drawn from the literature on return to work of workers with physical injuries or illnesses. The review is therefore not an exhaustive, systematic or complete review of all the relevant literature, but aims instead to be illustrative of the key of issues in the area.

## 2. Method

### 2.1 Search strategy and keywords

Two strategies were employed to search for relevant literature, firstly, the national experts who are participating in the present project were asked to identify and forward any relevant national literature that could be included in the present study. Secondly a literature search was carried out using DialogSelect and Askeric search engines on main concepts concerning this chapter which are Return to Work (RTW) and stress related illness. Synonyms associated with RTW which were included in the search were 'work resumption' and 'work re-integration'. Other related concepts also included were vocational rehabilitation, disability management and occupational rehabilitation. Most of the literature identified in the area of return to work and work related disability explores issues relating primarily to physical aspects of illness and disability.

Literature relating specifically to the return to work of workers who have stress related disorders proved to be more difficult to identify. While there is quite a lot of material on stress and health related breakdown, there is relatively little known about those who are unable to work and are on long-term sick leave due to stress, burnout and stress-related problems. Therefore, the search for information on stress related illness was extended to include people with depression, anxiety, burnout, mental illness, psychiatric disorders and physical ailments that may be a by-product of stress e.g. coronary illness.

<b>Keywords</b>	<b>Related concepts</b>	<b>Other concepts included in search</b>
Return to work	Re-integration Work resumption	Vocational rehabilitation Occupational rehabilitation Disability management Integrated disability management
Stress related illness	Stress Burnout	Anxiety Depression Mental health / illness Psychiatric disorders Co-morbid physical symptoms

Particular emphasis was placed on the links between these search terms. Thus, literature was only of interest in the current review if it linked the areas of stress related disorders and rehabilitation into the workplace. As might be expected, there are large and very large literatures available on these terms when they are looked at separately, but relatively few materials were found when these search terms are taken together.

Accordingly, this literature review is organised according to the schema outlined below:

- General methods of return to work
- Psychiatric rehabilitation
- Stress related disorders and return to work

### **3. Result section**

In this section, the main findings from the literature review are outlined. The first section (3.1) provides a description of the main models and concepts relating to return to work. The topic of occupational stress is not described in this section as it is comprehensively covered in chapter 2. The rest of this section (3.2, 3.3 and 3.4) considers the literature according to the classification described above.

#### **3.1 Main models and concepts**

The focus in this section is on workplace responses to absences due to disability, injury or illness. The main models in the area of RTW and work resumption are

- Disability management
- Integrated Disability management
- Return to work Programmes
- Vocational Rehabilitation
- Case Management

##### **3.1.1 Disability management**

Shrey, 2000, defines Disability Management or Occupational Rehabilitation (as it is also known) model is a worksite based approach to early intervention and covers the range of interventions that are implemented from the point of injury or onset of disability, through job retention interventions that ensure that the worker has been properly accommodated and that future lost time and work disability will be minimized. Traditional rehabilitation interventions tended to focus on the individual whereas, disability management provides a more holistic, interdisciplinary approach that address both worksite (environmental) and worker (individual) factors. The goals of disability management include prevention of chronic and progressive disability, effective return-to-work outcomes and employment retention of workers with disabilities. Early intervention and timely return to work is critical to achieving successful outcomes for the worker and the employer.

Disability management is an interdisciplinary process that requires careful planning, effective co-ordination, relationship-building, ongoing communication and the resources of a skilled and knowledgeable return-to-work co-ordinator. This process involves many steps in the disabled worker's progression from the point of injury or disability through successful return to work. It is important that these steps are orchestrated within the context of disability management policies and procedures that are jointly supported by labour and management.

##### **3.1.2 Integrated Disability Management**

Integrated disability management coordinates occupational and non-occupational disability programs and other related programs - such as group health plans, health promotion programs and employee assistance programs (EAPs) - to bring down total costs, improve overall workforce health and simplify administration. This integration encompasses illness and injury prevention efforts, rehabilitation, medical case management and return-to-work programs for all causes of disability.

### **3.1.3 Return to Work programmes (RTW)**

An early return to work program may be defined as any process that minimizes work disability from occupational injuries and illnesses. The employer in concert with internal and external resources, actively attempts to return to work an ill or injured employee at an early stage (and before complete recovery) without risking adverse health effects. The goal of RTW programmes is to reduce the financial and human resource costs associated with absence from work and to accommodate the employee permanently within the company.

Successful return to work programmes have clearly defined procedural components. Policies and procedures need to be developed at the worksite as guidance to the worker and others about the RTW process. This process aims to begin as early as possible after the onset of an injury or disability and end when the worker has made a safe return to work and is able to safely perform sustained and productive work activity. Designing and maintaining early return to work programmes at any job site requires careful planning and continuous monitoring. The management of a return to work programme determines its success. The key player in the management of the RTW programme is the RTW co-ordinator (OHN, HR person, supervisor) who assumes overall responsibility for the management and implementation of the programme and liaising with the worker, the organisation and relevant third parties (compensation companies, experts).

### **3.1.4 Vocational Rehabilitation**

Vocational Rehabilitation services were originally set up and provided by government agencies and NGOs and in many countries these agencies remain the main providers of vocational rehabilitation. However, there is a growth in private sector vocational rehabilitation services. Vocational rehabilitation services are usually provided by agencies external to the workplace. The aim of these services is to assist individuals who have disabilities and who are unemployed because of their disability in securing meaningful employment commensurate with their aptitudes, interests, and needs. This is achieved by providing planning, placement and long-term counselling in order to give the person the possibility of choosing, getting and keeping employment in an environment where he or she can be successful. Vocational rehabilitation services usually provide:

- Vocational counselling and planning
- Assistance finding and keeping a job, including special employer incentives
- If needed, training such as on-the-job training, non-paid work experiences
- Supportive rehabilitation services and additional counselling

### **3.1.5 Case Management**

Case management is ‘ a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet and individuals health needs through communication and available resources to promote quality cost effective outcomes’ (Case management society of America, 1995). The case manager oversees and coordinates, from the early stages of recovery (from illness or injury), the overall programme of rehabilitation and return to work activities planned for each individual. Case management is performed by a diverse group of skilled and experienced health care professionals, including nurses, vocational specialists, social workers, therapists, discharge planners, rehabilitation counsellors, occupational therapists and many others. There are two main types of case management:

- Field case management – which takes place outside or inside of workplace. An injured worker is assigned a case manager who personally meets the injured worker and maintains on-going face-to-face contact, including participation in physician visits, therapy appointments, visiting the worksite with worker and coordinating return to work.
- In-house or telephonic case management – involves co-ordinating return to work services over the telephone. The information obtained is the same as field case management however, no site calls or in-person call are made.

In occupational rehabilitation case management there is often more than one client – the employee, the employer, the insurance company. Providing a quality cost-effective service that meets the requirements of all parties can present a challenge for the case manager. For example, where an employer wants an early return to work to contain costs and the injured worker wants to wait until symptoms have completely gone before returning (Maki, 1998).

### 3.2 General methods of return to work

There are a number of standard approaches taken to the issue of rehabilitation and return to work in relation to the more common types of physical disability. These approaches have been developed and evolved over many years and they represent the mainstream approaches to the problems associated with rehabilitation and reintegration into the workplace. These approaches are outlined below in Table 1. They have been divided into three main areas – medical rehabilitation, which is mainly concerned with the improvement of physical and mental health, vocational rehabilitation, which is mainly concerned with the provision of new skills to the disabled person and reintegration or return to work strategies. This section primarily describes reintegration which is worksite based.

