Return to Work –
an Integrated e-Learning Environment

Life Long Learning Programme 2007-2013
Leonardo Da Vinci

Requirements for Training and Tool Support
D2.1

Due date of deliverable: 03/08

Actual submission date: 06/08

Deliverable completed by: WRC

Circulation List	
Name	**Company**
Jan Spooren	EPR
Nadege Jibassia	EPR
Tilia Boussios	EWORX
Chris Condos	EWORX
Wolfgang Zimmerman	NIDMAR
Frank Cunneen	WSG
Richard Wynne	WRC
Leonie Lynch	WRC
Donal McAnaney	WRC
Ivor Ambrose	IVOR AMBROSE Technical Services

Document History						
Edi	**Rev**	**Date**	**Confidentiality**	**Description**	**Action**	**Pages**
1		22/5/08	R	Created by WRC	C	84

(*) Action: I = Insert R = Replace C = Creation
Confidentiality: R = Reintegrate Consortium O = other (add to circulation list)

Table of Contents

1. INTRODUCTION 5
2. METHODOLOGY OF THE NEEDS ANALYSIS STUDY 7
2.1 FINDINGS FROM THE LITERATURE 8
2.2 OTHER TRAINING COURSES 8
2.3 THE USER SURVEY 8
2.3.1 Development and Content of the Questionnaire 8
2.3.2 Sampling 9
2.3.3 Analysis 9
2.4 THE NEEDS ANALYSIS WORKSHOP 10
3. RESULTS 12
3.1 LITERATURE REVIEW 12
3.1.1 Context 12
3.1.2 Getting Started 20
3.1.2.a Principles 20
3.1.2.b The Business Case 23
3.1.2.c Marketing, Persuasion and Overcoming Challenges 26
3.1.3 Policy Development 30
3.1.4 Building and Maintaining Capacity 33
3.1.5 Getting the Employee Back to Work 36
3.1.5.a Maintaining Workability 39
3.1.5.b Assessing the Return to Work Threshold 40
3.1.5.c Early Intervention and Case Management 47
3.1.5.d Interventions and Follow Up 51
3.2 OTHER AVAILABLE TRAINING 55
3.3 SURVEY 62
3.3.1 Quantitative 62
3.3.1.a Importance of the Elements –Frequencies and Means 62
3.3.1.b Level of Knowledge and Skills – Frequencies and Means 66
3.3.1.c Training Needs - Means 70
3.3.1.d Length of Training 74
3.3.2 Qualitative 74
4. CONCLUSION 81
4.1 LITERATURE REVIEW 81
4.2 OTHER TRAINING 82
4.3 SURVEY 82
4.4 TRAINING SPECIFICATION DIAGRAM 83
5. APPENDICES 86
5.1 APPENDIX 1: TRAINING NEEDS QUESTIONNAIRE 86
5.2 APPENDIX 2: FRAMEWORK OF POTENTIAL TRAINING ELEMENTS V1 91

Index of Tables

TABLE 1: FINANCIAL SERVICES (PROFILE 2007) 27
TABLE 2: CHEMICALS AND PHARMACEUTICALS (PROFILE 2007) 28
TABLE 3A: IMPORTANCE OF THE PREVENTION/INTERVENTION ELEMENTS –FREQS & MEANS 63
TABLE 3B: IMPORTANCE OF THE RETENTION/REINTEGRATION ELEMENTS –FREQS & MEANS 64
TABLE 3C: IMPORTANCE OF ALL ELEMENTS- MEANS FOR OSH STUDENTS, EUROPEAN REHABILITATION AGENCIES AND IRISH EMPLOYERS 65
TABLE 4A: LEVEL OF KNOWLEDGE & SKILLS (PREVENTION/INTERVENTION) – FREQS & MEANS 67
TABLE 4B: LEVEL OF KNOWLEDGE & SKILLS (RETENTION/REINTEGRATION) – FREQS & MEANS 68
TABLE 4C: LEVEL OF KNOWLEDGE & SKILLS FOR ALL ELEMENTS- MEANS FOR OSH STUDENTS, EUROPEAN REHABILITATION AGENCIES AND IRISH EMPLOYERS 69
TABLE 5A: TRAINING NEEDS –MEANS 71
TABLE 5B: TRAINING NEEDS –MEANS FOR OSH STUDENTS, EUROPEAN REHABILITATION AGENCIES AND IRISH EMPLOYERS 72
TABLE 6: LENGTH OF TRAINING - MEANS 74
TABLE 7: REASONS FOR WORK ABSENCE 75
TABLE 8: MOST IMPORTANT SERVICES FOR RTW 76
TABLE 9: BARRIERS TO RTW 77
TABLE 10: MOST IMPORTANT RTW FACTORS 78
TABLE 11: HR MANAGERS' KNOWLEDGE NEEDS 79
TABLE 12: HR MANAGERS SKILLS NEEDED 79

Index of Figures

FIGURE 1: THE THRESHOLD MODEL 43
FIGURE 2: RETURN TO WORK THRESHOLD 45

1. Introduction

This project sets out to transfer knowledge, skills and resources, which were developed in a wide range of European and national initiatives (RETURN[1], Stress Impact[2]) aimed at retaining and reintegrating, or in some cases redeploying, vulnerable employees into work (vulnerable employees are employees who have developed an illness or disease either at work or outside work who are at risk of long term absence).

Reintegrate will develop two innovative e-based outputs – an assessment tool for employers to help them identify the strengths and weaknesses of their current practice and a training course designed to address their specific training needs in relation to retention and recruitment practices focusing on health and disability issues.

The main target group for the project outputs are employers who make the retention/recruitment decision about employees who become ill or disabled, however the project will also target other agents who may influence this decision, such as trade unions. The potential target groups are listed under their common professional titles as follows:

- Human Resource Managers
- Occupational Health Managers
- Trade Union representatives
- Staff representatives
- Workers in service providing agencies (e.g. rehabilitation agency workers)

Research has identified the need to enhance the knowledge, skills and attitudes of employers, supervisors and co-workers in order to effectively retain or recruit workers who have become ill or disabled[3][4]. The training and tools to be developed within the project aim to redress this low level of knowledge and skills.

This report (deliverable 2.1) is the summary of the findings of all the activities carried out as part of workpackage 2 (WP2) of the project. The aim of WP2 was to specify the needs of the target group in relation to training and tool support for the implementation of effective return to work practices in organisations.

The specific aims of WP2 were:

- To identify target groups needs
- To identify similar approaches to the issue
- To produce a specification for training and tool support which will direct the work in WPs 3 and 4.

---

[1]RETURN (2002b) Summary Report of RETURN Project, Dublin, University College Dublin. www.wrc-research.ie/return

[2] Stress Impact (2003) *A Review and Inventory of Systems and Policy relevant to Stress and Long Term Absence*, Surrey, University of Surrey.

[3] Bruyère, S., & Horne, R. (1999). *Disability employment policies and practices in U.S.* Federal Government agencies. Report by the Presidential Task Force on Employment of Adults with Disabilities. Ithaca: NY: Cornell University, School of Industrial and Labor Relations, Extension Division, Program on Employment and Disability. Available from http://digitalcommons.ilr.cornell.edu/edicollect/62/.

[4] Bruyere, S., Erickson, W., & Ferrentino, J. (2003). *Identity and disability in the workplace*. William and Mary Law Review, 44(3), 1173-1196. Available from http://digitalcommons.ilr.cornell.edu/edicollect/125/

This WP built upon what was already known in relation to the needs of the target group in relation to training and tool support for the implementation of return to work practices. Specifically, it used the work of previous projects, the expertise of NIDMAR[5] (a partner in this project) and various literature sources to inform this deliverable i.e. the specification of needs. In addition, a survey, of potential users of the tool, was undertaken to establish needs in a more immediate manner. This deliverable reports on the specifications for the training (face to face and e-based) and the assessment tool support (e-based) to be developed in subsequent WPs.

[5] The National Institute of Disability Management and Research, established in 1994 in British Columbia, Canada

2. Methodology of the Needs Analysis Study

Undertaking the needs analysis study was a dynamic process involving four main elements:

- Surveying representative users of the training course to assess their current state of knowledge and their training needs
- Synthesising the findings from specific elements of the literature on return to work strategies
- Identifying other training courses in the area
- Integrating the findings from these sources in an internal project workshop

The aim of the methodology was to produce a statement of training needs that took into account both what is known in terms of best practice in the area of return to work and the needs of potential beneficiaries from the training. In addition, it sought to take account of other training courses in the area so that the Reintegrate training does not compete with or overlap with these.

It should be noted that the design of training outputs to be produced by the Reintegrate project was delimited by a number of considerations. These included the issues of existing training courses and national contextual issues as outlined below:

It was already known that there were a number of training courses available in the area (e.g. the NIDMAR courses). However, these courses covered the area in far more detail and to a much higher level than would be possible within Reintegrate. These courses are aimed at producing, for example, specialist case managers who would act as professionals in the field, whereas the aim of the Reintegrate project was to raise awareness and provide basic knowledge and skills to non-professionals in companies who have to deal with return to work issues.

There are a wide range of what might be termed contextual issues that influence the practice and policy of return to work. These include, the extent to which national systems act as an incentive or disincentive to return to work, eligibility for and level of benefits in different national systems, national legislation, the availability and disposition of external services in the area and a range of other factors external to the employing organisation. While acknowledging the potential importance of these factors, they will not be treated in detail in the training product, in part because of their local or national character, but also because the volume of material in this area is very large. However, appropriate reference to this type of material will be made in the training outputs. The focus in the Reintegrate project is specifically on actors within the enterprise that can influence or manage the return to work process.

It should be borne in mind that the outputs of the needs analysis study was required to identify training needs that would be treated in multiple ways, i.e. the project is producing a face to face course, a train the trainers course and an e-learning environment. This diversity of outputs required that a comprehensive needs analysis be undertaken and that a methodology for making decisions about the allocation of content to the different forms of training would be needed.

2.1 Findings from the Literature

One of the main components of the needs analysis included carrying out an analysis of scientific and other literature on return to work practices of relevance to building the training outputs of the project. Much of this literature was already known to the project and the WRC had been involved in some of the main studies in the area in Europe over the past few years. This work had formed the basis of the proposal for the Reintegrate project.

The task therefore was not so much concerned with identifying new literature, but with summarising the main findings from the existing literature. Specific issues of concern were to ensure that the information and training needs identified through the survey work could be covered from the literature available to the project. Where this would not be the case, additional material would be sought from outside of these resources.

2.2 Other Training Courses

The second part to the needs analysis task concerned the identification of already existing courses in the area of return to work training. Some of these courses were already known to the project consortium, e.g. the diploma level training offered by NIDMAR, but is was also important to identify other courses that may be available in the area in order to ensure that the Reintegrate project course does not overlap with other courses.

Accordingly, an internet search was conducted to identify any potential competing or complementary training courses in the area.

2.3 The User Survey

The third main component of the needs analysis was a transnational survey of people from the potential target groups (see Section 1) for the project.

This survey was to be used as a means of identifying:

- General opinions on return to work
- Opinions on specific return to work topics
- Opinions on how training should be organised

2.3.1 Development and Content of the Questionnaire

The questionnaire for the survey was developed with the aims of identifying the main issues that should be included in the training outputs from the project, assessing the

relative importance of these and identifying opinions on the formats that the training outputs should take.

Development of the questionnaire was a collaborative process with WRC proposing drafts of the questionnaire and all other partners commenting on these drafts until a final version was arrived at. Potential content for the questionnaire was obtained from a number of sources:

- The literature on return to work – these included European projects in which the partners had been involved and other sources (see Section 3.1 for details)
- The work of NIDMAR in Canada, who are a partner in the project

The questionnaire was organised in three sections. In section 1, a set of open ended questions were asked which concerned:

- Reasons for absence from work
- Services for ensuring return to work
- Barriers to return to work
- Human Resource (HR) managers knowledge needs with regard to return to work
- HR managers skills needs with regard to return to work
- The most important factors in ensuring return to work

The second section of the questionnaire asked a set of questions regarding 26 elements of the prevention/intervention and retention/reintegration axes of return to work practices. These questions sought to assess the level of knowledge and skills that HR managers have about these issues and the importance of these issues.

Section 3 of the questionnaire was concerned with how the training outputs of the project might be organised. Specifically, it asked questions about the overall duration of the course and the duration of specific elements of the course.

The full questionnaire is to be found in Appendix 1 to this report.

2.3.2 Sampling

The sample for the survey was drawn from three sources – mature students of occupational health management at University College Dublin, which was arranged by the WRC, people working as HR staff and occupational health managers in IBEC member companies which was arranged by the WSG and people working in rehabilitation agencies which was organised by EPR.

In all, 44 responses to the survey were obtained – 10 by WRC, 27 by WSG and 7 by EPR. Given the wide range of professional backgrounds and experience within the sample, these numbers allowed for sufficiently robust conclusions to be drawn from the results of the survey.

The sample used in the survey was not intended to be fully representative in a statistical sense. Instead, the sample was drawn from groups who are representative of some of the main stakeholders in the return to work process i.e. HR managers, Occupational Health (OH) personnel and from outside of the target organisations, people working in rehabilitation services. In addition, it was important to obtain some opinions from outside of Ireland and EPR supplied these from seven countries.

The questionnaire was generally administered in a real time, face-to-face manner (this was the case in Ireland for both the WRC and WSG samples). However, for the EPR sample, the questionnaire was administered via a telephone interview, given the fact that respondents came from seven countries.

2.3.3 Analysis

The main purpose of the analysis of the survey results was to identify the relative importance of certain qualitative key issues contained within the data rather than to test causative or associative theoretical models. The approach taken therefore to the data

analysis was mainly descriptive, based on frequencies and means. Overall, this analysis aimed to quantify the most important content areas for inclusion in the training outputs.

Of specific interest in the analysis was the question of what was the strength of specific training needs of the target group. As indicated above, two kinds of questions were asked in relation to 26 elements of return to work practice. The first question asked about the importance of issues, while the second question asked about the level of knowledge and skills that HR managers have about these issues. These scores were subtracted from each other to provide an indicator of the most important training needs.

The survey also contained a number of open ended questions and these were content analysed with a view to identifying the most important issues affecting return to work for potential inclusion in the training outputs. Overall, this analysis aimed to identify any potential 'missing' issues from the plans for the training outputs.

2.4 The Needs Analysis Workshop

The final part of the methodology consisted of a project workshop which was held in Athens on April 14th and 15th 2008. The participants were drawn from the project partners and it was also attended by the project external evaluator.

The aims of this workshop were to:

- Review all of the evidence from the three sources (literature, existing training and the needs analysis survey)
- Construct a framework for organizing the potential content material for the various training courses and treatments

A number of criteria were developed to assist in the task of synthesising the material that had been collected in the needs analysis process. These were:

- Practicality – Above all, the material selected for inclusion in the Reintegrate training had to be usable by people in organisations with responsibility for job retention and reintegration. The aim here is to impart usable knowledge and skills to people with practical tasks and need.
- Universality – the content selected for inclusion in the Reintegrate products must be capable of being used in a range of national and organisational settings. It must therefore be capable of dealing with, for example, larger and smaller enterprises, differing national contexts and traditions and be capable of being used by a range of users from different professional backgrounds.
- Strength of training needs – The findings from the needs analysis survey were used as a means of differentiating between what were perceived to be relatively important and less important issues. In addition, the size of the gap between the importance of potential content issues and the level of knowledge that respondents had about those issues (the training needs gap) was taken into account.
- Importance of the content – Previous research in the area indicates that some content issues more than others are essential to the proper implementation of return to work procedures. These include managing such issues as early return to work practices, managing communications and using case management techniques. Such core features of good return practice were included In the

training specification, regardless of their apparent level of training needs, since the training products to be developed are to be targeted at an audience wider than that used in the needs analysis study.

The output from the workshop was a prioritized and organised set of issues which were transformed into a matrix to be used as potential content material for the various training courses (see Appendix 2). This was then in turn condensed into a number of priority areas that will be incorporated into each of the types of training (the Training Specification Diagram which is presented in Section 4).

3. Results

3.1 Literature Review

3.1.1 Context

The way in which companies react to employees who become ill or who acquire an injury is significantly influenced by the external context. For example the early focus on return to work evolved in jurisdictions in which a workers' compensation system was operating. Specifically, North America, Australia and New Zealand were some of the first regions to produce return to work guidelines and in which return to work emerged as a competence of rehabilitation professionals. There were a number of reasons for these developments not least of which were that workers' compensation systems operate on the basis of a 'no fault' principle which meant that a staff member who develops or acquires an impairment in the workplace is entitled to compensation without having to enter into a legal process. For many years employers adopted a strategy of simply paying insurance premiums to cover the disability payments for such employees. But gradually the Workers' Compensation Boards began to realise that the costs of these payments were escalating and the situation was unsustainable and so they began to 'experience rate' insurance premiums for companies. This meant that the previous three years costs incurred by a company were used to calculate the premium it paid. Therefore, the more employees from a company who entered the disability payment net the higher the insurance costs of the company. As a result employers began to take a proactive approach to getting long-term absent employees back to work. This evolved into what is now referred to as the field of Disability Management (DM).