**Table 1. Common approaches to rehabilitation and return to work**

Focus of intervention	Type of intervention	Location
Medical rehabilitation	<ul style="list-style-type: none"> <li>• Emergency treatment</li> <li>• Medical interventions</li> <li>• Psychiatric interventions</li> <li>• Physical rehabilitation</li> <li>• Psychiatric rehabilitation</li> </ul>	Mainly outside of the workplace
Vocational Rehabilitation	<ul style="list-style-type: none"> <li>• Retraining for existing work</li> <li>• Training for new work</li> <li>• Sheltered work</li> </ul>	Training agencies/ worksite
Reintegration	<ul style="list-style-type: none"> <li>• Worksite reintegration policy</li> <li>• Management and labour support</li> <li>• Internal and external communications</li> <li>• Disability management co-ordinator</li> <li>• Occupational health and safety</li> <li>• Case management procedures</li> <li>• Return to work co-ordination</li> <li>• Transitional work options</li> <li>• Worksite accommodations</li> <li>• Programme co-ordination</li> </ul>	Worksite

### 3.2.1 Disability Management at the Workplace

In the US, Shrey has pioneered the concept of disability management at the workplace, i.e. the active management and reintegration of people who have become long term absent from work due to health reasons. This work has been built upon by the RETURN project (2001) within the European context.

Shrey (1998) provides a good overview of principles and approach of worksite based disability management programmes. The ultimate goals of disability management are to control the costs associated with absenteeism and to promote the sustained employment of workers with injuries and disabilities. Disability Management has three main objectives:

- To reduce the number and magnitude of injuries and illnesses
- To minimise the impact of disabilities on work performance
- To decrease the amount of lost time associated with injuries, illnesses and associated disabilities

There are three main fundamentals of approach to disability management:

- Employer involvement
- Early intervention
- The therapeutic worksite

Employer involvement in managing the process of return to work is seen as essential in ensuring an early and timely return to work as well as in the context of reducing the costs associated with absenteeism.

Early intervention is also seen as a critical element in ensuring a safe and timely return to work. Within the context of rehabilitation, the principle of early intervention for therapeutic reasons is seen as having a major influence on prognosis, e.g. (Galvin, 1985; Seligman, 1991). Within the context of disability management, early return to work is also seen as being important for reasons of maintaining the link with the workplace and ensuring that the person can maintain the role of being a worker. Of course, the precise definition of what constitutes an early intervention in this regard depends on the nature of the illness or injury.

The concept of the therapeutic worksite is also important in the context of early return to work. The therapeutic worksite can be characterised as having a strong infrastructure of policies, personnel and practices which are conducive to ensuring a smooth reintegration to work for the disabled worker. Typical interventions seen within a therapeutic worksite include strong policy protocols, labour and management support for return to work, work accommodations, transitional work options, worker evaluation and job analysis.

Disability management defines three levels of intervention – the micro, macro and mega levels. Micro level interventions at the worksite focus on the worker with the disability, and may involve interactions between the worker, supervisors and managers, co-workers, case managers and others. Macro level interventions refers to the organisational level of disability management in terms of the policies, resources and infrastructure available to support interventions taking place at the micro level. The mega level of disability management refers to the statutory provisions in terms of services and supports available the worksite to implement effective disability management.

Shrey cites research evidence that the approach of disability management can be effective in ensuring early return to work, successful reintegration of ill or injured workers and reductions in the costs associated with illness or injury. (e.g. Habeck, 1993; Mital and Shrey, 1996). In particular, where worksites assume internal responsibility and accountability for such programmes, results tend to be good. In addition, Shrey points to a number of key controls for effective disability management. These include taking a proactive management approach at each stage of the process, i.e. at:

- Initial reporting of injury or illness
- Emergency treatment
- Making an early response to expected absenteeism
- Developing individualised transitional work plans
- Active worker monitoring

In the USA, the majority of employers have a return to work program. Corporate RTW programs can vary significantly along a continuum (Wassel, 2002). At one end of this RTW continuum, programs return the injured or ill worker only when they can resume 100% of their original job functions and the employer still likes the worker. At the other end of the RTW continuum, well organised programmes have policies and procedures for effectively monitoring absences through integrating the management of both occupational and non-occupational disability. The majority of employers programmes somewhere in the middle of this continuum.

### **3.2.1.1 Return to work programmes**

This section looks at the key elements of return to work programmes, the processes involved in RTW and the various RTW options. It also gives an overview of the benefits of return to work programmes, the factors that influence RTW and describes two frameworks that have been proposed to organise the determinants of RTW. Examples of RTW initiatives that take place within companies and also an example of a RTW initiative provided external to the company are described.

### **3.2.1.2 Components of RTW programmes**

There are four key components of a successful RTW programme (Wassel, 2002).

1. developing a RTW program with a written policy statement
2. organising a RTW team
3. reviewing jobs
4. communicating the programme to all employees management and members of RTW team.

*RTW Policy* - A written policy statement generally requires the approval and commitment of senior management. With a written policy on RTW, management expectations are clarified and a corporate culture that values all employees is reinforced.

*RTW team* - To be successful the RTW program must use a team approach and include the employee, the RTW co-ordinator, the physician, managers and supervisors, the insurer and the rehabilitation specialists.

*Review jobs* - A well designed job analysis is one of the best tools to assist injured or ill employees to return to work. A job analysis involves a formal examination of the tasks associated with a job and should paint an accurate picture of the essential physical and environmental requirements of the job.

*Communicating programme* - The best designed RTW programme will be unsuccessful without regular ongoing communications between employees, upper management and all members of the RTW team.. Employees need to be familiar with the process for reporting injury and illness, all levels of management need to be in agreement, committed and adequately trained in RTW team responsibilities for the RTW programme to be successful. Initial communication on the corporate RTW policy and programme should begin with the initial employee orientation and be reviewed periodically during the course of employment.

### **3.2.1.3 RTW process**

Worksites have fairly standard administrative responses to work related injuries and non-occupational illnesses, beginning with the initial report of an injury or illness (Shrey, 2000). In general, it is the supervisor who is made aware of the initial illness or injury and it is usually the workers' responsibility to report promptly any injury or illness to the supervisor. The supervisor is responsible for completing accident or illness reports as required by workers' compensation statutes or federal laws dealing with occupational safety and health. Accident and illness incidents may be communicated to others within the workplace e.g. safety committees, human resource departments, insurance manager. Likewise such incidents may be communicated externally to workers' compensation boards, insurance claims managers and certain government agencies.

The employee is responsible for reporting injury or illness to supervisor immediately, participating in the accident investigation process, maintaining contact with RTW coordinator, keeping appointments with health care providers.

Many worksites designate others who are responsible for initiating the referral of workers with disability to designated return-to-work coordinator. Referral sources vary considerably among worksites and individuals making referrals to the RTW coordinator may include any of the following: union representatives, members of the worksite's return-to-work or safety committee, human resource managers, immediate supervisors, concerned co-workers, workers with disabilities (self-referral), worksite medical officers, case managers and safety officers. Referral agents must understand the criteria for referral as established by the worksite ( e.g. the number of days a worker must be absent for before participation in RTW is required).

### **3.2.1.4 Return to Work Options**

There are a range of RTW options which may be considered when attracting an employee back to work.

- Return to same job / same employer ( with no or temporary accommodations or transitional work).
- Return to different job / same employer
- Return to work with a different employer (similar job, modified job, vocational rehab to gain qualifications for a job)
- Training for self employment

### **3.2.1.4 Return to Work Strategies**

During early return to work, workers with restrictions may be attracted back to work through a range of strategies as described below.

#### ***Transitional work programmes***

Transitional work is a progressive, individualised, time-limited process, focused on returning the worker with restrictions to safe and productive employment. It can be defined as an combination of tasks, functions, jobs or therapeutic activities that a worker with functional restrictions can perform safely, for pay and without the risk of injury to self or other workers.

The worker's transitional work plan is a written document, designed with the worker's active involvement, to identify specific tasks to be performed for designated time periods. Jobsite modifications and accommodations are also important components of the transitional work plan, ensuring greater compatibility between physical job demands and the worker's functional capacities. The transitional work process includes ongoing evaluation of the worker's job performance, with gradual upgrading of job tasks as the worker gains strength and endurance through proper exercise, therapy and conditioning activities.

#### ***Modified Work***

Modified work or duty generally means temporarily modifying the employee's job or offering an alternative job, although it may entail a more permanent workplace modification to accommodate an employee with a lasting disability. Job modification – is any change in duties, hours or expectations of a job. For example, if a person does not have the energy or stamina to work 8 hours a day, part time work, flexible hours, or more frequent breaks may be arranged.

Job site or worker modification involves an assessment of the worker, job and the workplace. This information is used to identify alternatives for how the job can be performed. The emphasis is always on safety. For example, in the case of a physical injury, the work station may be altered by raising a chair or adding a ramp.

#### ***Restrictive Duty***

Restrictive Duty also known as Limited Duty and Alternate Work is defined as a job that is appropriate to an injured worker's skills, interests and capabilities. It is a new job designed for individuals who cannot return to their original work area and is created for either a temporary (a specified time such as a few weeks or months) or permanent placement (when a person will not be able to return to the original job) or both.

Light duty refers to some adaptation of the employee's original job. Depending on management's philosophy, the term 'light duty' may have a negative meaning: it may imply that a person is not working very hard, is doing an insignificant job ('busy work' or is only part of a job other employees may complain that not all of the job is being done and wonder who is going to finish it. Consequently words such as limited duty, restricted work or alternate work is used.

### ***Other return to work options***

A worksite may create a formal job bank, which serves as a reservoir of job tasks that can be temporarily assigned to the worker while he or she is recovering from an injury or illness. Transitional work programs are often strengthened by developing job banks, which is a cluster of temporary, meaningful and productive jobs or job tasks (sedentary to light work activity) that can be performed while the worker is making a recovery from their illness or injury (Shrey, 2000). Work tasks and jobs from the job bank can be flexibly assigned to workers, on a day-to-day basis, to facilitate a return to the worker's regular job or to a permanent modified job. Job banks can be created within a work unit or within an entire workplace by identifying and classifying tasks that can be performed safely by workers with restrictions.

#### **3.2.1.5 Benefits of Return to Work Programmes**

Reviews of the literature consistently show that employees involved in early Return to Work (RTW) programmes have a greater likelihood of eventual return to full employment (Perry, 1996; Di Guida, 1998; Shrey, 2000; Shaw et al, 2000). The development and implementation of such programmes is one of the most successful means of reducing workers' compensation costs. In a survey of corporations in the US (Watson Wyatt, 1997), respondents stated that disability program design was the primary factor in determining amount of lost work time. They noted that a well-designed plan provides incentives for employees to return to work quickly, perhaps in a modified duty program.

Formal return to work programs have demonstrated recurrent savings for worksites over the past several years. The General Accounting Office (GAO), in the USA, points out that the estimated lifetime savings for removing an additional 1 percent of the disabled beneficiaries from the rolls of the Disability Insurance (DI) and Supplemental Security Income (SSI) programmes each year will ultimately reach \$3.0 billion (cited in Sim, 1999).

In a study comparing two hospitals (Shrey, 2000), one with a return to work program and the other without found that the hospital with the formal program experienced a 50% decrease in the number of injuries. The hospital with the return to work program also recorded fewer than average lost workdays (13.5 days versus 18.5 days).

Data from a study comparing the incidence and costs of work-related illnesses and injuries prior to the introduction of a return to work program and over a 10 year period showed that a 55% decrease was observed in the rate of lost workday cases before versus after the return to work program. The number of lost workdays decreased from an average of 26.3 per 100 employees before, to 12.9 per 100 employees after, the return to work initiative. The number of restricted duty days went from an average of .063per 100 employees to 13.4 per 100 employees (Bernacki et al, 2000). This study demonstrates that a well-structured early return to work program is an integral part of a comprehensive effort to control the duration of disability associated with occupational injuries and illness.

At the Alberni Specialties Division of MacMilan Bloedel, Ltd., British Colombia, Canada, the worksite's long-term disability (LTD) and Short-term disability (STD) costs were found to be three times the industrial average. A disability management programme developed in 1995 achieved a total return of 38 workers over a 2 year period. The average lost time among these workers was 16 months, which is significant because typically 1 year or more of lost time usually results in a minimal probability of RTW. Through the programme LTD premium costs were reduced by 25%; STD premium costs were reduced by 20% and a saving of \$1.25 million was realised in just one year (cited in Shrey, 1998).

At the Somass Division of MacMillan Bloedel, Ltd., a formal disability management programme initiated as a pilot programme demonstrated the impact of joint labour management collaboration. Over an 18 month period, of the 120 workers who participated in the programme 112 had returned to work. The length of lost time ranged from 4 weeks to 13 years. Of 14 workers on LTD who returned to work, 6 had a total of 148 years of benefits payments remaining which had a net present value of \$2.486 million. Workers compensation costs were reduced by 50% and the frequency of lost-time accidents was reduced from 48 to 8 and the number of workers on workers' compensation was reduced from 37 in 1991 to five in 1996 (cited in Shrey, 1998).

### **3.2.1.6. Factors that impact on the return to work**

Return to work after long-term disability leave has been extensively studied in the research literature in terms of clinical factors, treatment factors such as pain management, socio-demographic factors such as age and gender and the physical characteristics of the work such as light or heavy work. However, there is no consistent evidence to suggest which particular factors are associated with successful RTW outcomes (Shaw et al, 2002; Krause et al, 2001; Shaw et al 2000; Shrey, 2000). Studies on RTW factors vary considerably, based on diagnoses, types of injuries, severity of disability and how successful outcomes are defined. Factors related to return to work often include age, gender, educational level, marital status, severity of illness or injury, injury to admission time and job attachment to the pre-injury employer (Gard, 1998; Talma et al 2002; Bernacki,2000; Shaw, 2000).

More generally, research in this area is confounded by a range of issues such as methodological issues due to small sample size, findings relating only to specific occupational groupings, the use of different definitions of disability (Anema, 2002; Krause et al, 2001; Shaw et al, 2002).

Environmental or worksite variables have been given little attention (Shaw et al, 2002; Krause et al, 2001). Where the relationship of workplace characteristics to return to work outcomes has been explored studies have primarily focused on the physical nature of the work and only a few studies have looked at social characteristics of the workplace, such as stress and the worker interface in the workplace and degree of autonomy and control over work pacing (Shaw et al, 2000).

#### ***Psychosocial variables***

A number of studies have looked at the influence that psychological conditions have on the probability of returning to work. In several studies variables related to psychological aspects are found to be significant. For example, the patient's expectation about the possibility for work resumption as well as the patient's understanding of his or her medical condition appears to affect the probability of return to work. Gard et al, 1998, found that psychosocial variables such as pre-injury job satisfaction, relationship with employers and co-workers and financial pressures were factors that affected the workers' successful return to work.

#### ***Job control and communication***

A study on return to work of patients with chronic musculoskeletal pain, found that factors motivating them to return to work were job control as related to information and communication (Gard et al, 1998). They wanted to have more frequent and regular information from supervisors. These workers who had jobs in the healthcare service sectors perceived that meaningful work tasks, jobs where they felt needed by others and relationships with colleagues were important aspects of their job satisfaction. The study concluded that participation in work and work satisfaction were strong reasons for returning to employment.