The term DM refers to a continuum of policies and procedures which are designed to reduce the number of employees who exit a company on the grounds of illness or impairment. It includes some elements that are evident in most companies such as Occupational Safety and Health and Risk Management but also incorporates Workplace Health Promotion (WHP) and Occupational Health Programmes (OHP). All these aspects of DM are considered to primarily focus on Job Retention. That is they are targeted at the general workforce with a view to reducing the chance that a person will develop or acquire an illness or impairment by controlling workplace hazards and promoting a healthier lifestyle amongst employees. The other core aspect of DM focuses on those who have acquired an impairment which has resulted in potential long-term absence. The main elements of this aspect are Early Monitoring and Intervention (in some cases as early as three days), Case Management (once the absence has exceeded 6 weeks) and

Interventions (which can involve rebuilding the employees capacity through rehabilitation or training and workplace adaptations).

A particular important development in the field of DM took place in British Columbia in 1994 with the establishment NIDMAR. The organisation is committed to reducing the human, social and economic cost of disability to workers, employers and society by promoting workplace-based reintegration programs based a set of widely recognised principles. At the core of the NIDMAR approach is the view that DM is best implemented through a consensus based process between worker representatives and employers. NIDMAR is a collaborative initiative undertaken by leaders in labour, business, government, education, insurance and rehabilitation. It has also contributed substantially

to the establishment of a international movement committed to promoting better practice in DM through an International Council, with senior representatives from Canada, Australia, Germany, Ireland, The Netherlands, and the United States.

The commitment to DM and return to work has been building momentum internationally over the past 15 years. A review of employment policies across national boundaries was carried out in 1997, joint founded by the European Commission (EC) and the ILO and in 1998 ILO/Gladnet carried out a review of Job Retention Policies.

In 2003 the OECD highlighted the issue and drew attention to the fact that if a person does exit the labour market into the social protection system, he or she has less than a 1% chance of entering employment again in any year. In comparison there is a 17% chance that a person will exit the social system as a result of death.

In 2002 the ILO published its Code of Practice on Managing Disability in the Workplace which was agreed at a Tripartite Meeting of Experts on the Management of Disability at the Workplace including employers, workers and competent authorities. This covers two systems one of which is focused on Employment Equity (i.e. recruitment, selection and promotion) and the other upon DM (i.e. job retention and reintegration) and this provides a good basis for responding to disability in the workplace.

The inaugural biennial meeting of the International Forum on Disability Management was held in Vancouver in 2002. Subsequent meetings have been held in Maastricht and Brisbane and the fourth forum takes place in Berlin in September 2008. The forum brings together employers, policy makers, funders and insurers, professionals and academics to promote the principles underpinning effective job retention and return to work. This is an excellent source of good practice and useful case studies. In parallel with the IFDM a network of researchers has formed and the first International Journal for Disability Management Research was published in 2006. This provides an evidence base for developing training materials to support the return to work of employees with illness or disability.

In 2003 the International Disability Management Council (IDMSC) was established by senior representatives of business, labour, government, and other stakeholder groups North America and Europe. The role of the IDMSC is to promote standards that are international, professional and based on consensus between employers and workers. As of December 31, 2005, the IDMSC had grown to include representatives from Australia, Austria, Canada, Germany, Ireland, New Zealand, Singapore, Switzerland and the UK. The standards being promoted by the IDMSC can also provide a useful element of an e-learning framework but more importantly the IDMSC presides over a certification system for professionals and an accreditation process for employers. This creates opportunities for those who wish to pursue DM as a career or organisations who wish to achieve excellence to benchmark against others and to gain international recognition for their

practice. In Europe there are a number of organisations who hold the IDMSC license including the UNUM Insurance Company in the UK and Rehab Group in Ireland.

EU policy is widely scattered with references to the important role of employment and health in the process of social exclusion. However, these policies are generally focused on unemployed and economically inactive jobseekers rather than those who are long-

term absent. Until relatively recently there was little focus on the issue of chronic illness and employment in the major policy areas of the EU. The responsibility and competence for all relevant policy areas to DM and return to work reside primarily at Member State level. As a result no coordinated approach was evident in EU policy areas such as employment, health, social security and equality, despite the shared goal of combating social exclusion.

For example, there were major gaps in prominent policy areas, such as ageing where little prominence was given to the prevention of the exclusion of older workers from the labour market as a result of chronic illness, and public health policy which made no reference to the workplace or to maintaining workers with chronic illness in the workplace. Public health policy is largely seen as being concerned with medical or health issues with almost no connection being made to social circumstances or consequences. From a work and health perspective, EU policy documents emphasise occupational health and safety measures within the workplace (see, for example, the work of DG Sanco and the European Agency for Occupational Health and Safety) rather then return to work processes.

Equally, the focus within the Framework Directive on Equal Treatment and Employment (2000) and the Madrid Declaration (2002) is upon a clearly delineated category of 'people with disabilities' rather than those who are long-term absent and at risk of social exclusion. These people are in a grey area when it comes to seeking protection under non-discrimination legislation.

The focus on return to work at EU level has only recently been incorporated into Employment Guidelines and the National Action Plans of some Member States. This is partly as a result of a growing awareness that as the labour force ages the challenge of maintaining the workability of workers increases and the policy imperative to keep older people at work becomes stronger. Nevertheless there have been a number of policy documents and report over recent years which have formed a basis for an EU wide initiative in return to work of ill or injured workers. This evolution in policy perspectives has been driven by a number of trends.

Firstly, the issue of the growing number of older workers is the subject of much policy debate and many policy initiatives in recent years. The issue has been approached largely from the perspective of the labour market, that is, to ensure an adequate labour supply for Europe in the future. Secondly, the European population is living longer, the length of the so-called third age is extending in duration and for structural and cyclical reasons the under-funding of state and private pension schemes has attracted increasing policy attention in recent years.

Thirdly, the causes of illness amongst the working population have been changing in recent years. A greater proportion of illnesses now relate to stress related illness and mental health problems, a trend that poses special difficulties with regard to retaining people with such illnesses in the workforce. For example health insurance data from Germany shows that sick days due to mental health problems increased by 28% between 1991 and 2004 while the corresponding data for other important diseases like CVD, musculoskeletal disorders and diseases of the digestive system showed a continuous decline for the same period. Mental disorders also accounted for 30% of the total number

of early retirements in Sweden and Germany in 2002 and 2003 respectively[6]. However, it should be noted that there is a difference in research carried out 'on behalf' of employers versus that carried out 'on behalf' of employees. In contrast to the above findings a survey carried out by IBEC (Irish Business and Employers Confederation) in 2004 found that 43% of companies indicated that long-term employee absences were related to recurring health problems such as back pain, cancer and heart disease, compared to only 2% of companies indicating mental health as the first cause of long term absence. This difference could be explained by NESF[7] findings that employees would not feel comfortable talking over their mental health with their employer because they felt that they would be viewed negatively by them.

Finally, many countries have seen recent and unsustainable rises in the prevalence of work disability. The causes of these rises relate to a complex mix of the ageing of the workforce, changes in eligibility criteria, interactions between social insurance schemes for disability and unemployment and perhaps also to the changing nature of the illnesses which give rise to disability claims.

One area in which disability policy has made great strides over the past 15 years is in relation to Equality, Rights and Non-discrimination. The impact of such legislation is indirect in that a worker who is long-term absent as a result of illness or injury is not guaranteed protection under such laws. Even when a worker is clearly protected the non-discrimination approach usually requires an employee to take a case either through a Rights Commission or the Courts. This process can drag on for years and thus early intervention and safe and timely return to work can be significantly delayed. This has the effect of reducing the likelihood of return to work.

The Employers Forum on Disability promotes an approach that can assist in enhancing the impact of equality and non-discrimination legislation on return to work of chronically ill and disabled employees. It advises its members to treat every case where an employee develops a disabling condition as though it could become a disability discrimination issue. In doing so, the Forum attempts to link equality legislation to job retention and reintegration interventions without the need for employees to have recourse to legal action. They recommend to employers that they consider providing reasonable accommodation and job retention support at as early a stage as possible in the disability process. In its advice to line managers, human resource personnel and health and safety officers, it encourages proactive interventions to prevent long-term absence and to encourage workers to return to work in a safe and timely manner.

In 2006 the UN adopted a Convention on the Rights of Persons with Disabilities which received it 20th ratification in March 2008. This is a landmark piece of international legislation which has the power to transform the way in which people with disabilities can participate in civil society and the roles they can play in society. From the perspective of the Reintegrate project the key article is Article 27k which places an onus on Members States to 'promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities'.

[6] WORKHEALTH project (2007): Hearts and Minds at Work in Europe, A European work-related public health report onCardiovascular Diseases and Mental Ill Health, Available at: http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Hearts_and_Minds_at_Work_in_Europe.pdf. [accessed July 28th 2008]

[7] National Economic and Social Forum (2007): *Mental Health and Social Inclusion*, Forum report no. 36. Ireland Available at: http://www.nesf.ie/dynamic/docs/final%20NESF%20MH%20Rpt36.pdf [accessed July 28th 2008].

Because the concept of DM evolved within the context of workers' compensation there is now an asymmetry in many jurisdictions between the way in which employees who acquire an illness or injury at work or on the way to work and those who develop or acquire it outside work. For example, in the case of an occupational injury, in which an employee acquires a low back injury, he or she is entitled to early rehabilitation, counselling, case management, return to work assessment, transitional work opportunities and work adaptations. If the same injury is acquired outside of work none of these are available through the employer and the employee must rely on the GP and the general health services. While good practice employers have begun to expand DM services to all employees there is still a substantial disparity between the way in which employees with and without occupational conditions are treated.

In contrast to the rapid dissemination of the concept of DM in North America, Australia and New Zealand, during the late 1980s and 1990s, there was very little awareness amongst employers, trade unions or insurance companies of the potential benefits of DM in Europe. In fact Germany was one of the first Member States to adopt the DM model. This was partly due to the fact the workers' compensation systems in North America were originally modelled on the German system. The key difference was that experience rating was not used in the German system and thus the business case for employers to adopt DM was less evident. The Dutch system embraced the concept of employer responsibility in the mid 1990s and has been gradually increasing the role of employers in Job Retention and Return to Work by placing substantial financial responsibilities on employers. At this stage Dutch employers are responsible for paying disability payments to employees who exit their workplaces for up to two years. This requirement applies to employees with work related and non-work related conditions. As a result the concept of DM has become accepted by most employers in The Netherlands.

In Ireland and the UK there have been two main challenges to the rapid take up of DM. In the first place, unlike most European continental countries, employers are not required to finance disability payments through a specific insurance scheme to employees absent from work, although they do contribute to the general social insurance system. In fact payments to absent employees are paid through the social protection and welfare systems and thus are financed out of general taxation. As a result there are no implications for employers who adopt less than good practice in relation to ill or injured employees. In the second place, workers who acquire an injury in the workplace are required to initiate a legal process in order to obtain compensation. In the context of an adversarial process it is more difficult to convince either party that an early return to work is worthwhile. The Irish system has recently introduced a process to reduce the impact of the adversarial system. The Personal Injuries Assessment Board (PIAB) provides an injured person with a straightforward and cost effective way of obtaining compensation. However, this does not operate well where there is a dispute over liability or where the amount being sought by the complainant exceeds the PIAB's guidelines. Nevertheless, the PIAB has been operating successfully for a number of years. What has not been evaluated at this stage is the impact it has had on the return to work of those who are long–term absent.

In addition to the establishment of the PIAB, Ireland has seen a significant change in the approach to long-term absence over the past ten years. A number of important

developments are evidence of this. Firstly, the Workplace Safety Group (a partner in this project) which involves all relevant organisations operating in the workplace including the two major employers' groups, IBEC and the Construction Industry Federation (CIF), as well as the Irish Congress of Trade Unions and the Irish Insurance Federation (IIF), launched its revised Workplace Safety Code in 2006 which emphasises return to work after injury. The Code is supported by State bodies including the Department of Enterprise Trade and Employment, the Health and Safety Authority, the PIAB and FAS (the National Training Agency). In addition, FAS has established a Job Retention Grant which provides employers with finance to fund a return to work assessment for an absent employee and to a further sum to support a return to work plan. While the uptake of this grant by employers has been relatively low a review of the procedures has been promised by Government to make them more effective. This commitment is part of a wider commitment to improve job retention and return to work services in Ireland which has been integrated into the Sectoral Plans of the Departments of Health and Children, Depart of Social and Family Affairs and the Department of Enterprise, Trade and Employment. These commitments include:

The Department of Enterprise, Trade and Employment:

- Recognises that it is essential that a comprehensive employment strategy should not only relate to work participation for those currently outside the workforce but also address job retention following the onset of disability while working,
- Commits to include Job Retention Rates as part of the impact indicators for performance of programmes,
- Supports the Workplace Safety Code approach to follow-up and return to work and the Health and Safety Authority's Workplace Wellbeing Strategy,
- Commits to review the Employment Retention Grant in partnership with the Department of Social and Family Affairs.

The Department of Health and Children:

- Commits to developing an integrated approach to rehabilitation services to support people back into work through early intervention and enhanced service provision.

The Department of Social and Family Affairs:

- Commits to tackle and remove benefits traps within income and related supports,
- Commits to promote continuation in employment of workers who acquire a disability,
- Adopts an employment activation approach that includes early intervention, segmentation, intermediation on behalf of long-term absent workers, support to return to work and outcome monitoring,
- Commits to more intensive engagement with people on disability or illness payment and a focus on the point of first engagement,
- Commits to integrate a new case management and early intervention system into the medical assessment system.

A number of developments in the UK are indicative of the greater emphasis and awareness of return to work issues. Of particular importance were the Job Retention Pilots carried out in 12 locations in the UK. While the results of the pilot were equivocal, as part of the process a survey of the views of employers in relation to long-term

sickness absence was implemented. The results of this are discussed in more depth below but what is important from a contextual perspective is the evident concern on the part of many key stakeholders in the UK about less than adequate outcomes in terms of return to work of ill and injured workers including, the Trades Union Congress, the Confederation of British Industry, the Department of Work and Pensions (DPW) and representative organisations of professionals e.g. Chartered Institute of Personnel and Development and the Royal College of Physicians.

Despite the strongly expressed views of all concerned over the past decade the evidence to support the view that substantial progress has been made is inconsistent. It is not easy to draw conclusions as to why this is the case. However, there are a number of challenges which have been identified as barriers to return to work which are still operating in the UK context. Firstly, as mentioned previously, it is still necessary for a worker to take legal action to obtain compensation for workplace injuries. Secondly, sick pay for the first six months is paid by the employer and reclaimed from the Department of Finance at the end of the year. A result the DPW is not aware of those who are absent from work until they apply for Incapacity Benefit after 6 months. It is generally accepted that by this stage the chance of returning to work has reduced to about 50%. Thirdly, Incapacity Benefit is financed out of general taxation and thus the business case for proactive DM is less evident.

Nevertheless, the Employers Forum on Disability has produced a number of useful publications and continues to advocate for more effective job retention and return to work policies on the part of employers. Furthermore, the Health and Safety Executive has highlighted the importance of reintegrating ill or injured employees and an insurance provider UNUM has begun to offer certified training for return to work professionals and DM specialists, based on a set of international standards. From an employer's perspective UNUM also offers an audit of workplace policies and practices based on established international best practice that can assist in highlighting good practice and areas for improvement.

Bibliography

1. Council of the European Union, 'Council decision of 22 July 2003 on guidelines for the employment policies of the Member States (2003/578/EC)', Official Journal of the European Union, No L 197/13 of 5th August 2003a. Available online at http://europa. eu.int/eur-lex/pri/en/oj/dat/2003/l_197/l_19720030805en00130021.pdf

2. Council of the European Union, 'Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation', Official Journal of the European Union, No L 303/16 of 2nd December 2000a. Available online at http://europa.eu.int/eur-lex/pri/en/oj/dat/2000/l_303/l_30320001202en00160022.pdf

3. Council of the European Union, 'Council Resolution of 15th July 2003 on promoting the employment and social integration of people with disabilities (2003/C 175/01)', Official Journal of the European Union, No C 175 of 24 July 2003b. Available online at http://www.aapd.com/downloads/EC/20Employment/20Social/20Integration.pdf

4. Dupré, D. and Karjalainen, A., Eurostat, Statistics in Focus: Employment of disabled people in Europe in 2002, Eurostat, Theme 3: population and social conditions, Statistical Office of the European Communities, 2003. Available online at http://europa.eu.int/comm/ eurostat/Public/datashop/print-product/EN?catalogue= Eurostat&product=KS-NK-03-026-N-EN&mode=download

5. EIM Business and Policy Research, European Commission, The Employment Situation of People with Disabilities in the European Union, Luxembourg, Office for Official Publications of the European Communities, 2001. European Expert Group on the employment situation of people with disabilities. Available online at: http:// europa.eu.int/comm/employment_social/news/2001/dec/2666complete_en.pdf

6. European Commission Directorate General for Employment, Industrial Relations & Social Affairs (1998). Employment and people with disabilities: report of the special meeting of the High-Level Group on Disability. Social Security & Social Integration. Published by the Office for Official Publications of the European Communities, Luxembourg, Belgium

7. European Commission, Social Protection in Europe 2001: Social security and social integration, Luxembourg, Office for Official Publications of the European Communities, 2001a. Available online at http://europa.eu.int/comm/employment social/news/2002/ nov/soc_prot_rep_en.pdf

8. European Commission, Disability and Social Participation in Europe, Eurostat, Theme 3: population and social conditions, Luxembourg, Office for Official Publications of the European Communities, 2001. Available online at http://europa. eu.int/comm/eurostat/ Public/datashop/print-product/EN?catalogue=Eurostat&product=KS-AW-01-001-N-EN&mode=download

9. European Commission, Joint Report on Social Inclusion, Luxembourg, Office for Official Publications of the European Communities, 2002a. Available online at http://europa.eu.int/comm/employment_social/publications/2001/ke4202521_en.pdf

10. European Commission, Report from the Commission to the Council, the European Parliament, the Economic and Social Committee, and the Committee of the Regions 'Report requested by Stockholm European Council, "Increasing labour force participation and promoting active ageing"', Commission of the European Communities, COM(2002) 9 final, Brussels, 2002c. Available online at http://europa.eu.int/comm/employment_social/news/2002/feb/com_2002_9_en.pdf

11. European Commission, The Social Situation in the European Union 2003. Luxembourg, Office for Official Publications of the European Communities, 2003a. Available online at http://www.eu-datashop.de/download/EN/inhaltsv/thema3/ so_lage.pdf

12. Thornton, P. and Lunt, N., ILO, Employment Policies for Disabled People in Eighteen Countries: A Review, Geneva, ILO, 1997

13. Government of Ireland, Social Welfare (Consolidation) Act, (Dublin, The Stationery Office, 1993).

14. Government of Ireland, Employment Equality Act, (Dublin, The Stationery Office, 1998).

15. OECD, Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People, Paris, OECD, 2003. Available online at http:// www1.oecd.org/publications/e-book/8103021E.PDF

16. Presidency Conclusions, Barcelona European Council [online], 15 and 16 March 2002. Available from http://ue.eu.int/pressData/en/ec/71025.pdf

17. Presidency Conclusions, Lisbon European Council [online], 23 and 24 March 2000. Available from http://ue.eu.int/Newsroom/LoadDoc.asp?BID=76&DID=60917&from= &LANG=1

18. Presidency Conclusions, Stockholm European Council [online], 23 and 24 March 2001. Available from http://ue.eu.int/Newsroom/LoadDoc.asp?BID=76&DID= 65786&from=&LANG=1

3.1.2 Getting Started

3.1.2.a Principles

The NIDMAR Code of Practice for DM is based upon values that are compatible with European Health and Safety systems such as ensuring the safe and productive employment of workers with disabilities, the provision of safe and healthy work, the reduced occurrence and impact of illness and injury due to work and consensus among government, labour and management on the achievement of these values.

The objective of the code is to promote workplace based systems of DM policies and which are:

- Agreed by management and labour representatives, unions and the individual worker,
- Supported by the coordination of work accommodations, health care and rehabilitation interventions,
- Underpinned by the promotion of continued safe employment for persons with disabilities, supported by external voluntary and statutory service providers.

The Code of Practice is relevant to all people affected by chronic illness or disability regardless of its cause, type, or nature and who have the ability to obtain, return to, or retain employment. It applies to all private sector employers regardless of size, location, nature of work relationship, or type of work carried out and to all levels of government and statutory agencies and their employees. The framework within which the Code operates incorporates:

- Protection for the person with a disability
- Support for RTW programs
- The prohibition of discrimination
- RTW compatible income support system
- Support of senior business, government and labour leaders
- Effective Health and Safety regulations
- Incentives towards participation
- Effective enforcement of compliance with core values and objectives

- Access to dispute resolution and support services

An important element of the Code is the role of the RTW Coordinator/DM Professional in facilitating early RTW and advocating the values and objectives of DM within a company.

A second code, the ILO Code of Practice, while taking a broader view of managing disability in the workplace, provides some very useful insights into how an effective in-house system for responding to disability can be built.

Inclusive workplace strategies can be characterised under four levels of description:

1. Policy & Legal System
2. Mediating Mechanisms
3. Context
    a. Social
    b. Workplace
4. Individual

The first two of these relate to the external influences upon the company in terms of the way in which the jurisdiction responds to disability and the responsibilities of employers, e.g. workers compensation vs. social welfare systems, and the external services available to provide support to employers in terms of counselling and case management. The latter two refer to the local context in terms of the factors operating in the work and non-work situation and the level of impairment being experienced in the individual's life.

The impact of external policy has been discussed in the previous section and the role of external services is addressed in Section 3.15 (Getting the employee back to work).

At this point it is important to review the key principles for effective workplace disability management from the perspective of the employer. It is clear that this requires a dual perspective. The first of these is upon workplace policies and practices and the second is upon the individual worker who is long-term absent.

Workplace policy and practice is a key driver of the disability process and an essential ingredient of an inclusive workplace strategy. The person with responsibility for developing and disseminating an effective return to work policy needs to take a broad view of the organisation. A useful framework for reviewing the current position within a company and planning more effective approaches must take account of:

Workplace enablers such as:

- Policy & Strategy
- Organisational Culture
- Processes & Procedures
- Knowledge & Resources

Workplace Drivers:

- Agreed Labour Management Support
- Responsibility and Accountability
- Internal and external Communications

Workplace Processes:

- Job Retention
- Reintegration
- Career Development
- Confidentiality of Information

Workplace Strategies:

- Priority assigned and integral to HR strategy
- Conformance with national policy & legislation
- Recruitment, Equal Opportunities and Retention
- Linked to Occupational Safety and Health measures; Risk Analysis;
- Including early intervention and workplace rehabilitation;
- Mentoring of employees
- Collaboration and consultation
- Worker representatives
- Disabled workers or their representatives
- Occupational health services
- Expert agencies with specialist knowledge
- Provision for workers who hold family responsibility for a disabled person or persons
- Matching workers properly to the job in terms of ability, work capacity and interest
- Regular Evaluation and Continuous Improvement
- Participation and access

Bibliography

1. Akabas, S., Gates, L., and Galvin, D. (1992). Disability Management: A Complete System to Reduce Costs, Increase Productivity Meet Employer Needs and Ensure Legal Compliance. American Management Association: New York.

2. Bruyere, S & Shrey, D. (1991) Disability Management in Industry: A Joint Labour Management Process, Rehabilitation Counselling Bulletin, Vol 34, No 3, pp 27-41.

3. Gladnet/ILO, (1998) Key Issues-International Research Project on Job Retention and Return to Work Strategies for Disabled Workers, Geneva, ILO.

4. ILO (2002) ILO Code of Practice: Managing Disability in the Workplace, ILO, Geneva,. Available online at http://www.ilo.org/public/english/employment/skills/disability/ download/code.pdf

5. James, P., Bruyère, S., and Cunningham, I. (1997). Absence and Disability Management. Review of Employment Topics, 160, 152-184.

6. James, P, Cunningham, I. and Dibben, P. (2002). Absence Management and the Issues of Job Retention and Return to Work, Human Resource Management Journal, 12, 2, 82-94

7. McAnaney, D., Webster, B., Lohan, M. and Wynne, R. (2001) 'Disability Management: A System of Response or a Response to a System', Australian Journal of Rehabilitation Counselling Vol. 7 No. 1, pp 1-12.

8. NIDMAR, Disability Management in the Workplace: A Guide to Establishing a Joint Workplace Program, 1st Edition, National Institute of Disability Management and Research 1995, p 3.

9. NIDMAR Resources: - Code of Practice for Disability Management, 2nd edition

10. RETURN (2002b) Summary Report of RETURN Project, Dublin, University College Dublin. www.wrc-research.ie/return

11. Shrey, D. & Hursch, N. (1999) Workplace Disability Management: International Trends and Perspectives, Journal of Occupational Rehabilitation, Vol. 9. No. 1.

12. Shrey, D & Lacerte, M., (eds) (1995) Principles and practices of Disability Management in industry, Orlando, Fl., GR Press.

13. Smith, B., Povall, M. and Floyd, M. (1991). Managing Disabilities at Work, Jessica Kingsley Publishers: London.

14. Thomason, T., Burton, J. and Hyatt, D (ed). (1998). New Approaches to Disability Management in the Workplace, Industrial Relations Research Association: Madison

15. Zimmerman, W. (1997) A Canadian Perspective, in National Institute of Disability Management and Research, Strategies for Success, British Columbia: National Institute of Disability and Research.

3.1.2.b The Business Case

It is difficult to obtain a clear demographic and statistical focus on the intended beneficiaries of the Reintegrate project. In a European wide survey carried out in 2003 over 50% of those who reported a Long-Standing Health Problem or Disability (LSHPD) indicated that it was as a result of non-work related diseases. Other than this the majority of absence data available at EU level, tend to relate specifically to work related accidents and diseases and other data sources are generally focused on those receiving early retirement or disability payments. Finally, while the relationships between age and enhanced risk of chronic illness or disability, and age and economic inactivity are well-documented it is not possible to disaggregate the number of older people currently in the process of exiting the labour market as a result of chronic illness through long-term absence (LTA).

Nevertheless, absence from work due to sickness has become an issue of major importance to employers as the direct and indirect costs involved are substantial. According to Confederation of British Industry (CBI), in the autumn of 2001, there were almost 2.2 million days lost to sickness in the U.K., which accounted for 2 per cent of the total scheduled working days. In 2004 CBI found that workplace absence had risen for the first time in five years.

The Labour Force Survey (LFS) collected information about sickness absence in a reference week. In spring 2004, some 1.7 million scheduled working days were lost to sickness absence and 2.9 per cent of employees took at least one day off work because of sickness or injury. Female employees and younger employees were most likely to be absent from work due to sickness

The 2005 CBI figures were 6.6 days on average in sick leave and a total of 164 million days lost. The rate of absence increased in 2006, with sick leave growing to an average of seven days off per worker, This amounted to 175 million working days lost with a cost to the economy £13.4bn.

What is more important from the perspective of the Reintegrate project is that the research revealed that long-term absence of 20 days or more accounted for 43 per cent of all working time lost (public sector - 52%; private sector - 38%) and cost £5.8bn. In 2006 absence cost £537 per employee and accounted for 3.3 per cent of working time.

A striking finding was that companies that offered rehabilitation programmes and flexible working can help employees back to work and lose less time to absence. The best performing organisations lost only 2.7 days per employee, while the worst lost 12 days. The public sector had the highest average absence at nine days per employee, up half a day from 2005, while the private sector lost 6.3 days. Despite the Government's efforts, public sector absence was 44 per cent higher than in the private sector.

More recent figures produced by the Chartered Institute of Personnel and Development (CIPD), based on a survey of human resource managers, estimated the average annual level of absence in 2007 as 3.7%, or 8.4 working days per employee (10.3 days in the public sector) and an average reported cost of absence of £659 per employee per year. There was a reported 31% increase in stress-related absence compared with a year earlier.

The analysis of return to work programmes in other jurisdictions not only provides evidence to support the business case for better return to work but also strongly indicates

that the adoption of a no fault approach to compensation and greater involvement of employers in the rehabilitation, retraining and return to work process could be an important facilitator of lower costs.

A survey of Canadian employers particularly within the manufacturing sector, e.g. Ontario Power Generation, BC Hydro & Norske Canada, identified that those companies adopting a DM approach, reported disability related cost reductions of between 30-50% and reduced long-term disability cases of between 30-60%.

In 2003 an Australian analysis of human resource costs and benefits, based on national human resources benchmarking data on older worker, considered recruitment, training, absenteeism and work injuries of older compared to younger workers. The analysis found that employers were better off retaining older workers in terms of a comparison of recruitment and training costs for new staff with the costs of absenteeism and work injuries.

An empirical investigation of the effectiveness of rehabilitation programs undertaken by 503 injured workers in the US in 1996 found that every $1 spent on rehabilitation services yielded a reduction of system costs of $2.31.

The benefits of the DM approach in the medium to longer term include:

1. Cost reduction
2. Reduced absence rates
3. Improved early identification of employees at risk
4. A reduction in the number of people developing disabilities
5. Enhanced motivation of employees
6. Increased productivity of workers with disabilities
7. Reduced recruitment and training costs

Bibliography

1. AARP. (2005). The business case for workers Age 50+: Planning for tomorrow's talent needs in today's competitive environment. Washington, DC.

2. Brooke, L. (2003). Human resource costs and benefits of maintaining a mature-age workforce. International Journal of Manpower, 24(3), 260–283.

3. Chartered Institute of Personnel and Development. (2008). A barometer of HR trends and prospects 2008. CIPD: London.

4. Confederation of British Industry: Healthcare Brief: Business and Healthcare for the 21st Century. CBI, 2001.

5. Confederation of British Industry. (2008). 2006 Absence and Labour Turnover Survey, CBI / AXA Survey.

6. Dent, G. (1990) Managing the Human and Financial Costs of Disability, California: Martin Dennison Press.

7. Hickie I, Groom G, Davenport T.(2004) Investing in Australia's future: the personal, social and economic benefits of good mental health. Canberra: Mental Health Council of Australia.

8. Murray CJL, Lopez AD, editors. The global burden of disease and injury series. Vol. 1. A comprehensive assessment of mortality and disability from diseases, injuries,and risk factors in 1990 and projected to 2020. Cambridge (MA): Harvard University Press; 1996.

9. National Institute of Disability Management and Research (1997) Strategies for Success: Disability Management in the Workplace. British Columbia: National Institute of Disability Management and Research.

10. NIDMAR Resources: - Disability Management Success: A global corporate perspective Rolle, L., Bill Blanford, & Grob, H. (2005) Measuring Return to Work: Controlling for the Effects of Size and Industry. Washington State Department of Labor and Industries, US. Accessed May 2008; http://www.lni.wa.gov/ClaimsIns/Files/DataStatistics/RTW/2004RTW42505.pdf

11. Wood, G., Morrison, S. (1997). Vocational Rehabilitation Programmes: A Financial Appraisal. Safety Science, 25, 1, 247-260.

12. Work Loss Data Institute (2008) Official Disability Guidelines, http://www.worklossdata.com/PR_ODG2008.htm

13. Wright, M. and Marsden, S. (2002). Changing Business Behaviour – Would Bearing the True Cost of Poor Health and Safety Performance Make a Difference? HSE Books: Norwich.

3.1.2.c Marketing, Persuasion and Overcoming Challenges

In parallel with organisational capacity building, it is also important to consider the views and attitudes of the workforce, their representatives, supervisors, line and senior management, and the board room. This requires not only a good understanding of the issues but also a solid strategy for persuading all vested interests of the advantages and cost-benefit of adopting an explicit and integrated workplace return to work policy and set of procedures. Clearly the facts and figures form an important foundation to support the business case, but in addition, it is also critical to pay attention to the needs and concerns of each interested party. At the core of peoples' concerns there is usually a lack of confidence in their own approach to disability or a complete lack of awareness of disability issues. In some ways people produce arguments against taking action as a rationalisation of how they feel rather than building a logical case from the evidence. Some of the counter-arguments include:

- Not rushing the person back to work
- Not intruding on the person at a time of distress
- The risk to other employees if the person returns
- The extra burden on colleagues
- The increased insurance risk
- The chance that return to work will aggravate the person's health condition
- The impact in terms of lost production
- The inconvenience and disruption caused by changes to work procedures
- Issues of demarcation
- The impossibility of transitional work opportunities

The marketing and persuasion process must involve individual face to face meetings with key opinion formers and focus group meetings with key communities of interest. However, the most important factor in an effective campaign is a Leader in the organisation who is willing to act as Champion for the process. A Champion can be a senior manager, a financial officer or a HR manager but the most effective leader is the CEO or Managing Director. Without the support of top management and the board, the challenges facing the person responsible for developing the return to work programme will be increased.

Persuading people of the importance of introducing a workplace return to work programme is not about telling them about the advantages or trying to convince them with facts or figures, the starting point is carrying out an Needs Analysis which actually listens to the concerns of all interested parties and which can then form the basis of a series of feedback meetings during which the case can be made.

There are ample resources available to help with the 'buy in' process, in the form of, organisational case studies from both inside and outside the E.U, the experiences of

those who have undertaken the tasks before and reports from representative organisations e.g. the IBEC/ICTU Workplace Safety Code. For example, one study of strategies aimed at facilitating the job retention and return to work of sick and injured workers examined the nature and potential significance of such strategies to absence management. The aim was to shed light on current employer policies and practices relating to the management of long-term absences. In addition to confirming CBI and CIPD findings that a large proportion of working days lost through sickness absence stem from relatively long spells of absence, it also concluded that the adoption of a proactive approach to supporting the return to work of ill and injured workers has beneficial consequences for employers. However, few organisations appeared to have comprehensive arrangements in place to handle cases of long-term absence and a number of areas where current employer arrangements could be changed were suggested.

Another study into managing long-term sickness absence concluded that it is becoming a priority for employers. The findings provide strong evidence that absence management and rehabilitation methods are proving most effective and document the costs and other consequences of prolonged absences from work for employers. The tables below provide an illustration of the type of information that is available to help convince colleagues of the importance of return to work.