### ***Relevance of work***

Shaw et al. (2002), in a study looking at return to work behaviours, found that two key constructs were important in understanding return to work from the individual's perspective. - the personal relevance of work and the personal meaning of disability. Participants sought to understand the long-term implications and consequences of their illness and disabilities upon their lives. The categories associated with personal meaning of disability were illness experience, the impact of disability on needs and the participants actions aimed at getting better. Participants beliefs and perceptions of how their impairments impacted upon their short and long term abilities to engage in activities contributed to the variation in return to work experiences. They found that 'return to work relevancy' (developed through the process of reflecting upon the personal meaning of work and motives for working and through the consideration of opportunities for work and workplace expectations) affected participants perceptions, their attitudes and beliefs about work and contributed to their decision to withdraw from or return to, work. Work tasks perceived as meaningful in terms of job content, highly needed by others and/or done in a satisfactory way according to own norms were found to be motivating factors in return to work of health care workers (Gard et al,1997).

### ***Financial incentives***

The occupational standing of workers prior to injury may shape their expectations and incentives for returning to work. For example, workers unable to return to their previous jobs may desire positions comparable in pay, benefits and status and may delay returning to work until they have found jobs meeting these criteria (Gard et al, 1998). Alternatively, the need for income, particularly for those who were the sole earners in their households, may lead to premature return to work that can adversely affect the injured workers recovery.

### ***Gender***

Early studies looking at gender differences in return to work found that women were less likely to return to work after being absent for some time than men (Veerman et. al, 2001). More recent findings indicate that rehabilitation rates are the same for men and women within the first year of absence (Houtman et al, 2002; Giezen et al, 1998; Giezen, 2000). On the other hand, women have a higher risk of being diagnosed as disabled for work after the first year of sickness absence (Houtman et al, 2002). A study of occupational health physicians showed that rehabilitation into work was more important for men than for women (Vinke et al, 1999). Employers appear to be more positive, and more active towards the (at first partial) rehabilitation of men (Cuelenaere, 1997; Vinke et al, 1999). Although the motivation to work does not appear to differ between men and women, women generally expect less from work at the outset of their career, and accommodate the raising of children during their career (e.g. Jorna & Offers, 1991; Naber, 1991; Van Schie, 1997).

### ***Supervisors role in return to work process***

Much is published about worker characteristics affecting the RTW process, but little is known about supervisors and managers reactions and their attitudes toward the return to work of injured or ill workers. The small amount of available research on this issue comes mainly from the literature on return to work of workers with physical injuries and heart conditions. Workplace supervisors are likely to play a significant role in the return to work process. As they come into daily contact with their employees they are in a position to serve as change and rehabilitation agents (Talma, 2002, Pransky, 2001). Providing they have a sound knowledge of the medical and psychosocial aspects of rehabilitation, they may support the employee during the RTW process and help them reintegrate more smoothly and successfully into the work place.

In a study examining the attitudes, reactions and anxieties concerning RTW of employees after myocardial infarction or coronary artery bypass graft. Supervisors of 58 employees who returned to work were surveyed. The supervisors themselves believed that they contributed significantly to the successful occupational rehabilitation of heart patients and emphasised the importance of on-going consultation with occupational physicians. However, many of the supervisors in the study considered such employees to be problematic to a considerable extent, because their occupational functioning is often impaired initially and special attention and support is required (Talma, 2002). Gard (1997) found that where relationships with supervisors were perceived as poor it acted as a de-motivating factor for return to work and that self-confidence was factor of importance for return to work.

Research shows that employer responses to workers reporting work-related musculoskeletal discomfort have significant and independent effects on disability outcomes (Pransky et al, 2002). They found that negative employer responses to the report of injury were significantly associated with adverse work outcomes. The findings of a pilot training programme which aimed to improve employer attitudes and practices to injured workers found that post training supervisors demonstrated significant decreases in a) blaming employees for the injury, b) not taking the condition seriously and c) in discouraging the worker from filing a claim. Positive trends in confidentiality of discussions, access to medical care and accommodation and work modifications were also noted (Pransky, 2001). Furthermore, anecdotal evidence from the same study indicated a consistent decrease in work-related lost time after the intervention.

Nordqvist et al (2003), in a study examining the factors that hinder or promote return to work, the sample was drawn from a cohort which had been followed for 11 years and was made up of workers who had had a new sick-leave spell that lasted at least 28 days with back, neck or shoulder diagnosis. Data from interviews with 5 focus groups on these issues show that the respondents spontaneously emphasised the importance of the employer. Specifically, they stressed the need for a structured back-to-work program at each workplace, which should include contacting absent employees and informing fellow workers of possible changes in task assignments upon return of the absent person. The factors they reported as hindering RTW included lack of such information, leading to envy and harassment. Respondents also asserted the importance of work supervisors in creating a positive emotional atmosphere.

A study, led by Dr. Linda Duxbury at Carleton University, which looked more generally at support by managers found that employees who view their managers as unsupportive of their work-life needs miss nearly twice as many full days of work in a six-month period - 6.2 days versus 3.7 days - as employees with supportive managers (Bauer, 2003).

### ***Involvement of Professionals in RTW***

From the literature it is evident that communication and coordination between professionals involved in the return to work process is poor and may negatively impacts on the employee's return to work (Houtman, 2002; Anema, 2002, Shrey, 2000, Maki, 1998). In a study looking at supervisors attitudes toward return to work after coronary related illnesses, supervisors firmly believed that occupational physicians had a significant contribution to the patient's occupational rehabilitation (Talma, 2002). Almost 70% believed that the occupational physician was much or very involved in the RTW process. It is the occupational physician who has a systematic and appropriate knowledge of workplace characteristics and the demands relevant to RTW issues. A study examining ineffective disability management by doctors found that occupational physicians regarded the clinical waiting period, duration of treatment and view of the treating GPs as obstacles for return to work (Anema et al,(2002)). In only 19% of patients was there communication between OP and the GP. A review of the literature in cardiac rehabilitation suggests that there is minimal communication between

cardiac rehabilitation programmes and employers and that rehabilitation interventions at worksite are generally non-existent (Shrey, 2000). To create a transition to work for these workers cardiac rehabilitation staff need to explore the physical and psychosocial dimensions of jobs, the receptivity of the employer and the accommodations needed to promote a safe and timely return to work.

Shrey, (2000) concluded that successful RTW outcomes can be affected by factors specific to:

1. the worker with the disability (e.g. job satisfaction, motivation to return to work, economic disincentives or incentives to work, psychosocial factors, age, family support)
2. the work environment (corporate culture, internal communications during RTW, external communications with case managers etc, health promotion programmes etc.)
3. the availability and quality of community resources and services and (e.g. Services – medical, physical conditioning, psychological etc. transitional )
- 3 laws and regulations related to employer obligations, (worker’s compensation statues, disability insurance policies and government programmes) .

### **3.2.1.7 Negotiating a successful RTW**

The most frequent resistance points identified by companies in a comprehensive disability management plan are related to implementing an early return to work programme. Some of the reasons cited as to why companies resist implementation of RTW programmes include many fears that the companies can readily justify (Di Guida, 1995). For example, fear of change, potential cost increase, loss of productivity, fear of re-injury and subsequent outcomes, fear of abuse of programme by employees and lack of knowledge on how to implement a programme effectively. Other obstacles that make establishing early return to work programs difficult, include lack of resources (for example to conduct job site analysis, continuous on site monitoring of employees), union contracts and lack of cooperation by health care providers (Perry, 1996).