Table 1: Financial Services (Profile 2007)

Employer (employee nos.)	Estimated annual cost of long-term absences	No. of employees currently on long-term absence	Most effective means of managing long-term absence
Computershare (1,430) (W)	£120,000	7 (actual)	External occupational health service
esure (600) (S)	£350,000 (for all types of sickness absence)	12 (actual)	Occupational health/company physician
Europe Arab Bank (320) (W)	-	1 (actual)	HR
GMAC (300) (W)	-	4 (approx.)	External occupational health service
Lifestyle Services Group (LSG) (329) (W)	£5,000	2 (actual)	HR
Money Advice Trust (150) (W)	£63,000	4 (actual)	External occupational health service
National Australia Group (10,000) (W)	-	200 (approx.)	Occupational health/company physician

Employer (employee nos.)	Estimated annual cost of long-term absences	No. of employees currently on long-term absence	Most effective means of managing long-term absence
Old Mutual (140) (S)	£30,000	1 (actual)	External occupational health service
Open + Direct Insurance (170) (W)	£3,000	1 (actual)	Line manager
Provident Insurance (430) (W)	£686 per employee, but much higher if management time is taken into account	5 (actual)	HR
Prudential UK (4,700) (W)	£6 million (direct and indirect costs)	50 (approx.)	HR
Wesleyan Assurance Society (850) (W)	£1 million	15 (approx.)	External occupational health service

Table 2: Chemicals and Pharmaceuticals (Profile 2007)

Employer (employee nos.)[1]	Estimated annual cost of long-term absences	No. of employees currently on long-term absence	Most effective means of managing long-term absence
Barloworld Scientific (300) (S)	-	7 (actual)	HR
Boots Manufacturing (1,300) (W)	£2 million	50 (approx.)	Line manager
Constar International UK (180) (W)	£50,000	3 (actual)	Occupational health/company physician
GR Land Health Products (150) (W)	£70,000	3 (actual)	-
Huntingdon Life Sciences (1,200) (W)	£1.25 million	-	Line manager
Intervet UK (285) (W)	£40,000	1 (actual)	External occupational health service
Perrigo (720) (W)	£94,000 in sick pay.		

An important lesson to be learned from the literature is that badly planned and poorly executed return to work can create problems not only for the returning worker but also for the employer. One study, in Ontario, Canada, explored the impact of policies on small

workplaces of a particular set of policies and practices, called 'early and safe return to work', an approach that emphasised workplace self-reliance and return to work before complete recovery via 'modified' work accommodation. The study found that early and safe return to work can disrupt workplace norms and patterns of social interaction, and can create hardship for both employers and workers. Employers experienced conflict between their administrative role in the early and safe return-to-work process and the demands of running a small business, while injured workers found that their participation was governed more by the 'discourse of abuse' and the social dislocations of injury and modified work than by best rehabilitation practice. This resulted in an erosion of trust arising from what both employers and workers perceived to be the betrayal of moral understandings in the workplace, to the 'hardening' of co-operative intent, and to an

increasing tendency to 'play it smart' with the system of early and safe return to work. This subverted the objectives and intent of the policy, and compromised possibilities for mutually satisfactory solutions.

Bibliography

1. Barham, C. & Leonard, J. (2002) Trends and sources of data on sickness absence. Labour Market Trends, vol 110, no 4

2. Barham, C. & Begum, N. (2005) Sickness absence from work in the UK. Labour Market Trends, vol 113, no 04, pp 149-158

3. Burchardt, T. (2003) Employment Retention and the Onset of Sickness or Disability: Evidence from Labour Force Survey longitudinal datasets - A study carried out on behalf of the Department for Work and Pensions, Her Majesty's Stationery Office (HMSO)

4. Card, L., & O'Donnell, M. (2004). Ejection vs. retention: Weighing the programs and cons of employing elders. In B. McIntosh (Ed.), Aging and the workforce. Retrieved March 24, 2006, from http://www.bsad.uvm.edu/Research/inProgress/Resources/AgingEmp/

5. Eakin, J. M., MacEachen, E. & Clarke, J. (2007) 'Playing it smart' with return to work: small workplace experience under Ontario's policy of self-reliance and early return. Policy and Practice in Health and Safety, Issue 2 , pp. 19-41(23)

6. Information Systems Management Institute, Latvia (2005) Distance Education Course, "Employment of People with Disabilities" Ability not Disability in Employment, LDV (WAVE & Access to Work Services)

7. James,P., Cunningham,I., & Dibben,P. (2002) Absence management: The issues of job retention and return to work, Human Resource Management Journal, 12(2), 82-94.

8. Murphy, N, (2007) How employers manage long-term absence. IRS Employment Review 887

9. National Rehabilitation Board, Employing people with disabilities: employers' experience, NRB, Dublin, Ireland, 1996.

10. NIDMAR Resources: - Industrial Disability Management: An Effective Economic and Human Resource Strategy

11. NIDMAR Resources: - The Impact of Disability Management Programs on Employers and Employees: A Canadian Perspective.

12. NIDMAR Resources: - Disability Management in the Workplace: A Guide to Establishing a Joint Workplace Program

13. Paoli, P. and Merllié, D., European Foundation for the Improvement of Living and Working Conditions, Third European survey on working conditions 2000, Luxembourg, Office for Official Publications of the European Communities, 2001. Available online at http://www.eurofound.eu.int/publications/files/EF0121EN.pdf

14. Smith, A., & Twomey, B. (2002) Labour market experience of people with disabilities, Labour Market Trends, vol 110, no 8

3.1.3 Policy Development

Our review of the literature points to a high degree of concurrence between different sources across a wide range of settings on the subject of return to work policy development

Firstly, it is critical that policy and guidelines are written down, agreed and integrated into the standard operating procedures of the company.

A coherent Return to Work policy should include the following elements:

- Organisational Early intervention and referral to appropriate services
- High quality health assessment
- Availability of therapeutic interventions
- Measures for a gradual resumption of work
- Work adaptations and adjustments
- An active case management system for overseeing the reintegration process
- Explore work or obtain experience in an alternative job
- Use of support and technical advice
- Opportunities for ill/injured workers to access retraining
- Role integration between internal actors including HR, Line Management, Occupational Health and external providers
- Awareness of RTW and rehab policy throughout the organisation

Secondly, in addition to a specific Return to Work policy, it is also essential to integrate return to work into existing policies including Health and Safety, HR, and a number of other policy areas.

The RETURN Employers Guide provides a useful starting point for policy development. It provides guidance on a number of policy areas in which an employer can initiate actions which lead to the establishment of an effective return to work process.

The basis for good practice in relation to managing the early and timely return to work of people who have become long term absent is a sound and comprehensive workplace policy. There are a number of strands to policy which are important in this regard. Some of these policies may already exist within the enterprise, while others will need to be

created or amended to ensure that it is clear that early return to work is a goal of the organisation to which it gives its full support.

The overall aim of policy is to ensure that there is a clear statement that early return to work is the norm within the organisation and to ensure that there are the necessary infrastructures, skills and practices in place to realise this aim. This policy should incorporate the roles and responsibilities of the stakeholders within the enterprise who are to be involved, the ways they should interact, the activities they should undertake, the resources available to them and the types of outcomes they should achieve.

The main areas through which reintegration management policy operates are:

- Occupational health and safety
- Human Resource management
- Equality
- Training and personnel development

Occupational health and safety policy:

Occupational health and safety policy is generally concerned with the control and management of occupational risks. However, it can also play a major role in the reintegration process through the monitoring of the returnees health and wellbeing, through assessing the risks associated with the job which the returnee is working at and through communicating to management and co-workers the capabilities of the returnee. Policy on occupational health and safety needs to be altered to reflect this expanded role.

It should also be made clear that occupational health and safety practice plays an important role in relation to the prevention of occupation related illnesses or accident. This preventive role, which also incorporates workplace health promotion, seeks to prevent the need for rehabilitation and reintegration in the first instance.

Human resource management policy:

The Human Resource Management (HRM) function is the best place to locate responsibility for the reintegration process as it is generally responsible for many of the processes and personnel which need to be involved in the reintegration process.

Critical elements of HRM policy which contribute to the positive reintegration process include:

- Employment contracts
- Remuneration
- Job design
- Work organisation
- Liaison with external agencies
- Job placement
- Reintegration management
- Incentives
- Joint labour-management agreements
- Occupational health services
- Training and development

- Safe and early intervention
- Transitional work

An important function of the HRM department concerns the communication of reintegration management policy throughout the organisation. This helps to overcome

one of the main barriers to integration – lack of knowledge and awareness of the process of reintegration which often leads to bias and discrimination against the individual.

Occupational health policy:

Occupational health support for return to work includes:

- Hazard identification,
- Risk management,
- Provision of information,
- Modifying work activities,
- Providing training on occupational health-related issues,
- Monitoring trends in health.

Occupational health often takes second place within Health and Safety, and has no distinct identity. Often no specific budget is allocated for OH support.

Health and Safety representatives and managers are central to increasing awareness of the importance of occupational health in the rturn to work process.

Equality policy:

The new developments at legislative level in relation to equality policy need to be reflected at enterprise level. These developments provide the opportunity and the obligation to incorporate improved treatment of workers who are returning to work following illness or injury. At minimum, equality policy at company level should state the commitment of the company to provide equal opportunities for returning workers to have access to suitable employment.

Bibliography

1. Advisory Committee for Disabled People in Employment and Training (ACDET). (1999). Report of the Sub-group of ACDET on Job Retention. DfEE, DSS, and DoH:London

2. Bruyère, S. and James, P. (1997). Disability Management and the Disability Discrimination Act. Human Resource Management Journal, 7, 2, 5-17.

3. Butler, R., Johnson, W. and Baldwin, M. (1995). Managing Work Disability: Why First Return to Work is not a Measure of Success. Industrial and Labor Review, 48, 3, 452- 467.

4. RETURN (2002a) Employers Good Practice Guide, Dublin, Work Research Centre. www.wrc-research.ie/return

5. Shoemaker, P., Robin, S., Robin, H. (1992). Reaction to Disability Through Organisation Policy: Early Return to Work Policy. Journal of Rehabilitation, 3, 18-34.

6. Watson, A., Owen, G., Aubrey, J., Ellis, B. (1997). Integrating Disabled Employee: Case Studies of 40 Employers. Research Briefs. Research Report No.56. Paper found- New recruits

7. Workers Compensation and Rehabilitation Commission (1998) Management Practices, Medical Interventions and Return to Work. Accessed May 2008; http://www.workcover.wa.gov.au/NR/rdonlyres/41AD9216-1AA9-4450-9320-5A167BB363F5/0/ManagementPracticesMedicalInterventionsandReturntoWork.pdf

3.1.4 Building and Maintaining Capacity

A prerequisite for an effective return to work programme within a organisation is to ensure that it has the capacity to deliver on commitments contained within its policy framework. Key areas where capacity needs to be developed and maintained include:

- Needs-based health interventions (physical fitness, mental well-being, rehabilitation)
- Work environment interventions (health and safety improvements, ergonomic improvements)
- Work organisation interventions (team building, leadership training, human factors balance sheet building)
- Educational interventions (applied computer skills, vocational skills training)

A useful specification of the competences required by those responsible for the return to work of ill or injured workers is contained in the NIDMAR Occupational Standards. The Occupational Standards in DM for Certified Return to Work Coordinators and Certified Disability Management Professionals are based upon a survey of working professionals and other stakeholders. The Certification for Return to Work Coordinators is most relevant to those who work internally or externally in helping individuals to return to work. The Certificate for Disability Management Professionals is for those who also perform higher-level executive functions, such as policy development, planning and monitoring DM programmes.

It is generally accepted at this point that it is counterproductive to initiate a DM or return to work initiative by applying the approach to a specific long-term absent employee out of the blue without properly preparing the organisation. If the approach is adopted with an individual without prior warning he or she is likely to feel victimised or singled out. The company could be accused of rushing the employee back to work before he or she is ready. It is also possible that if a transitional work option is proposed it will run into difficulty with the trade unions on the grounds of demarcation concerns. Even if the worker, his representative, management and supervisor are enthusiastic about the return to work programme it is highly likely that the programme will run into difficulties as a result of lack of commitment from senior management, insufficient resources, lack of knowledge and skills on the part of the actors or appropriate services. This will ultimately lead to disillusionment with the concept and irreparable damage to the return to work project.

The key areas in which a company needs to build capacity are:

Job Retention Processes:

- Accident Prevention and Safety Programmes
- Occupational Health Programmes
- Workplace Health Promotion Programmes
- Job Design & Work Organisation
- Management Information systems of Injury, Illness and Loss time patterns
- Creating positive job retention incentives and influences
- Accident prevention systems
    - Regular internal/external audits re regulations and best practice
    - Health and Safety Team involved in DM
    - Team properly trained and qualified to national standards
    - Accident prevention and safety included
    - Good safety performance recognised
    - Hazard identification and risk-analysis
- Documented Occupational Health Policy
    - Disability issues addressed
    - Trained and qualified Occupational Health staff or Sub-contract to an external Occupational Health provider
    - Regular Health examinations
    - Sickness absenteeism monitored
    - OHS actively involved with return to work
- Specific budgets for Workplace Health Promotion (WHP) and Job Retention (JR)
    - WHP & JR fully integrated with H&S and Quality
    - WHP & JR is needs-based
    - WHP & JR part of an on-going programme
    - Worker participation in WHP & JR
    - WHP & JR evaluated and updated

Specific Return to Work and Redeployment Mechanisms:

- Specific budget to support Return to Work interventions e.g. workplace adaptations or individual functional capacity building
- Early Intervention and Case Management processes
    - Early Monitoring & Contact
    - Safe and timely intervention
    - Consultation & Collaboration
    - Worker & Supervisor Involvement
    - Monitoring Providers Performance
    - Liaising with Insurance Providers
- Transitional work programme (TWP) and retraining
    - TWP focused on return to original job at the original worksite

  - TWP based on joint agreement
  - Formal comparison of functional abilities with the demands of job
  - Job bank with functional job descriptions of tasks
- Vocational Rehabilitation and redeployment
  - Strengths & Needs Assessment
  - Vocational Guidance & Counselling
  - Return to Work Coordination
  - Job-trialling
  - Ergonomics and assistive technologies
  - On & Off-Site Capacity Building
  - Job Demands Person Fit
  - Re-Skilling
  - Knowledge & Resources (internal/external)
  - Functional capacity assessment
  - Job demands analyses of potential posts
  - Vocational assessments and career guidance & counselling
  - Vocational Rehabilitation

This is a very comprehensive framework to support the development of specific return to work processes and mechanisms. It has been synthesised from the NIDMAR/IDMSC Standards, the ILO Code of Practice and the RETURN Protocol developed in 2002 through an EU funded project under the Fifth Framework for Research and Technological Development. It is a tried and tested approach which can form the basis for a targeted Reintegrate training course.

The RETURN Employers Guide provides some further insights in terms of infrastructure and resources.

In order to ensure an efficient return to work process, adequate resources and infrastructures need to be established by the employer. Appropriate resources include:

- **Budget** – Successful return to work programmes need an adequate and specific budget if they are to function effectively.
- **Training** – training for the function of return to work management is essential, as this is a relatively new concept and it is unlikely that the necessary skills would be available without such training.
- **Designated reintegration management function** - Research has shown that where there is a designated per-son or team responsible for managing the reintegration process, the process becomes more effective. This function is responsible for all aspects of the process, i.e. for maintaining contact with the ill or injured employee, liaison with external agencies providing medical and vocational rehabilitation, co-ordination of internal services and functions (OSH, HRM, training, line management) and provision of job design and job placement services.

- **Agreed Approach between Management and Worker Representatives** - Where there is regular liaison between management and labour, it is useful to conclude an agreement regarding return to work practices in this forum. This helps ensure wide support for the policy of reintegration.
- **Management Information System** - It is vital to have a management information system which gives reliable and timely information on health related absenteeism. Important types of information include duration and frequency of absenteeism, causes of absenteeism, and case details.

Bibliography

1. Gotlieb, A., Vandergoot, D. & Lutsky, L. (1991) The Role of the Rehabilitation Professional in Corporate Disability Management, Journal of Rehabilitation, April/May/June 1991, pp.23-27.

2. Hiscock, J., Ritchie, J. (2001). The Role of GPs in Sickness Certification. Department for Work Pensions: London.

3. Parker, G. (1996). General Practitioners and Occupational Health Services. British Journal of General Practice, 46, 303-305.

4. Scully, S. Habeck, R., & Leahy, M. (1999) Knowledge and Skill Areas Associated with Disability Management Practice for Rehabilitation Counsellors, Rehabilitation Counselling Bulletin, Vol. 43, No 1, pp.20-29

5. Shaw, L. and Polatajko, H., 'An application of the Occupational Competence Model to organising factors associated with return to work', Canadian Journal of Occupational Therapy, Vol. 69, No. 3, 2002, pp. 158-167.

6. Tyers, C. (2007) Workplace Health Connect: January 2007 Progress Report. IES/Health and Safety Executive. Accessed May 2008; http://www.hse.gov.uk/workplacehealth/whcreportjan07.pdf

7. Wright, M., Beardwell, C. & Marsden, S. (2005) Availability of rehabilitation services in the UK: A research study for the Association of British Insurers. http://www.abi.org.uk/BookShop/ResearchReports/Availabilty%20of%20Rehab.pdf

3.1.5 Getting the Employee Back to Work

Policies operating in isolation are not enough to ensure that good practice takes place. It is also necessary to resource these policies and to adopt a proactive management practice to ensure their implementation. Effective return to work management practice requires a proactive management of policy and methods which places the return to work of ill or injured workers high on the agenda of the organisation.

Workplace health management is a set of multidisciplinary, multilevel and participative processes, supported by external specialists and providers where needed, aimed at creating a continuum of intervention and support. It spans prevention, job retention and reintegration of employees who require help with health conditions that impact on their work capacity and ideally includes joint labour-management consensus about policy and practice.

The focus must be on developing sustainable solutions to give employees the best opportunities to return to work. The endpoint need not always be inside the organisation, but may involve the outplacement of the employee in another more suitable job with another employer. Experience has shown that it is important to intervene as early as possible when an employee has become ill or injured. Both the manager and the employee have a responsibility to identify a potential rehabilitation situation as soon as possible, and to subsequently establish contact with a social advisor, OSH or Human Resource Department. Many cases can be solved in the employee's own department though redeployment or by generating a job with some adaptations made for the individual. OSH expertise is core to the rehabilitation process.

Accurate information about the return to work threshold is essential to enable the return to work team, which should include the long-term absent worker, to make informed decisions about the return to work programme. The starting point is to describe the abilities of employees rather than their restrictions. Using ability profiles of long-term absent workers it is possible to match the person to a detailed analysis of job requirements. It is also important to incorporate other personal and environmental factors such as family influence, social environment, educational qualifications, colleagues and supervisors into the equation. The result is a return to work threshold profile specified in terms of potential interventions including ergonomic improvements, appropriate placement and rehabilitation or medical interventions.

Important elements of effective return to work include:

- **Co-ordination of the reintegration process** - making an explicit commitment to this role signifies that the organisation takes the issue seriously, and it provides a focal point for the reintegration process (details on the duties of this role are outlined in the next section).
- **Development of clear responsibilities and reporting relationships** – return to work is best situated within the HRM function. Establishing clear responsibilities and reporting relationships enables the effectiveness of the function to be monitored and assessed.
- **Communication of policy to all levels of the organisation** - one of the main barriers to successful return to work concerns the level of awareness amongst all levels of the organisation about what a successful reintegration policy involves. Active management requires that all parts of the organisation are aware of the policy and their responsibilities within it, thereby reducing the possibility of barriers being erected to reintegration.
- **Active monitoring of contacts with external rehabilitation agencies** - suppliers of medical and vocational rehabilitation services play an important role in the return to work process and there is a danger that the employer relinquishes responsibility entirely to these agencies during the rehabilitation period. It should not be assumed that these agencies are necessarily working towards reintegration into the workplace. They therefore need active monitoring to ensure that the reintegration process proceeds as smoothly as possible.
- **Development of appropriate skills** - there are likely to be skills and knowledge gaps in the organisation's capacity to deliver effective reintegration management. These skills gaps may relate to the technical aspects of the process (e.g. job

- design, work organisation, assistive technologies), or they may relate to attitudes and knowledge (e.g. bias or discrimination against workers with disabilities). The employer needs to commit to training programmes to overcome these deficits if the reintegration process is to be managed effectively.
- **Adopt a case management approach** - this means that the organisation should take a systematic approach to the entire return to work process for each case of Long Term Absence. The approach involves liaising with the person involved, monitoring the agencies involved in rehabilitation, internal communications and liaison with management and supervisors, identifying and designing appropriate work and jobs for the returnee etc.
- **Assessment of costs and benefits** - measuring the costs and benefits of the reintegration programme is desirable from the perspective of developing the business case for the programme. Both direct and indirect costs and benefits should be taken into account as should monetary and non-monetary costs and benefits.

In essence, the approach taken to managing the reintegration process should be similar to the management of any other personnel issue in the organisation. It should involve policy, planning, resourcing and monitoring actions. Following this course enables the return to work programme not only to achieve maximum effectiveness but it also to enables its effectiveness to be demonstrated. An overview of the literature relating to getting the long-term absent employee back to work provides a number of steps in the process. These are:

1. Maintaining Workability
2. Assessing the Return to Work Threshold
3. Early Intervention
4. Case Management
5. Interventions
6. Follow Up

Bibliography

1. Ahlgren, C. and Hammarstrom, A. (1999). Has Increased Focus on Vocational Rehabilitation Led to an Increase in Young Employees' Return to Work after Work- Related Disorders? Scandinavian Journal of Public Health, 27, 3, 220-227.

2. James, P., Cunningham, I. & Dibben, P. (2003) Job retention and vocational rehabilitation: The development and evaluation of a conceptual framework, Research Report 106, HSE Books. Accessed May 2008 http://www.hse.gov.uk/research/rrpdf/rr106.pdf

3. NIDMAR Resources: - Challenges in Disability Management: A Resource Manual for Return to Work Practitioners

4. Tate, D. (1992). Workers' Disability and Return to Work. American Journal of Physical Medicine and Rehabilitation. 71, 2, 92-96.

3.1.5.a Maintaining Workability

There is ample evidence that a focus on promoting health and wellbeing amongst employees not only reduces absence but also contributes to more positive return to work outcomes. A major approach to this process concerns the maintenance of work ability.

The concept of workability, originally developed in Finland (see Ilmarinen and Louhevaara, 1999), is concerned with ensuring that employees have the good health and job related skills necessary to undertake work in a health conducive environment. The concept was developed in response to evidence that workers who had low levels of work ability were much more likely to become long term absent from work. In Finland, there were high rates of long term absence throughout the 1980's and 1990's and the Maintenance of Work Ability programme was developed as a direct response to this situation.

Studies carried out in the 1980's and 1990's by the team led by Ilmarinen at the Finnish Institute of Occupational Health (see Ilmarinen, 1999, 2006) had demonstrated not only the power of the concept of workability to predict long term absence, but also the fact that deteriorations in workability could be reversed with appropriate interventions. In order to achieve this, the Maintenance of Work Ability programme focuses on four areas of intervention:

- Working environment
- Work community
- Individual functional capacity and health
- The professional competence of the individual

Interventions at the working environment level, focus on the traditional risk factors to be found in the work environment and consist of improvements to the ergonomics of work tasks, health and safety and work hygiene. Interventions directed at the work community are largely concerned with improving the psychosocial work environment and with improving the quality of management and supervision so that these take account of the changed working capacity of the individual employee.

The Maintenance of Work Ability approach also points to interventions to be made at the individual level – functional capacity and health and professional competence. The first of these interventions is concerned with improving the individuals' health and wellbeing, mainly through health promotion interventions, and with improving functional capacity through improving psychological and social capacities. The second focus of intervention at individual level is concerned with improving the job related knowledge and skills of the individual employee, either to cope with their new health situation or for purposes of coping with the demands of a new or altered job.

The Finnish experience strongly indicates the importance of making interventions of each of the four types, even though it is acknowledged that some interventions are easier to undertake than others. Surveys of employers indicate that the most frequent interventions are of the health promotion variety, but when these are effectively combined with the other three types of interventions, results in terms of improvements in workability are more effective.

However, in the case of returning long term absentees to work, there is still a need to ensure that good practices in relation to early intervention, case management and so on are in place. Focusing solely on workplace level responses has not been sufficient to achieve major reductions in the numbers of people entering long-term disability benefit – there is a need for an active response on the part of external players also.

Bibliography

1. Ilmarinen, J. (1999). Ageing workers in the European Union – Status and promotion of work ability, employability and employment. Finnish Institute of Occupational Health, Ministry of Social Affairs and Health, Ministry of Labour, Helsinki.

2. Ilmarinen, J. (2006). Towards a longer worklife – ageing and the quality of worklife in the European Union. Finnish Institute of Occupational Health, Helsinki.

3. Ilmarinen, J. and Louhevaara, V. eds. (1999). Finnage – respect for the ageing: Action programme to promote health, workability and wellbeing of ageing workers in 1990-1996. Research Reports 26, Finnish Institute of Occupational Health, Helsinki.

3.1.5.b Assessing the Return to Work Threshold

In Wisconsin a study of the return to work of an entire population of workers with job-related injuries revealed a number of determinants of return to work. Returning to the same pre-injury employer was one of the main determinants in speeding up return to work. The worker's pre-injury employment history also played a large role. The length of time off work was an important determinant of the probability of being employed 1 year after the first return to work. Results did not differ by gender.

Data from the WorkCover Authority of New South Wales (NSW) collected in 1992 indicated that the injury variables were less important than worker characteristics in explaining amount of lost time. Other factors identified included insurer type, employer size and referral to an accredited rehabilitation provide.

A study which examined factors influencing return to work following severe fracture to a lower extremity, found that despite relatively high rates of recovery, one quarter of *persons with lower extremity fractures did not return to work by the end of the first year. The analysis pointed to subgroups of individuals who were at high risk of delayed RTW, with implications for interventions at the patient, employer, and policy levels. Taking the extent of impairment into account, characteristics of the worker that correlated with higher rates of RTW included:*

- Younger age
- Higher education
- Higher income
- The presence of strong social support
- Employment in a white-collar job that was not physically demanding
- Receipt of disability compensation had a strong negative effect on RTW

A Swedish study explored factors associated with a positive outcome of vocational rehabilitation at three time-points 6, 12 and 24 months after rehabilitation. The results indicated that younger, male, employed persons, with an early start on rehabilitation, in a

programme including education had the greatest chance of successful rehabilitation. In contrast, older, female, unemployed people, with a delayed start on rehabilitation, without education, were at greater risk of being unsuccessful with vocational rehabilitation.

A recent review of the current literature suggests a direct relationship between:

a) Workers' demographic and disability-related characteristics and
b) Early referral to rehabilitation and successful return to work.

Variables found to be significantly related to return to work outcomes included workers' age, education, and wages before injury, job seniority and severity of the injury. Workers who successfully returned to work had higher seniority in their jobs, more education and were paid higher wages. Workers, whose injuries were more severe and longer lasting, were less likely to return to work. Back impairments appeared to be a particular risk factor for return to work regardless of vocational rehabilitation intervention.

A study of the influence of the attitudes of patients on their return to work found that their beliefs about their illness influenced recovery and rehabilitation on discharge from hospital. Their ideas about their illness clustered around five cognitive dimensions:

- Identity
- Cause
- Time line
- Consequences
- Beliefs about cure or control

A belief that the illness could be controlled or cured was related to subsequent attendance at a cardiac rehabilitation course. Perceptions that the illness would last a long time and have serious consequences were associated with a longer delay before returning to work. Identifying perceptions about illness at an early stage could improve the outcomes of cardiac rehabilitation programmes.

Even though the severity and type of impairment emerged from studies as being less influential on return to work outcomes than the characteristics of the workplace and the individual, it is still vital to adapt the approach taken to the nature of the health condition. There is ample information about the most appropriate approaches and interventions to take with various types of health conditions.

Over the years there has been a number of position papers that suggest that expectations of disability income is a factor in delayed return to work. However, as early as 1986 data from the Social Security Administration Survey of Disability and Work revealed that anticipation of higher levels of disability income does not correlate with cessation of work. In contrast the nature of illness and the structure of work do. The conclusion reached was that policies that are based on the assumption that long-term absentees were malingering could be detrimental to the disabled and chronically ill.

In this review of the literature, studies on return to work for a wide range of health conditions were identified including:

- Musculoskeletal conditions
- Mental Ill-health

- Pain
- Cardiac conditions
- Visual impairment
- Acquired brain injury

There are also a wide range of studies exploring the impact of age on return to work. It is clear that age has a significant influence on the return to work process. A recent cross-sectional study investigated the role of both aging and disability on employment status over the life span. The impairments in the study were polio, cerebral palsy, spinal cord injury. A significant "age by disability" interaction suggested that employment decline is a result of both aging and having a disability. A college education improved employment rates for people with disabilities in their 20s and 30s but did not prevent significant employment loss by their 40s.

In 2003, a comparison of outcomes of workplace injuries in three states - California, Washington, and Wisconsin suggested that older workers were more likely than their younger counterparts to have permanent disabilities as a result of those injuries. This was true even though older workers had fewer workplace accidents. In addition, older workers suffered larger wage losses over the first few years after injury, they had lower replacement rates from workers' compensation benefits, and they experienced more injury-related days of non-employment.

One way of characterising the multiple and complex factors that are operating when a person exits the workplace to long-term absence and when he or she attempts to return to work is to view the factors, influencing the decision to go absent or to return to work, as constituting a threshold made up of individual, workplace and external factors including the person's social network, available services and supports and regulations.

At the individual level, factors such as the nature of the illness, the motivation of the individual, age and gender have all been shown to influence the transition from work to absence. For example, older workers are more likely to cross the threshold to absence due to illness, workers with chronic illness are more likely to become long-term absent (as compared to acute illness) and women are more likely than men to remain out of work as a result of long-term absence.

At the workplace level, factors such as the presence of policies for retention and reintegration, the presence of supportive services such as OSH, disability management, training and retraining and the availability of alternative work, all contribute to increasing the likelihood that an ill or injured worker will be retained in work. Conversely, the absence of such factors in a workplace lowers the absence threshold and raises the return to work threshold. Factors outside of the workplace such as the personal and social circumstances of the worker also play a role in influencing absence and return to work thresholds. Factors such as the personal finances of the worker and the level of support available to the worker are important here.

At the level of services, important services include rehabilitation services, training and retraining services, and disability management services. Welfare services and benefits systems also play a role in raising or lowering the absence and return to work thresholds. A key issue concerns the level of co-ordination between these services and the strength of the relationship that such mechanisms have with the workplace.

Finally, public policy in the areas of retention and reintegration also plays a major role in influencing thresholds. Relevant policy areas include social insurance, equality, social inclusion, vocational training and the levels of benefits and the accessibility of benefits to the ill or injured worker. A key question for policy level responses is the extent to which they actually focus upon the retention and reintegration of chronically ill or disabled workers. In many instances, public policy has confusing and conflicting objectives, for example, where benefits may be seen solely as income replacement measures rather than as a means to provide resources for reintegration. In addition, the complexity of policy and benefits provisions may militate against a smooth reintegration process, thereby raising the threshold for returning people to work.

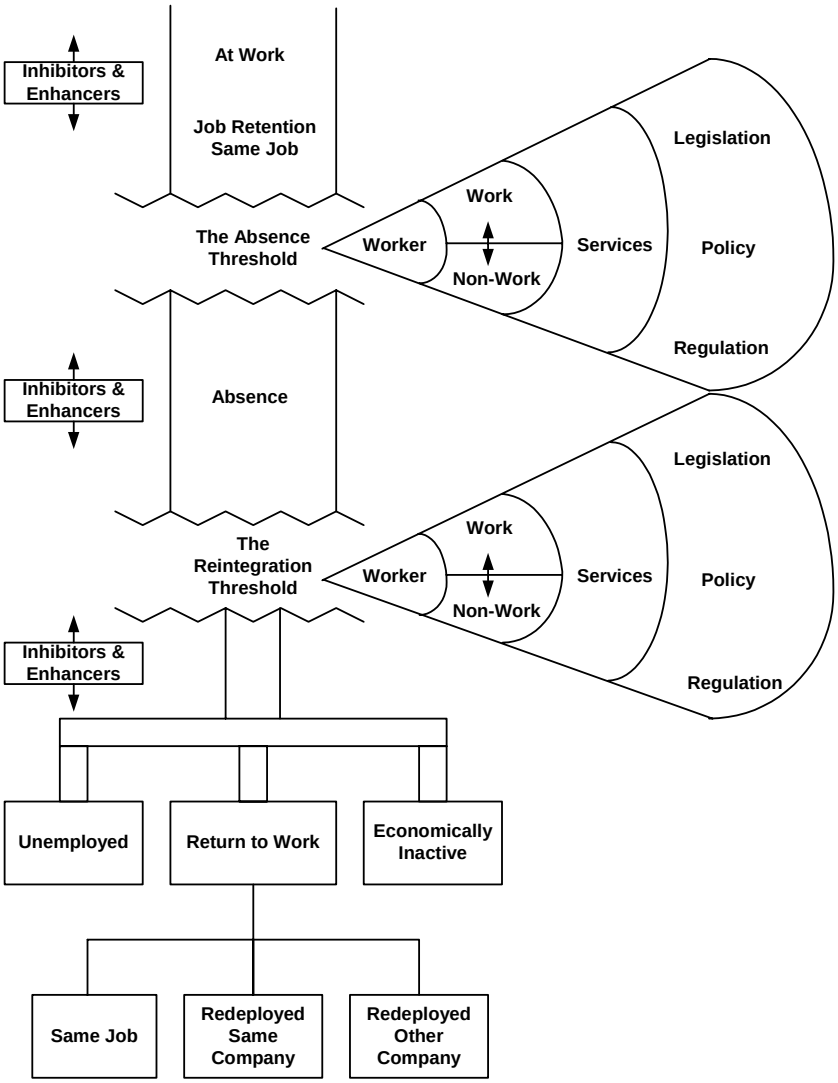


Figure 1: The Threshold Model

Further information about the return to work threshold emerged from a study into the role of stress in the absence and return to work process.

The majority of respondents in the Stress Impact study indicated that their reason for absence had emerged gradually and that they could see it coming. In this regard one has to ask the extent to which preventative measures were implemented in the workplace to assist and retain their jobs rather than go out sick. It is also likely given the gradual emergence of their health conditions, that they were considered to be ineligible for protection or support that was provided to people with more established disabilities. People who were less well were fundamentally less likely to be able to work. However, people with similar levels of workability experience very different outcomes in terms of participation in employment and return to work. The study documents that environmental and personal factors played important intervening roles in the labour market inclusion/exclusion process.

The study also provided evidence that the recently launched WHO International Classification of Functioning, Disability and Health (2001) (ICF) can provide a way in which we can begin to describe the push and pull factors that result in someone remaining within or exiting the workplace, or reintegrating into work after long-term absence. Thus an employee experiencing a reduction in work functioning or capacity will remain at work if the threshold to absence is high. Threshold factors include personal factors such as health, functioning, age, ethnicity, aspirations and skills of the worker.

Other factors that may push an employee into absence or enhance the probability of remaining at work include workplace factors such as physical environmental adaptations, changes in work organisation, employer and colleagues' attitudes, worksite supports and incentives. Other factors that can inhibit or enhance the likelihood that an individual will exit the workplace to long-term absence include non-work factors such as family responsibilities, personal relationships and community participation. Within any jurisdiction decisions to exit the workplace will be influenced by the policy, legal and regulatory context within which the employing organisation and the employee are located. In particular, factors such as the existence of positive or negative incentives to absence or return to work, financial and administrative arrangements for sick pay and pensions, eligibility requirements for subsidies and supports and overall responsibility for return to work activities.