### **3.2.1.8 Frameworks for examining determinants of disability and RTW**

Literature looking at determinants of disability is beset with methodological difficulties (small sample sizes, poor quality research), it comes from a variety of diverse disciplines (e.g. occupational therapy, medicine, psychology, economics, public policy), and the knowledge base is fragmented and disorganized (Krause et al, 2001). Where systematic reviews of the literature have been conducted, they are generally limited to particular aspects of the problem (e.g. health care factors or work place factors) and are often inconclusive. In addition, the literature does not reflect a consistent understanding of the multidimensional nature of either work disability or the facilitators for return to work (Shaw et al, (2002)). As can be seen from the examination of the factors impacting on return to work a wide range of variables have been explored in an effort to explain factors in return to work or treatment programmes that might account for the variation in individuals who resume work and individuals who withdraw from work after disability. However, the precise combination of determinants of successful return to work remains unclear. In an effort to address these issues, both Krause et al and Shaw et al have developed conceptual frameworks to help examine the interaction of factors that present as barriers to return to work.

### ***Occupational Competence Model***

In an attempt to identify the gaps in the literature relating to factors associated with return to work and to better understand the interaction between factors that prevent return to work and facilitate re-entry (Shaw et al, (2002)), developed the Occupational Competence Model. This model was used to organise and synthesise the factors from previous studies on work outcomes identifying what factors research in this area concentrated on and also identifying gaps in work outcomes. Findings from this review indicate that the main factors of interest in the study of work, to date, outcomes pertains to the individual (person descriptors and physical skills and abilities of the individual) and that variables looking at the nature of work and environmental factors are infrequently studied. The OCM can be used to address and identify the interaction of factors that present as barriers to return to work. For example, when a worker perceives stress in the workplace as the barrier preventing a return to work, the provider can use the OCM as a framework to better understand the nature of the interaction of the domains. Using the OCM, the perceptions of the individual (person), the nature of the workplace environment (micro-environment), the nature of the work (occupation), and the ability of the individual to cope within the work environment (person-microenvironment) are potential areas for exploration. Following the identification and understanding of the multidimensional barriers, providers can target and develop appropriate strategies in collaboration with the client and the workplace to elicit change and enable return to work.

### ***Framework for exploring determinants of disability***

Krause et al (2001), undertook a selective review of the literature with the aim of providing a context for and evidence to support a suggested framework for developing research priorities. They devised a preliminary list of core risk factors which can be used to further explore the determinants of RTW outcomes. The list of determinants of RTW outcomes covers seven domains - individual worker characteristics, injury descriptors, medical and vocational rehabilitation, job task level physical and psychosocial job characteristics, organisational level employer factors, employer or insurer-based disability prevention programmes and societal level legislative, social policy and macroeconomic factors. It is intended that this framework will be used, in future research, to explore return to work issues using the interaction of the items in each of these domains thereby improving the quality, understanding and relevancy of research.

### **3.2.1.9 Alternative RTW Solutions**

Early return to work is frequently cited as a strategy for successful return to employment following an injury or illness. Generally, disability management and early return to work programmes focus on bringing the disabled worker back to the job site from which they originated. In some cases, the original job is modified so that the employee can do the job with the restrictions due to disability. In other cases, a new position is given to the employee. The main thrust is that the employee continues to work and therefore is more likely to continue to work.

Although companies may have a desire to establish early return to work programs, it is often beyond their resources. Job site analysis, continuous on site monitoring of employees, union contracts and lack of cooperation by health care providers are just a few of the impediments that make establishing a program difficult (Perry, 1996, Di Guida, 1995).

An alternative solution - REACH which is an acronym for recovery, employment, and community help - is an early return to work programme developed by a Midwestern

department store in 1993 in an effort to reduce costs associated with workers' compensation (Perry, 1996). Returning disabled workers to work proved difficult as worker union contracts made it difficult to offer restricted duties and there was no occupational health professional on-site to monitor workers. Workers in the REACH programme were employed by a furniture warehouse and distribution centre, were involved in furniture delivery and had been absent from work due to an injury suffered at work.

In an effort to help the disabled worker continue in employment while waiting for return to full duty or placement into a vocational rehabilitation programme this new scheme was developed. Through this scheme, if employee could not be offered work at their original place of employment, they would work at a workshop for developmentally disabled people. Employees would receive 100% of their regular pay for hours worked and continue all benefits. This scheme acted as an incentive to workers who would otherwise receive less money from indemnity payments under the workers' compensation scheme. So effectively, employees receive 100% of wages while recovering and donate their time to a workshop for the developmentally disabled (sheltered workshops). The flexibility of workshops make them ideal for accepting employees, even as early as, the same day or next day after injury. Employees who chose not to participate work forfeit workers' compensation wage replacement benefits. Employees average 3 weeks in the program and the goal is to limit participation to a maximum of 90 days per employee. It is considered that this timeframe is usually long enough to determine whether the employee will recover enough to return to workplace, or if s/he needs to be referred to vocational rehabilitation for job placement outside of the company. In the 2 year period following implementation of REACH average costs per claim, which were above the national average, have dropped by more than half.

### **3.3 Psychiatric Rehabilitation**

In general terms, psychiatric rehabilitation has focused mainly on people with severe or psychotic disorders and on people who have been psychiatric in-patients. Rehabilitation in these terms is primarily focused on the treatment of the disorder and on remedying the various psychological deficits associated with the disorder. To the extent that work is considered to be a focus of the rehabilitation process, it generally consists of the provision of a range of individually oriented interventions to address work related deficits and the establishment of various 'simulated' work situations. It is very clear from the literature that most rehabilitation focuses on people who have lost contact with the workplace and the labour market. The following are some examples of psychiatric rehabilitation programmes.

#### ***3.3.1 ACCEPT Northern Ireland– Assessment, Counseling and Coaching in Employment, Placement and Training for consumers***

ACCEPT Northern Ireland is part of a European partnership of organizations from Finland, France, Germany, the United Kingdom, Greece, Italy, Portugal, Netherlands and Sweden known as the ACCEPT Network. The network aims to educate people with mental health problems (consumers) and the public to reach the goal of increasing working opportunities for consumers. ACCEPT North Ireland has taken a proactive approach to promoting awareness about mental health, with a strong focus on the workplace. The ACCEPT Northern Ireland project is supported by Action Mental Health (AMH), the largest voluntary regional provider of vocational training and personal development programs in the UK. ACCEPT Northern Ireland set up four, one-stop information facilities in high-profile locations of Northern Ireland, essentially bringing mental health services "out of the closet" and "into the high street." These centers offer guidance and counseling and also provide personal development

courses, including pre-employment training. Since 1995, the program has helped 600 consumers move into the workforce or gain further training, advised 1,600 consumers of their options, helped 1,200 consumers obtain certificates in various subjects and provided general mental health information to more than 12,000 people. ([www.accept-net.org](http://www.accept-net.org))

### ***3.3.2 The Fountain House Clubhouse Model Program***

The clubhouse model program, now operating in many countries around the world, serves as a very successful, highly structured model for those assisting individuals with mental health problems to cope with their illness and to re-integrate into society. The original program, known as Fountain House in New York City, has thrived and includes a training component for anyone setting up a similar program. The program consists of establishing “club houses,” where people with mental health conditions (known as members) meet and receive support and services, with the goal of returning to the workplace as productive employees.

Fountain House understands that members need purpose in their lives to speed their recovery from mental illness, and employment falls into this need. Since 1948 Fountain House has assisted 16,000 members to take an active role in their community. Not only do clubhouses help members finding places to live, they have three different programs to help members make the transition back into the workplace: transitional employment (TE), independent employment (IE) and supported employment (SE) ([www.reintegration.com](http://www.reintegration.com)).

#### *Transitional Employment*

Most clubhouse members ease back into the workforce through transitional employment. The “clubhouse” provides the training necessary for the positions provided by various participating companies in the community. Members are allowed to work at their own pace with each placement lasting between six and nine months. The member may move to another placement after the first is completed.