There are a number of tools that can be used to help the person responsible for assisting an employee to return to work. One useful framework is presented in Figure 2. This diagram illustrates the main area of focus that should be taken onto account when assessing the return to work threshold for a long-term absent employee.

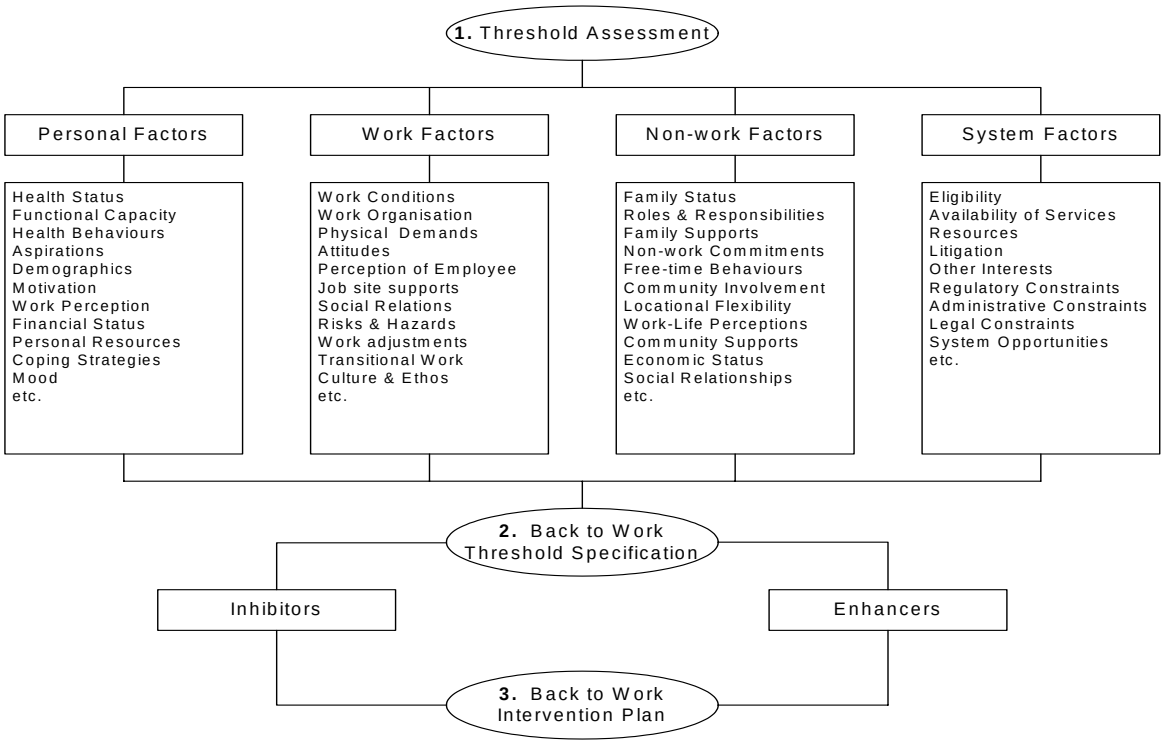


Figure 2: Return to Work Threshold

Another important tool for carrying out the assessment of ability is the computer-based analysis -Integration von Menschen mit Behinderungen in die Arbeitswelt (IMBA). Developed in Germany, IMBA allows a multidisciplinary team to match an individual's abilities to job demands along a number of dimensions including:

- Physical demands
- Information demands
- Complex characteristics
- Environmental influences
- Occupational safety
- Work organisation
- Mental demands

It is strongly emphasised that IMBA does not replace a team approach to decision-making and problem solving.

In the US another very comprehensive system has been developed to assist in the job-person matching process. The O*Net system is available on the web and provides a wide range of tools for assessing an individual's capacities and potential.

Bibliography

1. Ash, P. and Goldstein, S. (1995). Predictors of Returning to Work. Bulletin of the American Journal of Psychiatry and the Law, 23, 2, 205-210.

2. E J MacKenzie, E. J., Morris, Jr., J. A., Jurkovich, G. J., Yasui, Y., Cushing, B. M., Burgess, A. R., DeLateur, B. J., McAndrew, M. P. and Swiontkowski, M. F. (1998) Return to work following injury: the role of economic, social, and job-related factors. Am J Public Health. 88(11): 1630–1637

3. Grundemann, R.W.M. & Van Vuuren, T. (1997) Preventing Absenteeism at the Work Place, European Research Report, Dublin, European Foundation for the Improvement of Living and Working Conditions.

4. Industrial Relations Services. (1998). Sickness Absence: A Survey of 182 Employers. Employee Health Bulletin, 5, October, 2-13.

5. Kenny, D. (1994). Determinants of Time Lost from Workplace Injuries: The Impact of the Injury, The Injured, The Industry, The Intervention and the Insurer. International Journal of Rehabilitation Research, 17, 333-342.

6. Making occupational information interactive and accessible for all... http://online.onetcenter.org/

7. Marnetofdt, S., Selander, J., Bergroth, A., Ekholm, J. (2001). Factors Associated with Successful Vocational Rehabilitation in a Swedish Rural Area. Journal of Rehabilitative Medicine, 33, 71-78.

8. McAnaney, D. and Wynne, R (2006). Stress, absence and reintegration: Perceptions and practice of professionals in six European Member States, International Journal of Disability Management Research 1 (1): 31-42.

9. McAnaney, D. & Wynne, R. (2005) Employment Retention, Early Intervention, Social Inclusion and Emerging Disabilities. In Disability and Employment: What the Research Tells Us. National Disability Authority. Available at http://www.nda.ie/cntmgmtnew.nsf/0/A3CFE76BE6EE5B7080257117005B2A1B/$File/disability_research_conference.htm

10. Two out of three employers believe that return-to-work interviews have cut employee absence rates, according to a study by Personnel Today's sister publication, Employment Review.

11. Petrie, K. J., Weinman, J., Norman Sharpe, N. & Buckley, J. (1996) Role of patients' view of their illness in predicting return to work and functioning after myocardial infarction: longitudinal study. British Medical Journal 1996;312:1191-1194.

12. Workers Compensation Research Institute. (1996). 'What are the most important factors shaping return to work? Evidence from Wisconsin'. Research Brief, 12, 9.

13. Wynne, R. and McAnaney, D. (2004). Employment and Disability: Back to Work Strategies. The European Foundation for the Improvement of Living and Working Conditions, Loughlinstown, Dublin.

14. Wynne, R., McAnaney, D., Thorne, J., Hinkka, K. and Jarvisalo, J. (2005) The RETURN Project - between work and welfare: Improving return to work strategies for long term absent employees. In Disability and Working Life, Mannila, S. and Jarvikoski, A. (Eds). Rehabilitation Foundation, Helsinki University Press, 74-100.

3.1.5.c Early Intervention and Case Management

One of the recurring findings in the literature is the importance of early intervention in the return to work process. It is probably better to refer to this as 'safe and timely return to work' because early return to work can be interpreted as forcing people to go back to work before they are ready. Nevertheless, the findings suggest that at six months the probability of returning to work has reduced to about 50% and those who are absent for 12 months have about a 20% chance of returning.

Early intervention involves a continuum of actions that begins with early monitoring after three days, the offer of assistance at six weeks, the offer of a return to work assessment at twelve weeks and the assignment of a case manager to coordinate the interventions indicated by the assessment.

The case management may seem like a costly intervention but there is ample evidence to support the view that it is an essential ingredient of successful return to work. It is possible to describe the role of the case manager with reference to the elements of the ICF. Case managers become involved with clients at different phases of the disability process. Some people may have recently acquired an illness or injury. Others may have a developmental disability that as a result of a change in their circumstances is creating difficulties for them. Others may be in need of a lifetime care plan. Thus the case manager engages with a client at whatever stage in the disability process that client is and co-ordinates appropriate environmental interventions and supports and mobilises personal resources in order to improve activity levels or to minimise participation restrictions.

In order to achieve this, the case manager must focus not only upon the impairment of function or activity limitation of the person but also upon the barriers and challenges created by the external environment. Within the environment there are important resources such as assistive technology, rehabilitation, training and personal assistance and these need to be brought together in a coherent package on behalf of the individual. On the other hand, the environment can be a source of inhibiting factors that can mitigate against a person achieving their full potential. In this regard, the case manager must attempt to find solutions to these factors and act as an advocate for the client in overcoming these challenges.

On this basis, the case manager must adopt a comprehensive, multidisciplinary and integrated approach to developing the intervention plan. They must provide the client with clear, accurate and accessible information about their strengths and weaknesses and

assist them in problem solving, decision making and life planning in so far as their client is capable. The person must be placed at the centre of the process and the plan must provide solutions to identified needs, building on what a person 'can do'. The case manager should involve the client in an active participant role within the rehabilitation process and continually feedback to the client the outcome of assessments and interventions.

Most importantly, the case manager should adopt an holistic approach to defining needs and identifying appropriate solutions. Thus, while it is important that appropriate interventions are provided to respond to the physical/functional needs of the individual and to ensure that clients achieve a maximum restoration of function and experience minimal activity limitation, it is also the responsibility of the case manager to assess the external context of the individual to identify resources and potential challenges. In particular, the environmental, social and occupational contexts should be evaluated and interventions planned to reduce the extent to which a person's participation in these is restricted. Finally, it is important for the case manager to take cognisance of the financial and economic contexts within which the person finds himself or herself post injury and to examine the educational and psychological resources and needs that a person brings to the rehabilitation process.

By adopting such a comprehensive approach to developing a case management plan, the case manager is taking cognisance of all elements of the ICF framework and the plan itself is more likely to result in positive outcomes for the client.

The case manager needs to overcome a range of contextual constraints in order achieve a successful return to work. Some of these challenges are described below.

The purchaser:

A wide range of organisations, companies and agencies can purchase case management and rehabilitation services across the public and private sector. Insurers, defendant lawyers and personal injury lawyers may all decide for a variety of reasons to contract case management services. Statutory insurers are also beginning to adopt the case management approach. Individual employers and employment services are also potential purchasers. Each of these will have a variety of reasons for contracting a case manager. In some cases it may be seen as a way to reduce claims for compensation, in other cases case management is a service provided to clients by an insurer, in other cases it may be about preventing social exclusion and promoting return to work. Whatever the needs and

values of the purchaser, the case manager is in a position that requires he/she to balance the needs of the individual and the purchaser.

The disability process:

The stage at which the case manager becomes involved with a client will also place constraints on the type of activities that can be included within a case management plan. For example, case management is often applied at an early stage after an acquired injury or illness with a view to minimising activity limitations and returning an employee to work. On the other hand, case management can be mobilised for someone who has a longstanding impairment, which is, as a result of changing circumstances, impacting on their participation.

The status of the claim:

Whether an individual is involved in litigation is a critical constraint on the role of the case management plan. If there is no claim, or if the case management is taking place within a context where 'no fault' insurance is in place, the main focus of the case management plan is unambiguous and easily defined i.e. getting the employee back to work in a timely and safe manner. It is only where the claim for compensation is in process that the case manager has the added burden of balancing client and other interests in the case management process. If the claim and liability is undisputed then the task is less complex. However, where a claim is contested, the role of the case manager can become significantly constrained.

System values and approach:

The legal and regulatory framework of a particular jurisdiction will also impact significantly on the flexibility with which the case manager can operate. In some ways, Ireland and the UK are unique in the adoption of an adversarial system to establishing appropriate compensation for a workplace illness or injury. In other jurisdictions, a 'no fault' approach has been in operation for many years. Within the Dutch system, responsibility lies firmly with employers whereas within Germany, professional associations and social insurance providers are responsible. Case management services differ across these jurisdictions because of the differing locations of responsibility.

Level of customer knowledge:

A major constraint upon developing effective case management plans is the extent to which the purchaser has knowledge and awareness of the potential impact of such plans and the degree to which they are able to judge between alternative case management products. Across Europe, it would be fair to say that case management is at a relatively early stage of evolution and effort is required to raise awareness amongst employers of the potential benefits of case management.

Level of fragmentation/availability within the provider network:

The other side to the 'customer awareness coin' is the level and quality of services available to be purchased by the case manager. A skilled and knowledgeable case

manager will have identified a range of needs and challenges to be overcome by the client in order to achieve a more productive and independent life. In jurisdictions where case management is an emerging profession and where rehabilitation services have been traditionally centre based rather than community based, it can be difficult to identify appropriate, high quality and experienced providers.

One of the key players in the return to work process is the GP. The way in which the family doctor deals with the long-term absence is a particular problem for the case manager. To some extent it is somewhat of a lottery for long-term absent workers what approach their GP will take to sickness absence. A recent survey explored the knowledge, attitudes and experiences of GPs acting as certifying medical practitioners, and investigated what kind of help and advice they provided to their patients of working age. It also explored GPs views of how they fit within the wider range of services aimed at helping people with disabilities move into or remain in work. Wide variations in practice were identified in terms of judging incapacity for work, managing the return to work process and providing medical evidence.

The most striking characteristic of the responses of professionals across the six jurisdictions surveyed during the Stress Impact study was the lack of congruence or coherence in views and beliefs. The heterogeneity of responses within the same professional group across jurisdictional boundaries and the lack of congruence between professionals within the same jurisdiction were striking. This effectively means that a person who is enmeshed in the absence/return to work process takes part in a 'lottery' when it comes to getting appropriate and timely supports and interventions.

There is little evidence that any clear message is getting across to professionals in the field. Respondents were just not aware that they lacked sufficient knowledge to respond to long-term absence. Medical professionals need to be able and willing, to respond in more flexible and holistic ways to the issues arising from long-term absence, particularly in the use of psychosocial and work-based supports or interventions.

It is critical that case managers get linked directly into mediating services such as RTW and Mental Health services to enhance the RTW process. The importance of communications between work-based and external professionals during the return to work process also needs to be taken on board by the case manager.

Bibliography:

1. Case Management Society of America (1995) Standards of Practice for Case Management, Journal of Case Management, Vol. 1. No. 3, pp.7-16.

2. Gardner, J. A. (1991) Early referral and other factors affecting vocational rehabilitation outcome for the workers' compensation client, Rehabilitation Counselling Bulletin, March, No 34, pp 3.

3. McAnaney, D. F. (1998) From fragmentation to co-ordination: cost effective rehabilitation. Journal of Personal Injury Litigation, 2/98, 118-127.

4. Nice, K. & Thornton, P. (2004) Job Retention and Rehabilitation Pilot: Employers' management of long-term sickness absence – Research Report 227. Department of Work and Pensions, Her Majesty's Stationery Office. Accessed May 2008; http://www.dwp.gov.uk/asd/asd5/rports2003-2004/rrep227.pdf

5. Pennsylvania Department of Public Welfare, Targeted Case Management Program Questions and Answers, Accessed May 2008: http://www.dpw.state.pa.us/ServicesPrograms/MedicalAssistance/AIDSWaiverProgram/003671801.htm

6. Raderstorf, M. & Kurtz, J. (2003) Managing mental health disability in the workplace. The Case Manager , Volume 17 , Issue 1 , Pages 54 – 59

7. Washington Business Group on Health (1996) Case Management: An Essential Element in Delivery Systems that Work, Washington D.C, Washington Business Group

3.1.5.d Interventions and Follow Up

One of the most challenging tasks of the person responsible for coordinating the return to work process is selecting the most appropriate interventions for the long-term absent employee. In a study of injured workers and their employers in Australia, workers focused on the perceived failure of the system to provide adequate care while employers were concerned with cost containment and productivity. The only significant differences between those who returned and those who did not return to work were satisfaction with pre-injury pay and provision of training in occupational health and safety procedures. Worker characteristics, the timing and meaning of the injury to individual workers, and conflicting and unstated agendas in the occupational rehabilitation process, were all identified as critical factors which impacted on return to work outcomes.

The workplace based approach to occupational rehabilitation depends on the availability of, and employer willingness to provide suitable duties to workers with injuries who were either temporarily or permanently unable to perform their pre-injury work duties. Most employers experience difficulty in providing suitable duties to their workers with injuries. This can only be dealt with in the preparation phase before the launch of a return to work initiative to ensure that all relevant stakeholders such as worker representatives, management, supervisors, trade unions etc have agreed to the proposed return to work initiative.

A review of employers who provided modified duties to facilitate the rehabilitation process found that employers who offered modified work to their injured employees achieved an earlier return to work than would ordinarily be possible. Modified work is regarded by many as a cornerstone in the job rehabilitation process. A systematic review of the scientific literature on modified work published since 1975 synthesised and critically appraised the research on modified work, and assessed the effectiveness of modified work programmes. The main finding of this review was that modified work programs facilitate return to work for temporarily and permanently disabled workers. Injured workers, who are offered modified work, return to work about twice as often as those who are not. Similarly, modified work programs cut the number of lost work days in half. The available evidence also suggested that modified work programs are cost-effective.

The most relevant and useful toolkit to assist in the management of return to work that was identified in this review of the literature was the Get Back! Pack. This toolkit provides the person responsible for the return to work with a set of guidelines that includes:

1. An employer's guide and checklist
2. An assessment checklist for services providers
3. A case management guide
4. A report writing guide
5. Disability specific guides including employees with:
    a. Stress related difficulties
    b. Brain Injury
    c. Muscular or skeletal impairment
    d. Blind or partially sighted employees.