#### *Independent Employment*

Members with prior work experience or those who have been through a number of TE placements and want to hold jobs outside the clubhouse’s economic community can turn to their clubhouse for necessary support. The independent employment unit helps members prepare for interviews, write resumes and set up interviews for job placement. While they work, members can continue to call the clubhouse for support.

#### *Supported Employment*

SE is a combination of independent employment and transitional employment for members interested in additional work options. While it offers initial on-the-job training and assistance, its main goal is to provide ongoing support to members who have permanent jobs on their own.

Over 730 Massachusetts companies employed clubhouse members in 2001 according to the employment survey released by the Massachusetts Clubhouse Coalition (MCC) ([www.employmentoptions.org](http://www.employmentoptions.org)). The MCC survey highlights the positive contributions people with mental illness make in their communities. Members of clubhouses in the MCC earned \$7,765,013 in 2002, bringing in needed tax revenue to the state while following their path to recovery. One of the clubhouses in the coalition - Employment Options has 200 members. Those who engaged in work earned a total of \$125,473 in the fiscal year 2002 through supported and transitional employment alone ([www.employmentoptions.org](http://www.employmentoptions.org)). Another Clubhouse in Massachusetts – Genesis Clubhouse with 400 members - had 142

members involved in employment and together they earned in excess of \$700,000 in the fiscal year 2001. Seventy one members earned their income through TE, 21 through SE and 50 through IE ([www.genesisclub.org](http://www.genesisclub.org)).

### ***3.3.3 The Ontario Council of Alternative Businesses (OCAB)***

OCAB was started for and by consumers of mental health services, to help them successfully obtain employment. It is a non-profit, provincially mandated organization with the Ontario Ministry of Health, whose mission is to provide employment/economic opportunities to psychiatric survivors.

OCAB's accomplishments:

- Entirely run and managed by people with mental health problems;
- More than 800 people with mental health conditions, previously deemed "unemployable," are employed;
- Eight small businesses exist, that include services such as carpentry, landscaping, janitorial, food service and retail outlets;
- All businesses are developed for and by people with mental health problems and, over the course of time, have evolved with the needs and concerns of the group.

OCAB fosters an environment where people with mental health conditions do not experience the shame, fear and rejection that may keep them from returning to the workforce. They are given the chance to feel the dignity that comes from work, build new skills and find their place in the community ([www.iComm.ca/ocab](http://www.iComm.ca/ocab))

## **3.4 Experience of Stress Related Disorders and RTW**

The relevance of much of the literature for the rehabilitation of stress related disorders such as anxiety or depression is not abundantly clear. Most rehabilitation processes deal with people who have experienced problems of such a degree that they require major input to enable them to achieve some level of mental wellbeing. (Of course, rehabilitation of people with severe psychiatric disorders often involves working in sheltered workshops and similar situations). They focus on achieving clinical outcomes, and though social outcomes (including the (re)establishment in a work role) are given consideration, rehabilitation processes do not seem to frame return to work as a major objective. There is large body of literature looking at the causes and impacts of workplace stress and related issues (these are comprehensively discussed in Chapter 1), however, there is very little consideration given to the return to work of workers' on sickness absence due to stress-related illnesses.

Given the nature of the stress related disorders of concern in the current context, which may be characterised as being acute, possibly recurrent, and in which contact with the workplace is still ongoing, the lack of focus of traditional rehabilitation services on the workplace or on the open labour market may be seen as a major problem.

### **3.4.1 Stress related leave**

Most research post injury is concerned with physical rather than psychological injuries and occupational stress research tends to focus on at-work samples. In 1999, Dollard et al. in an Australia study explored the predictors of stress-related leave by examining compensation claims in a large welfare agency in the public sector. This study investigated predictors of

stress claims, with particular regard to gender, sick leave history and the nature of the injury reported. It also sought to determine factors that supported or inhibited an early RTW after a claim had been lodged. A case study approach was used, where all staff members of a large public sector welfare agency who had made a compensation claim for work-related stress during a 12 month period (n=19) were interviewed in-depth. Data was obtained from 16 workers.

Findings show that stress claimants had taken twice as many days of sick leave as the organisational average in the year preceding their claim. The nature of the stress related injury precipitating the stress claim could be divided into three types with 19% experiencing a critical incident only; 37% experiencing a critical incident on top of chronic work stressors and 44% experiencing chronic work stressors only. Chronic work stressors included high workload, unmet needs for training, conflict with fellow workers or management, escalating grievances, job dissatisfaction through lack of recognition and promotion opportunities, the violent nature of the work environment, high demands and very high responsibility, redeployment failure (lack of suitable work), lack of support in ones' position, chronic turnover of managers and job uncertainty. A clear relationship was found between type of stress precipitant and length of stress-related leave, suggesting that the organisational response to specific stressful incidents was much more effective than its response to chronic work stressors. The role of non-work stressors was not seen by the workers as critical in the development of strain.

Half of the work stress claimants rated their manager's or supervisor's response to their problem as 'bad' and a quarter as 'average'. The way in which supervisors, in particular, and co-workers responded to the worker's open expression of distress was cited as a critical factor in the long-term resolution of the claim. In this study, the majority of evaluations of supervisors were negative. With many respondents perceiving management as totally unsupportive, unresponsive, untrustworthy, untrained and lacking in all human/communication skills.

Another study, in the Netherlands, looked at workers who experienced mental health problems and stress (Houtman, 2002). This study examined the types of mental health problems reported, what could be done to reduce mental health problems, to stimulate a return to work and to identify the determinants of rehabilitation to work. The participants were followed up 12-20 weeks after reporting absent and again after 12 months. With their consent, their GPs and OHP were also interviewed after 12-20 weeks. The study looked at work conditions, symptoms (burnout, anxiety depression), type and frequency of interventions (visits to GPs, OHPs, preventative action by employer and employee; work rehabilitation (12 month interview only)). Of the sample, 13% experienced burnout, 23% experienced anxiety and depression, 12% experienced burnout and anxiety and depression, 34% had a high GHQ score and 18% had no mental health problems. Findings show that every employee was in contact with either their GP or the OHP in first 4 weeks (74% GP and 70% OHP). Results also show that OHP and the GP hardly contact each other about a case (3%); that employees absent due to psychological problems are not frequently referred to psychologists or other specially trained professionals; that very few employees (6%) consider that employers take measures directed at rehabilitation and almost half of employees do not think that employers do enough to rehabilitate employees.

Results show that after one year 51% of workers were completely rehabilitated and 6 months later, 91% of these, were still well. Of those completely rehabilitated after 18 months, 80% were rehabilitated to their original employer.

A recent report on mental health at work ((FIOH, 2003), shows that regional or national level programmes have been established to address concerns about mental health in the majority of European countries. The report states that more emphasis is needed on enterprise level

projects and provides examples of good practice in the area of workplace health promotion and mental health promotion from a number of European countries. The focus of the report is on mental health promotion and it recommends that mental health promotion should be integrated into already existing company structures. It notes that mental health problems and specially those of co-morbidity with dual diagnoses (i.e. physical problems with underlying mental health problems) are under-recognised and under-treated. The research found that companies consider stress, bullying, harassment and violence at work, but do not usually deal seriously with anxiety or depression. It also states that many workers are reluctant to discuss their moods, feelings and ability to concentrate with others.

### **3.4.2 Issues related to stress leave**

Despite advances in understanding and treatment, there is still a significant social stigma surrounding depression and other similar conditions. Employees fear the consequences, whether perceived or actual, of being identified as suffering from a mental health disorder. Their fear often leads them to hide the true cause of their disability from their employers (Watson Wyatt, 2003). In a recent survey conducted for the Quebec Mental Illness Foundation, 40 percent of respondents indicated that they would not tell their employer if they suffered from depression (The Gazette, Montreal 2002). This strongly suggest that employers are not getting an accurate picture of the impact of mental health disorders on their employees.

This suggestion was confirmed by the Australian study outlined above, which found that claim workers had used a range of strategies to avoid taking stress leave. Seven of the 16 respondents took other kinds of leave, sometimes before stress leave and sometimes afterwards, to deal with the problem. In some cases, workers used all of their annual leave, sick leave and long service leave rather than take stress leave. Workers also described the stigma associated with taking stress leave. One manager intimated to a worker that a compensation claim would mean the end of her career prospects. The worker concluded in retrospect that it would have been better to take sick leave than stress leave.

Among those who are aware of their benefits, many people are concerned about using their employee benefits to obtain treatment for mental illness out of fear that their bosses and colleagues will learn about the problem and use it against them. Many professional workers who either resign a job or take a medical leave of absence related to a mental illness episode (i.e., depression) experience difficulty maintaining a working, discrimination-free relationship with their employer. Those returning to the same work environment find that performance and behavioral difficulties that initially interrupted work have altered employer perception of their professional abilities (www.nmhi.com).

### **3.4.3 Actions and Strategies for the RTW of people with stress related and mental health problems**

Mental health associations have indicated that among the most significant tools to address mental illness is meaningful work and enlightened workplaces for people with mental health problems. Work can play an important role in supporting good mental wellness or health. Employment provides time structure, social contact, social context outside the family, identity and regular activity – all valuable components in promoting mental well-being. (www.nmhi.com)

While there is very little research literature on the issue of return to work of people with stress related illnesses, practitioners working in the area of RTW and associations for people with mental health illnesses have recognised that stress and mental health related absences are a concern and they have proposed and developed actions to address this issues. This section outlines some of the actions proposed by these organisations, agencies and consultants working in the area to re-integrate people with stress related illnesses into the workplace.

Disability management programmes are typically designed to deal with employees who experience absence from work due to physical impairments. Stress related illness and mental health disorders tend to be far more complex conditions and accordingly, the needs of employees returning to work following a mental health-related absence may be far different from those of an employee returning after back surgery. Pimentel (2001), however, suggests that the basic principles of return-to-work strategies as developed for people with physical injuries apply equally to people with stress related illnesses. However, he emphasises that to successfully reintegrate stress related absentees, disability managers and return to work co-ordinators need to learn about and incorporate issues specific to stress related and mental health illnesses.

Mental health associations and other groups working specifically with people with mental health problems have long recognised the impact of the workplace on employee health and well-being. They have strong evidence that suggests that reintegration into the workplace can occur successfully (CMHA, NIMH). These associations consider the prompt reintegration of employees into the workplace after treatment for mental illness is crucial to the health and productivity of the individual. To this end, they have drawn up specific steps employers can take to help an employee return to work after treatment for a mental health problem such as depression, for example. These recommendations are targeted at dealing with the issues at two levels – the organizational level (which considers policies and practices to be adopted by the organisation) and the individual level (which looks at the issues that support return to work).

### ***Organisational level strategies***

Employers and managers can play a role in altering the impact that mental health problems have in the workplace by:

- Reviewing corporate medical programmes and employee health benefits
- Making sure employee assistance programme staff are trained to recognize depressive disorders, make appropriate referrals and provide other assistance consistent with policies and practices
- Increase management and supervisors awareness of mental health issues.
- Educate employees about symptoms and treatments for mental health illness.
- Work with national or community organisations to obtain, display and distribute information about mental health issues at the workplace and provide employees with referrals to treatment. ([www.workplaceblues.com](http://www.workplaceblues.com))

### ***Individual level strategies***

- Informing the physician of the exact duties of the job to help the physician make a final decision on return to work.
- Encouraging an early return to work. The longer an employee is out of work due to treatment, the more he/she will worry about losing the job. And the longer a person is away from the job, the more mentally detached he or she will become. Also, many

employers find that once an employee is absent for mental health reasons for three months, the likelihood is very high that the absence will extend to more than one year.

- Considering a gradual return to work. Allowing part-time and flex-time work, as well as a temporary change in job duties, may help reduce stress, leave time for additional medical counseling and allow workers to gradually get back to a normal routine. However, there should be a clear understanding between the employer and the employee as to the details of the return-to-work arrangement, including the expected length of time for special accommodations, work duties and supervision.
- Incorporating other possible stress-reducing accommodations for returning employees, such as altering the pace of work; lowering the noise level; providing water and/or ice to combat a dry mouth caused by medication; providing extra encouragement and praise of job performance when warranted; avoiding over-protection of the employee; and making sure the employee is treated as a member of the team and not excluded from social events, business meetings or other activities relevant to the job. ([www./workplaceblues.com](http://www.workplaceblues.com), [www.nimh.nih.gov](http://www.nimh.nih.gov)).

Watson Wyatt (2002) proposed a set of actions to help assist employers to translate their concern about the costs associated with mental health disorders into action in order to appropriately address the impact on their organizations. They suggest that specific actions taken by employers should consider include:

- **Examining STD/LTD Claims.** Conducting a review of STD and LTD claims will reveal an organization's mental health claims experience, which may be higher than expected. The results of the review will also provide benchmarks that can be used to design and evaluate the effectiveness of new policies and procedures.
- **Reviewing Return To Work Policies.** Mental health disorders do not fit the typical model of disability, which many employers still view in terms of a physical impairment. Existing return to work arrangements should therefore be reviewed and revised as needed to address such situations.
- **Preparing Education Programs.** Education about causes, symptoms and treatment is the key to overcoming the remaining stigma surrounding mental health disorders and ensuring that individuals seek early treatment. Employers can assist in this regard by ensuring that everyone in their organization, from the top down, is informed about issues relating to mental health and illness. While the implementation of such programs cannot guarantee that all employees will seek early treatment, it will reduce the stress faced by those suffering from mental health disorders.
- **Examining Internal Culture.** Along with an education program, employers should enlist the services of external professionals to conduct an examination of their organizational culture. Such an examination will reveal if there are any workplace issues (i.e., harassment, adversarial relationships between management and employees, etc.) that are creating unnecessary stress and hostility in the workplace. Such conditions will have a detrimental impact on all employees, especially employees dealing with mental health disorders. Employers should take steps to remedy any problems that emerge as a result of such an examination. While some of the other steps listed can be conducted by the employer, the use of outside experts for this endeavour is essential to ensure objectivity and confidentiality.
- **Implementing/ Revising Employee Assistance Programs.** Employers with no employee assistance program (EAP) should consider implementing such programs to address mental health, and a variety of other issues. Some insurers provide disability rate discounts to smaller employers who implement an EAP, usually through a

preferred provider. Even if an organization already has an EAP in place, the program should be reviewed and revised as needed to better address the needs of employees dealing with a mental health disorder. Specific elements to be examined could include the need for meaningful reports, performance standards and user feedback. Internal reviews include comparing EAP utilization and absence data by operating unit to identify internal 'best practices' which can be introduced across the organization. Make sure your employee assistance program staff are trained to recognize depressive disorders, make appropriate referrals, and provide other assistance consistent with policies and practices. Last but not least, the availability of an EAP should be communicated to employees on an ongoing basis.

### ***Transitional Employment Strategies for People with Stress Related Absences***

Stress is a complicated issue. But often employer attitudes and feelings about stress are as complicated or difficult as the issue itself. By taking an objective, unemotional approach to the problem of stress, employers can bring resources to bear to the advantage of both the employees and the organization Pimentel (2002). He suggests that Transitional employment strategies have an important role to play in the return to work of employees with stress related absences. Pimentel states that it is not possible to develop a standard Transitional Employment Plan for all employees with stress as each case and circumstance is necessarily different. However, just as there are some common considerations for Transitional Employment assignments for physical impairments, so there are some common considerations for stress-related impairments. The following are some ideas he proposes that can be used to start thinking about possible elements of a Transitional Employment Plan for employees with stress.