Finally, it is essential that the return to work process does not end when an employee returns to work. Follow up must be incorporated into the company policy and practice. At an individual level this means that job retention support is provided to the employee during the subsequent period of adjustment. This is where the HR, OH and WHP policies play a major role. From an organisation's perspective it is also important to review, evaluate and improve the way in which the return to work programme is being operated. One particularly useful tool for evaluating and improving return to work processes within a company is the Consensus based Disability Management Audit. Based on the NIDMAR Code of Practice, the Audit Framework for DM can evaluate company policies and practices and allow a company to benchmark against evidenced based international best practice.

Bibliography

1. British Society of Rehabilitation Medicine. (2003). Vocational Rehabilitation: The Way Forward. 2nd Edition, BSRM: London

2. Chartered Society of Physiotherapy. (1999). The Difference is Physiotherapy: Here is the Evidence. Chartered Society of Physiotherapy: London

3. Gutenbrunner, C., Ward, A. B. & Chamberlain, M. A. (2007) White book on Physical and Rehabilitation Medicine in Europe, Journal of Rehabilitation Medicine Supplement 45.

4. Kenny, D. (1995b). Common Themes, Different Perspectives: A Systematic Analysis of Employer-Employee Experiences of Occupational Rehabilitation. Rehabilitation Counselling Bulletin, 39.1. 54-57.

5. Kenny, D. (1995a). Failures in Occupational Rehabilitation: A Case Study Analysis. The Australian Journal of Rehabilitation Counselling. 33-45.

6. Kenny, D. (1999). Employers' Perspectives on the Provision of Suitable Duties in Occupational Rehabilitation. Journal of Occupational Rehabilitation, 9, 4, 267-276.

7. Krause, N., Dasinger, L. and Neuhauser, F. (1998). Modified Work and Return to Work: A Review of the Literature. Journal of Occupational Rehabilitation, 8, 113-139.

8. National Institute of Disability Management and Research (2000) Worksite Disability Management Audit, British Columbia: National Institute of Disability Management & Research.

9. NIDMAR Resources: - Code of Practice for Disability Management: Describing Effective Benchmarks for the Creation of Workplace-Based Disability Management Programs

10. Occupational Hazards (2003) The Top 10 Signs That Your Disability Management Program Needs an Upgrade,http://www.occupationalhazards.com/Issue/Article/36753/The_Top_10_Signs_That_Your_Disability_Management_Program_Needs_an.aspx

11. Rehab UK (2003) The GET BACK! Pack, RNIB Peterborough

12. Thorne, J., McAnaney, D., Biggs, H. & Wynne, R., 'The Development and Utility of an Interactive Assessment Protocol for Evaluating Company Based Responses in Managing Employees on Long Term Absence', The Australian Journal of Rehabilitation Counselling, Vol. 8, No. 1, 2002, pp.50-63.

13. Thorne, J., McAnaney, D., Biggs, H. and Wynne, R. (2002) The Development and Utility of an Interactive Assessment Protocol for Evaluating Company Based Responses in Managing Employees on Long Term Absence, The Australian Journal of Rehabilitation Counselling, Vol. 8, No. 1, pp.50-63.

Bibliography Miscellaneous

Impairment and Disability:

1. Bloch, F.S. and Prins, R. (Eds.), (2001). Who Returns to Work and Why? A Six Country Study on Work Incapacity and Reintegration London: Transaction Publishers.

2. Grammenos, S., European Foundation for the Improvement of Living and Working Conditions, Illness, Disability and Social Inclusion, Luxembourg, Office for Official Publications of the European Communities, 2003. Available online at http:// www.eurofound.eu.int/publications/files/EF0335EN.pdf

3. Yelin, E. (1986). The Myth of Malingering: Why Individuals Withdraw from Work in the Presence of Illness. Milbank Quarterly, Vol 64 (4) 622-649.

Musculoskeletal Conditions:

1. Lee, R. and Higgins, G. (2006) Medical Advice on Return to Work with regard to Musculoskeletal Disorders, Health and Safety Executive, UK. Accessed May 2008; http://www.hse.gov.uk/research/hsl_pdf/2006/hsl0669.pdf

2. Schmidt, S., Oort-Marburger, D., Meijman, T. (1995). Employment after Rehabilitation for Muscoskeletal Impairments: The Impact of Vocational Rehabilitation and Working on a Trial Basis. Archives of Physical Medical Rehabilitation, 76, 950-954.

3. Straaton, K., Maisiak, R., Wrigley, J., Fine, P. (1995). Muscuskeletal Disability, Employment and Rehabilitation. Journal of Rheumatology, 22, 3, 505-513.

4. Workcover, New South Wales (2007) Consultation Paper - Soft Tissue Injury Guides: Overview of Results of Stakeholder Consultation and Proposal for Future Actions, Accessed May 2008; http://www.workcover.nsw.gov.au/NR/rdonlyres/3F72D24D-B6FF-4304-B3B5-1ACFD402E571/0/soft_tissue_injuries_insurer_guide_consultation_paper_5233.pdf

5. Yelin, E., Sonneborn,D.,& Trupin, L.The prevalence and impact of accommodations on the employment of persons 51–61 years of ago with musculoskeletal conditions. Arthritis Care and Research, 13(3), 168–176.

Mental Ill-health:

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Arlington (VA): The Association; 2000.

2. Kessler RC, Barber C, Birnbaum HG, Frank RG, Greenberg PE, Rose RM, et al. Depression in the workplace: effects on short-term disability. Health Affairs 1999;18:163–71.

3. Stress Impact (2003) A Review and Inventory of Systems and Policy relevant to Stress and Long Term Absence, Surrey, University of Surrey.

Pain:

1. Anema, J., van der Giezen, A., Buijs, P., van Mechelen, W. (2002). Ineffective Disability Management by Doctors is an Obstacle for Return-to-work: A Cohort Study on Low Back Pain Patients Sicklisted for 3-4 Months. Occupational Environment Medicine, 59, 0-4.

2. Arenoff, G.M., McAlary, P.W., Witkower, A., and Berdell, M.S. (1987). Pain Treatment Programmes: Do they Return Workers to the Workplace? Spine, 12, 123- 136.

3. Johnson, W., Baldwin, M., Butler, R. (1998). Back Pain and Work Disability: The Need for a New Paradigm. Industrial Relations, 37, 1, January 1998, 9-32.

4. Symonds, T.L., Burton, A.K., Tillotson, K.M., and Main, C.J. (1995). Absence Resulting from Low Back Trouble can be Reduced by Psychosocial Intervention at the Workplace. Spine, 20, 2738-2745.

5. van der Giezen, A., Bouter, L., Nijhuis, F. (2000). Prediction of Return-to-Work of Low Back Pain Patients Sicklisted for 3-4 Months. Pain, 87, 285-294.

6. Vendrig, A. (1999). Prognostic Factors and Treatment-Related Changes Associated with Return to Work in the Multimodal Treatment of Chronic Back Pain. Journal of Behavioural Medicine, 22, 3, 217-232.

7. Verbeeek, J. (2001). Vocational Rehabilitation of Workers with Back Pain. Scandinavian Journal of Work, Environment and Health, 27, 5, 346-352.

8. Waddle, G., Feder, G., and Lewis, M. (1997). Systematic Reviews of Bed Rest and Advice to Stay Active for Acute Low Back Pain. British Journal of General Practice, 47, 647-652.

Cardiac Conditions:

1. Dafoe, W., and Cupper, L. (1995). Vocational Considerations and Return to Work. Cardiac Rehabilitation, 6, 1, 191-204.

2. Mulcahy, R., Kennedy, C., Conroy, R. (1988). The Long-Term Work Record of Post- Infarction Patients Subjected to an Informal Rehabilitation and Secondary Prevention Programme. European Heart Journal, 9, 84-88.

3. Renzill, A.G., Gobbato, F., and Maisano, G. (1988). The Interaction between Man- Work-Environment and the Return to Work of Coronary Patients: The Philosophical Aspects. European Heart Journal, 9, 5-7.

4. Shrey, D. and Mital. A. (2000). Accelerating the Return to Work (RTW) Chances of Coronary heart Disease (CHD) Patients: Part 2 – Development and Validation of a Vocational Rehabilitation Programme. Disability and Rehabilitation, 22, 13/14, 621- 626.

Visual Impairment:

1. Jeppsson-Grassman, E. (1989). Returning to Work after the Onset of Visual Impairment. Journal of Visual Impairment and Blindness, 83, 5, 241-244.

Acquired Brain Injury:

1. British Society of Rehabilitation Medicine (2003) Rehabilitation following acquired brain injury: National clinical guidelines; Royal College of Physician, UK. Accessed May 2008; http://www.rcplondon.ac.uk/pubs/contents/43986815-4109-4d28-8ce5-ad647dbdbd38.pdf

Age:

1. Biddle, J. E., Boden, L. I. and Reville, R. T., (2003) Older Workers Face More Serious Consequences from Workplace Injuries" . Health and Income Security for an Aging Work Force, Vol. 5. Available at SSRN: http://ssrn.com/abstract=571062

2. Bruyère, S. M. (2006). Disability Management: Key Concepts and Techniques for an Aging Workforce, International Journal of Disability Management Research Vol. 1 (1) 149–158.

3. Ghosheh, N.S., Lee, S., & McCann, D. (2006). Conditions of work and employment for older workers in industrialized countries: Understanding the issues. Geneva, Switzerland: International Labour Office.

4. Gustman A, Mitchell O, Steinmeier T. Retirement measures in the health and retirement survey. J Hum Resources 1995;30:557–83.

5. Ho, P. (2002). Disability and employment status among older workers. Washington, DC: National Rehabilitation Hospital, Center for Health and Disability Research.

6. Ilmarinen, J. (1999). Ageing workers in the European Union. Finnish Institute of Occupational Health. Helsinki.

7. Ilmarinen, J. (2002). Physical requirements associated with the work of aging workers in the European Union. Experimental Aging Research, 28(1), 7–23.

8. Mitchell, J.M., Adkins, R.H., & Kempt, B.J. (2006). The effects of aging on employment of people with and without disabilities. Rehabilitation Counseling Bulletin, 49(3), 157-165.

3.2 Other Available Training

The third part of the needs analysis task was the conducting of an internet search to identify other training courses in the area of return to work. The main results of this search are summarized below in two sections, Online training and Offline training. At this stage only a search in English has been conducted, however a similar search will be conducted in the languages of the countries where the train the trainers training and the testing will take place

Online Training

4 quite relevant online training courses were found. The majority of these were from outside Europe and were quite different from our proposal e.g. too basic (no. 1), too advanced (no. 4), tailored in-house approach (no. 3). The one course we found online within Europe was from the U.K. and was focused entirely on absence management.

Online Training No. 1

Title	Return to work- the basics
Organisation	Canadian Centre for Occupational Health and Safety
URL	http://www.ccohs.ca/products/courses/return_to_work/
Country of Origin	Canada
Course Length	1 hour
Cost	Canadian 100$
Summary	This course provides a practical overview of Return to Work strategies, solutions and program implementation. Topics include: • Cost Effects of Workplace Injuries and Illness • Return to Work – Definition, Importance and Workplace Policy • Key Return to Work Concepts • Getting Your Employee Back to Work • Claims Management and Monitoring • Factors that Influence Return to Work • Keys to Successful Return to Work

Online Training No. 2

Title	Absence Management e-learning
Organisation	Fenman Ltd (training consultancy)
URL	http://www.fenman.co.uk/
Country of Origin	United Kingdom
Course Length	2 hours
Cost	£990+VAT
Summary	This course is designed to ensure managers and employees implement absence management best practice. It has three modules: • During the absence: Both the employee's and manager's responsibilities during the absence period • The return to work interview: the key stages of the return to work interview • Follow up: How to monitor future absence, assess progress and take further action if required The course is cross-referenced to the National Occupational Standards for Management and Leadership.

Online Training No. 3

Title	Corporate Return-to-Work Program Development Services
Organisation	UNUM (an international insurance Group)
URL	http://www.unum.com/products/large/absence_management.aspx
Country of Origin	U.S.A
Course Length	Tailored to company
Cost	Unknown
Summary	This is a tailored service which aims to help a company with learning more about absenteeism, better training their staff about it, and better planning for it, to minimize workplace disruption and realize measurable cost savings. The program support includes web-based education.

Online Training No. 4

Title	Online Return to Work Coordinator Program
Organisation	NIDMAR (a Reintegrate project partner)
Country of Origin	Canada
URL	http://www.nidmar.ca/education/education_online/online_module_date.asp
Course Length	250-300 hours approximately
Cost	Canadian $170-$225 per module (25 in total)
Summary	This program consists of 25 modules designed to provide the skills and competencies essential for disability management / return to work practitioners as they assist workers, who have incurred injuries and illnesses, in returning to the workplace. The 25 twenty-five modules may be taken as a complete program or as individual modules to develop expertise in specific areas. Modules include: • disability management • return-to-work coordination • Physical and mental health, rehabilitation services and RTW • Job analysis • Legislation and occupational rehabilitation & worker's compensation • Management and organisational skills for RTW • Evaluating the return to work process and disability management • Injury prevention and health promotion • Managing the RTW process All modules have been endorsed for Certified Disability Management Professional (CDMP) and Certified Return to Work Coordinator (CRTWC) professional development.

Offline Training

The majority of offline courses that were found to be relevant were from outside Europe. There were a number available in Australia, mainly as a result of legislation there that requires companies above a certain size to have a 'return to work coordinator', no.2 and no. 3 below are examples of these. Within Europe the majority of courses available are absence management courses such as no. 4 below. Other courses such as no. 7 below

are focused differently (employees with disabilities) and do not include all the necessary elements of the return to work process.

Offline Training No. 1

Title	Manager's Guide to Early & Safe Return to Work
Organisation	The Ontario Service Safety Alliance
Country of Origin	Canada
URL	www.ossa.com
Course Length	2 hours
Cost	Canadian $119
Summary	These workshops are designed to provide employers, managers, HR professionals, health & safety representatives etc with the information and skills needed to uphold their legal obligations and to create an effective health & safety program in the workplace. By the end of this course, participants will be able to: • Demonstrate knowledge of the legislated responsibilities of employers, workers, and the WSIB, as defined within the Workplace Safety and Insurance Act (WSIA) • Identify the fines and penalties for failing to meet Early & Safe Return to Work obligations under the WSIA • Define the key steps involved in returning an injured worker to work • Outline how to create and implement an Early & Safe Return to Work plan for an injured worker • Define the factors and best practices that contribute to a successful Early & Safe Return to Work program • Explain how to evaluate the effectiveness of a company's Early & Safe Return to Work program

Offline Training No. 2

Title	Intro to Return to Work Co-ordination (advanced also available)
Organisation	Rehab Management (training consultancy)
Country of Origin	Australia
URL	http://www.rehabmanagement.com.au
Course Length	2 days
Cost	Unknown
Summary	A return to work coordinator is a worker nominated by an employer whose principal purpose is to assist injured workers to return to work in a safe and durable manner. Under NSW workers compensation law, employers (ie. employers whose basic tariff premium exceeds $50,000, as well as self insurers, and employers who are insured by a specialised insurer and who employ more than 20 workers) must have a return to work coordinator. Rehab Management assists employers to formally train employees as Return to Work Coordinator(s) Expected Outcome: The program has been designed to give the necessary tools for organisations to implement an effective and comprehensive rehabilitation program.

Offline Training No. 3

Title	An Introduction to Return to Work Coordination
Organisation	QBE Australia - (insurance group)
Country of Origin	Australia
URL	http://www.intermediary.qbe.com.au/Business/Workers-Compensation/Training/XPRODCT001089?ssSourceSiteId=AAPEXT_CON450$
Course Length	2 days
Cost	Australian $400-$450
Summary	This training session has been developed to provide the information and skills for Return to Work Coordinators to support employers and facilitate successful return to work of injured workers. Topics covered include: • Overview of injury management concepts • Components of an employers return to work program • Role of the return to work coordinator • Working with key stakeholders, including doctors, rehabilitation and treatment providers • Role of the insurer – premiums and claims management • Benefits for injured workers • Developing a return to work plan • Dispute prevention and resolution • Resources

Offline Training No. 4

Title	Managing Sickness Absence and Return to Work
Organisation	The Health and Safety Laboratory (an agency of the Health and Safety Executive)
Country of Origin	U.K.
URL	http://www.hsl.gov.uk
Course Length	1 day
Cost	£395 + VAT
Summary	This workshop is designed to provide supervisors and line managers with the knowledge and techniques to help them minimise the impact of sickness absence in their teams. The course covers: • Background to the sickness absence issue – real costs and impact. • Understanding the causes of sickness absence. • The differences between short term and long term absence. • Measuring sickness absence – when does it become an issue? • Approaches to managing sickness absence. • Overcoming possible barriers to managing sickness absence

Offline Training No. 5

Title	Internationally recognised occupational rehabilitation training programme
Organisation	Brunel University (& UNUM & NIDMAR)
Country of Origin	U.K.
URL	*http://www.brunel.ac.uk/research/rsdo/cpd/courses/ortc*
Course Length	25 days plus homework
Cost	£250 approx. per module (25 in total)
Summary	This is the UK's first internationally recognised occupational rehabilitation training programme . It is designed to enhance the knowledge and competence of those involved in helping people who are ill or injured enter or re-enter the workplace. It will provide an introduction to the skills required to administer disability and absence management programmes. The programme will assist and enhance the work of occupational therapists, physiotherapists, occupational health and human resource professionals, as well as other practitioners dealing withdisability-related issues. Modules include: • Effective Disability Management programmes • Introduction to return-to-work coordination • Job analysis • Legislation and Occupational Rehabilitation • Insurance and other benefits • Problem-solving with organisations • Occupational Rehabilitation from a HR perspective • Assistive technology and accommodation • Injury prevention and health promotion • Professional conduct • Managing the return-to-work process

Offline Training No. 6

Title	Encouraging Return to Work (managing absence training also available)
Organisation	Workplace Law Network
Country of Origin	U.K.
URL	http://www.workplacelaw.net/training/course/id/43
Course Length	Half day
Cost	Unknown
Summary	This course is designed to enable organisations to consider ways to retain staff in your organisation who have been on a long break (e.g. maternity leave). It aims to help companies consider different ways of maintaining staff loyalty and commitment as well as focusing on how the company needs to comply with the legislative requirements in this area. Topics covered: • Introduction and objectives • Legal context of maternity, career breaks and long term sickness • Barriers to returning • Flexible working • Communication with absent employees • Action plans

Offline Training No. 7

Title	Providing Support to the employee with a disability
Organisation	Orbis Consultancy
Country of Origin	Ireland
URL	http://www.orbis.ie/training/3_Providing_Support_to_the_employee_with_a_disability.htm
Course Length	2 days
Cost	Unknown
Summary	This workshop is designed for supervisors and personnel in the workplace who are involved in staff retention. It aims to provide information on assistive technology, aids, adaptations and grants, available to support individuals with a disability. Topics include: • Learning to build an enabling environment for people with disabilities to retain employment • Carrying out environmental and ergonomic analysis • Understand the range of barriers, which a person with a specific disability can face in the work place • Draw up an individual support profile for different people

Overall it is very evident that there is a gap in the type of available course particularly in Europe. It seems that there is a need for a 'return-to-work programme at the level we are proposing since the only one available is the Brunel/NIDMAR/UNUM collaboration which is an internationally certified academic course that would be too long a commitment for the average employer.