When considering modified assignments for persons with stress, there are at least three major issues to consider:

1. *Employee's physical/emotional condition*

The employee's physical/emotional response to stress needs to be considered when developing a Transitional Employment Plan. Depression, anxiety, insomnia, exhaustion and headaches are common responses to stress. The physical symptoms of stress should be factored into the Transitional Employment assignment, just as they would be for anyone who had these conditions.

2. *Effects of medication*

It is not only the employee's physical/emotional response to stress that can affect his or her Transitional Employment needs. Many employees experiencing stress are put on medications. These medications can be very effective, however, they can also negatively impact the employee's job performance. Consider the effect of medication on the return-to-work process for an employee with stress just as you would any other medication an employee may be taking, and develop your return-to-work plan accordingly.

3. *Organizational issues.*

The employer needs to consider all of the elements of management style. Some of the important issues are:

- Employee feels "out of the loop" with regard to important decisions that affect him or her.

Be sure to involve the employee in the development of the Transitional Employment Plan. Even the best plan, if created without input from the employee, undermines the goal of helping the employee to feel more in control of the situation. Experience has proven that employees are more successful in Transitional Employment Plans where they have had input.

- Lack of clarity about employee's job responsibilities and goals

All employees need clear direction. Lack of clear direction and inconsistency about responsibilities and goals is a stress factor in itself. The duties and responsibilities of the employee and the supervisor in the Transitional Employment Plan also need to be spelled out in writing. The employee needs to understand that the goal of Transitional Employment is to help him or her to transition back into the regular job.

- Lack of supervisory skills and knowledge about work-related stress

By the time an employee shows symptoms of stress, it is not unusual for the supervisor/employee relation to be filled with conflict, suspicion and frustration. Getting supervisors to buy-in to the process is as important as getting employees to buy-in to it. When provided with training, tools and direction to help make the Transitional Employment Plan work, the supervisor will be able to give the employee the support that he or she needs to work through the stress.

- Communication

The success of the Transitional Employment Plan will often depend on the day-to-day interactions between the employee and the supervisor. When a supervisory style allows for employee feedback and problem resolution, the employee may be able to regain and maintain a sense of control, and the organization will be able to help the employee meet necessary productivity and performance goals.

In conclusion, Pimentel states that as long as corporate disability management programs fail to include stress and psychiatric conditions in their Transitional Employment and Work as Therapy strategies, the negative impact of these conditions will continue to grow, not only in the area of cost of treatment but also production, attendance and turnover. With the right attitude and preparation, companies and their employees with stress and psychiatric illnesses can and will benefit from Transitional Employment in the same way that their physically injured or ill counterparts have benefited.

## 4. Discussion

There is very little literature available dealing specifically with the issue of re-integration into the workplace of people with stress related illness or mental health problems. Most of the available literature relating to RTW comes from the area of physical illness or injury. While this body of literature provides a wealth of information on issues relating to RTW, given the diverse nature of this area there are no definitive studies in the area. Much of this literature focuses on a range of factors specific to the individual e.g gender, age, physical skills of the individual, though more recently there are a number of studies considering the impact of the workplace on the issue of return to work. Most of the studies cited in the literature have been conducted on small samples from specific occupational groupings or workplaces. A wide range of variables have been explored in an effort to explain the factors that may differentiate between those individuals who return to work and those who withdraw from work. However, the literature fails to identify the precise combination of determinants of successful return to work and does not reflect a consistent understanding of the multidimensional nature of either work disability or facilitators for return to work. Overall, it may be said that the literature in this area is of poor methodological quality (small sample sizes, poor quality research, unsystematic), it comes from a diverse range of disciplines (e.g. medicine, occupational therapy, physiotherapy, economics, public policy) and the knowledge base is fragmented and disorganised.

A number of studies consider the issue of return to work of people with psychiatric disorders. However, these tend to focus on the rehabilitation of individuals who have generally been unemployed for a significant length of time or who may never have worked previously. Most of the literature on integration or re-integration of people with mental health problems focuses on vocational rehabilitation programmes. These are generally individually oriented programmes delivered, in the main, by state and voluntary agencies.

There is a considerable literature dealing with the practical aspects of delivering RTW programmes and with the range of work options and strategies available to employers to attract absent employees back to the workplace. Again the current return to work and rehabilitation models are developed mainly in response to people with physical injuries or illness and as a result may be considered ineffective in responding to the needs of workers experiencing either short or long term absence as a result of stress related, psychological or mental health problems. While there is almost no research specifically in relation to returning workers with stress related or mental health problems to the workplace, the issue has been considered by a number of practitioners working in this area and by associations and organisations concerned with mental health issues. These organisations and consultants have developed and adapted range of actions and strategies to help employers develop and set up RTW programmes specifically targeted at this group.

It can be concluded that there is a definite gap in the literature on the issue of return to work of people with stress related or mental health problems. This is a significant issue, particularly, as the literature shows there is an increase in the experience of stress in the workplace for a range of reasons including structural changes, changing work contexts, the shift to more knowledge-based work and the continuous introduction of new technology. It is important to note that work related stress, and other related issues such as harassment, bullying and violence at work, are recognised as a concern to workplaces across Europe, and the management of these issues is addressed in some way through health and safety and health promotion policies and practices. However, these responses are generally only targeted at 'at work' groups leaving workers absent from work due to these issues vulnerable. Furthermore, while stress, bullying, harassment and violence are considered by

workplaces, other aspects of mental health such as anxiety and depression are largely ignored both for workers within the workplace and for those absent for these reasons.

Important issues relating to return to work identified in the literature reviewed above that are pertinent in the study of return to work of people with stress related and mental health problems and need to be considered by this study are outlined below. These have been divided into issues relating specifically to the provision of RTW services and those relating to the experience of stress in relation to RTW.

***Service provision issues:***

***The coordination of services*** - a number of studies have identified the poor communication and co-ordination that exists between health and employment services. The issue of coordination between professionals dealing with an returning worker outside of the workplace and professionals within the workplace needs to be emphasised as does, co-ordination of the provision of service within the organisation and with the individual concerned.

***Managerial support for RTW programmes and processes.*** Studies show that like all business processes, the success of RTW programmes will not be achieved without management support and the allocation of appropriate resources.

***Supervisor's role.*** The supervisor has a fundamental role in managing relations with the returning worker both when absent and also when returning to work and also in managing the perceptions and expectations of co-workers.

***RTW programme adaptation.*** The adaptation of already existing actions and procedures for the RTW of workers absent due to stress related and mental health problems has already been identified. The present study could further explore this issue.

***Issues relating specifically to the area of stress related and mental health problems***

***Underreporting of stress related illness.*** Evidence from research indicates that because of the stigma attached to these illnesses and the perceptions of management, supervisors and co-workers about the abilities of the worker experiencing stress related or mental health problems, employees are reluctant to overtly take stress leave from work and conceal the real reasons for the absence by claiming it as absence due to some other illness, holiday leave or other annual leave. This has important implications for this study in terms of identifying a study sample.

In conclusion, stress related and mental health issues are a very real and significant problem in all workplaces. While addressing these via programmes targeted at managing disability is valid, necessary, and should be implemented in a routine and on-going manner; the primary focus needs to be on actively promoting health and providing support in the workplace. By taking steps aimed at stopping problems before they start, such as reducing workplace stressors, facilitating work-life balance and promoting healthy lifestyle choices, employers can reduce the incidence of stress related and mental health disorders and a wide variety of other forms of illness in the workforce. The next chapter explores the issues relating to interventions.

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