In addition, no online Return to Work programmes were found in Europe which would suggest that an integrated e-learning environment would be a significant addition to the available training materials in the area.

3.3 Survey

This section contains the main results from the survey of user needs undertaken as part of the project.

The quality of the responses received was generally good with very little missing data and apparently well considered answers to the open ended questions on the questionnaire. There were 44 completed questionnaires received from the partners – 37 from Ireland and 7 from other European countries – one from each country participating in the train the trainers event in November 2008. 10 Irish responses came from students who worked in all sectors but were doing a course on occupational health management, the other 27 Irish responses came from a sample of a major Trade Union's member organisations, which are largely private sector and semi-state, while the remaining 7 international responses came from rehab agencies.

The data is therefore skewed in favour of Irish employer opinions. To mitigate against this skewing of data, checks are being built into the project to ensure that the training

materials developed as a result of this needs analysis will be appropriate for other country settings. These checks include verifying the results against other available survey data e.g. Optiwork8 and holding a session during the train the trainers event to ask international participants from Rehab agencies whether they feel that the responses and resulting training requirements are relevant to their own context.

The analysis applied was basic – frequencies and means (where appropriate) were obtained for all of the quantitative variables. The results are presented in two sections, the first deals with the quantitative data and the second with the qualitative data.

3.3.1 Quantitative

3.3.1.a Importance of the Elements –Frequencies and Means

Table 3 below shows the responses given in regard to how important the respondent thinks the elements (listed in the left hand column) are in terms of return to work practices. The table is split into 2 sections to reflect the questionnaire used in the survey, the first being prevention/intervention and the second being retention/reintegration.

There were four choices for each element: 1) not at all, 2) of some importance 3) very important and 4) essential. The table shows how many respondents filled in each column. For example, no respondents thought that 'organisational early intervention practices' was 'not at all' important, none thought it 'of some importance', 15 felt it was 'very important' and 28 thought it 'essential'.

The above responses were then analysed to calculate a mean score for each element. This was done by applying the following code to the responses: 1= not at all, 2= Of some importance, 3= very important and 4= essential. The elements are presented in descending order of their mean score, which can be seen in the far right column.

[8] OPTIWORK project: Available at: http://www.optiwork.org/ [accessed 28th July 2008].

Table 3a: Importance of the Prevention / Intervention elements – Frequencies & Means

Prevention / intervention	Not at All	Of Some Importance	Very Important	Essential	Means (1-4)
Organisational early intervention practices	0	0	15	28	3.57
Organisational accident prevention and safety activities	0	1	19	22	3.35
The nature of the employee's illness or injury	0	8	9	26	3.34
Organisational occupational health services	0	9	26	9	3.15
Employer knowledge of pay and social welfare entitlement	3	4	22	15	3.13
Employer awareness of relevant legislation	1	9	20	14	3.05
Social services available to help employees and employers	4	7	22	11	2.90
Grants and financial supports for employers and employees	4	6	26	8	2.86
Employer knowledge of medical rehabilitation services	0	12	23	9	2.95
Employer knowledge of vocational training services	3	14	19	8	2.74
Employer knowledge of external occupational health services available	1	14	26	3	2.71
Organisational workplace health promotion	6	5	26	6	2.65

According to the respondents, the 3 most essential elements in the area of prevention/intervention section were: 1) Organisational early intervention practices 2) organisational accident prevention & safety activities and 3) The nature of the employee's illness or injury.

The lowest scoring elements were: Employer knowledge of vocational training services, Employer knowledge of external occupational health services available and Organisational workplace health promotion.

Table 3b: Importance of the Retention/Reintegration Elements – Frequencies & Means

Retention/Reintegration	Not at All	Of Some Importance	Very Important	Essential	Means (1-4)
Organisational policies/ practices/systems in place to facilitate return to work	0	0	17	27	3.61
The support of management and employees for return to work practices	0	1	19	24	3.53
Organisational communications with all employees on all aspects of organisational return to work practices	0	2	24	18	3.36
The benefits to the employee of return to work	0	6	19	19	3.28
Organisational training and development facilities for employees	0	5	24	15	3.22
Organisational procedure in place for communicating with employee(s) absent due to illness/accident	0	13	12	19	3.14
Organisational case management activities	0	14	13	17	3.07
Organisational absenteeism (ill or injured) information management system in place	3	4	26	11	3.05
Job re-design/ alternative job possibilities	0	7	29	8	3.01
The employer having a resource person who is responsible for ensuring safe return to work	0	8	24	10	2.98
Transitional work arrangements	0	8	31	5	2.92
The business case for return to work (for the employer)	5	14	13	11	2.70
Assistive technology available in the organisation	4	12	24	4	2.63
Job out-placement practice/ in place/familiar with	0	23	19	2	2.53

In the retention/reintegration table above it shows that the top scoring elements were 1) Organisational policies/ practices/systems in place to facilitate return to work 2) The support of management and employees for return to work practices and 3) Organisational communications with all employees on all aspects of organisational return to work practices.

Respondents felt that the least important areas were 1) The business case for return to work (for the employer) 2) Assistive technology available in the organisation and 3) Job out-placement practice/ in place/familiar with.

Table 3c: Importance of all Elements- Means for OSH students, European Rehabilitation Agencies and Irish Employers

Prevention / Intervention	OSH Students	Rehab Agencies	Employers
Employer awareness of relevant legislation	2.6	3.2	3.2
Social services available to help employees and employers	2.5	3.3	3.0
Grants and financial supports for employers and employees	2.7	2.7	3.0
Employer knowledge of pay and social welfare entitlements	3.0	2.8	3.3
Employer knowledge of medical rehabilitation services	3.2	3.2	2.8
Employer knowledge of vocational training services	2.7	3.2	2.7
Employer knowledge of external occupational health services available	2.8	3.0	2.6
Organisational accident prevention and safety activities	3.2	3.0	3.6
Organisational workplace health promotion	3.2	2.3	2.5
Organisational occupational health services	3.3	2.7	3.2
Organisational early intervention practices	3.5	3.0	3.7
The nature of the employee's illness or injury	3.4	2.3	3.6
Retention / Reintegration			
Organisational policies/practices/systems in place to facilitate return to work	3.5	3.5	3.7
Organisational case management activities	2.9	3.7	3.0
The employer having a resource person who is responsible for ensuring safe return to work	2.9	3.5	3.0
Job re-design/ alternative job possibilities	3.2	3.7	2.8
Job out-placement practice/in place/familiar with	2.8	3.0	2.3
Transitional work arrangements	3.2	3.0	2.8
Assistive technology available in the organisation	2.5	2.8	2.7
Organisational training and development facilities for employees	2.8	3.2	3.4

Retention / Reintegration			
Organisational procedure in place for communicating with employee(s) absent due to illness/accident	3.4	3.3	3.0
Organisational communications with all employees on all aspects of organisational return to work practices	3.5	3.0	3.4
The support of management and employees for return to work practices	3.3	3.7	3.6
Organisational absenteeism (ill or injured) information management system in place	3.1	3.2	3.0
The business case for return to work (for the employer)	3.0	3.5	2.4
The benefits to the employee of return to work	3.6	3.0	3.2

The above table shows how the different groups of respondents rated the elements. It can be seen that respondents are, unsurprisingly, answering from their own contexts e.g OSH students rate the importance of workplace health promotion (WHP) - the area in which they will be working - much higher than the other groups. Rehab agencies rate case management and having a resource person much higher.

It is interesting to note that rehab agencies rate 'early intervention', accident prevention, workplace health promotion and in house OSH (3.0) lower than the students (3.5) and employers (3.7), but perhaps that is because the nature of their work deals only with the aftermath of the person's illness or injury. Surprisingly, employers ranked 'business case' (2.4) lower than the other groups (3.0 and 3.5), one would expect that the employers would have the most interest in this element.

Overall the table above indicates that there was a greater variation in the responses between groups for the prevention/intervention elements compared to the retention/reintegration elements.

3.3.1.b Level of Knowledge and Skills – Frequencies and Means

Table 4 below shows the responses given in regard to the level of knowledge and skills that the respondent felt exists in their organisation or in organisations that they come in contact with.

There were four choices for each element: 1) none, 2) low level 3) moderate level and 4) high level. To calculate the mean scores a similar system of codes, as applied previously, was used. In this case, 1=none, 2= low level, 3= moderate level and 4= high level. Again the elements are presented in descending order of their mean score.

Table 4a: Level of Knowledge & Skills (Prevention / Intervention) – Frequencies & Means

Prevention / intervention	None	Low level	Moderate Level	High Level	Means (1-4)
Organisational accident prevention and safety activities	11	7	16	9	2.92
Employer knowledge of pay and social welfare entitlement	0	15	19	10	2.90
The nature of the employee's illness or injury	5	8	26	5	2.74
Organisational workplace health promotion	3	14	12	15	2.53
Employer awareness of relevant legislation	5	23	7	9	2.46
Social services available to help employees and employers	5	16	20	2	2.43
Grants and financial supports for employers and employees	2	27	12	3	2.37
Organisational occupational health services	12	8	18	6	2.35
Employer knowledge of external occupational health services available	12	11	12	7	2.30
Employer knowledge of vocational training services	7	20	16	1	2.24
Employer knowledge of medical rehabilitation services	12	14	16	2	2.18
Organisational early intervention practices	11	10	16	7	2.05

Table 4a above shows that 'Organisational accident prevention and safety activities' and 'employer knowledge of pay and social welfare entitlement' are top of the list in terms of the level of knowledge that exits. These are followed by 'the nature of the employee's illness or injury' and 'Organisational workplace health promotion'. 'Employer knowledge of medical rehabilitation services' and 'Organisational early intervention practices' are bottom of the list suggesting that there is a possible training need in those areas.

It is interesting to note that in Table 3a employers rated 'early intervention' as the most important element of prevention whilst here it is bottom of the table. This seems to suggest that although employers have little expertise in early intervention they realise that it is a critical element of prevention/intervention.

Table 4b: Level of Knowledge & Skills (Retention/Reintegration) – Frequencies & Means

Retention/Reintegration	None	Low Level	Moderate Level	High Level	Means (1-4)
Organisational policies/ practices/systems in place to facilitate return to work	6	12	19	7	2.62
Organisational procedure in place for communicating with employee(s) absent due to illness/accident	3	26	13	2	2.33
Job re-design/ alternative job possibilities	1	30	11	2	2.33
The benefits to the employee of return to work	6	19	17	1	2.24
The support of management and employees for return to work practices	2	29	11	1	2.21
Transitional work arrangements	7	26	9	1	2.09
Organisational case management activities	14	14	16	0	2.05
The business case for return to work (for the employer)	12	20	11	1	2.04
Organisational training and development facilities for employees	12	24	8	0	1.91
Job out-placement practice/ in place/familiar with	17	17	7	2	1.87
Organisational communications with all employees on all aspects of organisational return to work practices	20	7	14	1	1.81
Organisational absenteeism (ill or injured) information management system in place	19	18	5	2	1.77
The employer having a resource person who is responsible for ensuring safe return to work	21	16	7	0	1.68
Assistive technology available in the organisation	22	14	8	0	1.68

Under Retention/Reintegration, the 3 areas in which there seems to be the highest level of knowledge are 1) Organisational policies/ practices/systems in place to facilitate return to work 2) Organisational procedure in place for communicating with employee(s) absent

due to illness/accident and 3) Job re-design/ alternative job possibilities. The 2 bottom areas in terms of knowledge are 1) The employer having a resource person who is responsible for ensuring safe return to work and 2) Assistive technology available in the organisation.

Overall, the tables indicate that there is a higher level of knowledge in the area of Prevention/Intervention than in Retention/Reintegration.

Table 4c: Level of Knowledge & Skills for all Elements-
Means for OSH Students, European Rehabilitation Agencies and Irish employers

Prevention / Intervention	OSH Students	Rehab Agencies	Employers
Employer awareness of relevant legislation	3.1	2.7	2.2
Social services available to help employees and employers	2.6	2.2	2.4
Grants and financial supports for employers and employees	2.4	2.7	2.3
Employer knowledge of pay and social welfare entitlements	3.2	2.8	3.2
Employer knowledge of medical rehabilitation services	2.7	2.0	2.0
Employer knowledge of vocational training services	2.5	1.8	2.6
Employer knowledge of external occupational health services available	2.7	2.4	2.2
Organisational accident prevention and safety activities	3.2	3.0	2.8
Organisational workplace health promotion	2.5	2.2	3.0
Organisational occupational health services	2.6	3.0	2.2
Organisational early intervention practices	2.3	1.8	2.0
The nature of the employee's illness or injury	2.4	1.8	3.1
Retention / Reintegration			
Organisational policies/practices/systems in place to facilitate return to work	2.5	2.3	2.8
Organisational case management activities	2.3	1.8	2.0
The employer having a resource person who is responsible for ensuring safe return to work	2.2	2.0	1.8
Job re-design/ alternative job possibilities	2.5	2.7	2.2
Job out-placement practice/in place/familiar with	2.2	2.5	1.6
Transitional work arrangements	2.3	2.2	2.0

Retention / Reintegration			
Assistive technology available in the organisation	2.4	2.2	1.3
Organisational training and development facilities for employees	2.5	2.3	1.6
Organisational procedure in place for communicating with employee(s) absent due to illness/accident	2.8	2.0	2.2
Organisational communications with all employees on all aspects of organisational return to work practices	2.2	1.8	1.8
The support of management and employees for return to work practices	2.5	2.2	2.2
Organisational absenteeism (ill or injured) information management system in place	2.5	2.0	1.8
The business case for return to work (for the employer)	2.4	2.5	2.2
The benefits to the employee of return to work	2.4	2.4	2.3

As can be seen from the table above, the Rehab agencies have indicated that their level of knowledge is lower than the other groups with regard to early intervention and WHP, which may go someone way towards explaining perhaps why they also rated these type of elements lower in table 3c – importance of elements.

It is interesting to note that employers rated not only knowledge of external occupational health services lower than the other groups, but also knowledge of internal occupational health services. Surprisingly, Rehab agencies rated their knowledge of case management lower than the other groups.

The table shows that employers rated a number of retention/reintegration elements lower than the other groups e.g. job redesign, out placement, training and development, communications with the absent employee and both the rehab agencies and the employers gave a lower score to their knowledge of absenteeism management systems.

3.3.1.c Training Needs - Means

The table below subtracts the mean presented in table 4 from the mean presented in table 3 i.e. subtracts the level of knowledge from the importance of the issue to give the 'training need' for an element. For example, in the case of 'organisational early intervention practices', the importance rating (from table3) = 3.57 and the level of knowledge (taken from table4) = 2.05, which gives a training need of 3.57-2.05 = 1.52.

Therefore, where the difference is large (e.g. 1.55 for communications with all employees) there is a strong training need, while where the value is low or negative, there is less need.

Table 5a: Training Needs –Means

Prevention / intervention	Means
Organisational early intervention practices	1.52
Organisational occupational health services	0.80
Employer knowledge of medical rehabilitation services	0.76
Employer awareness of relevant legislation	0.60
The nature of the employee's illness or injury	0.59
Employer knowledge of vocational training services	0.50
Grants and financial supports for employers and employees	0.49
Social services available to help employees and employers	0.47
Organisational accident prevention and safety activities	0.42
Employer knowledge of external occupational health services available	0.40
Employer knowledge of pay and social welfare entitlement	0.23
Organisational workplace health promotion	0.12
Retention/Reintegration	
Organisational communications with all employees on all aspects of organisational return to work practices	1.55
Organisational training and development facilities for employees	1.31
The support of management and employees for return to work practices	1.31
The employer having a resource person who is responsible for ensuring safe return to work	1.30
Organisational absenteeism (ill or injured) information management system in place	1.28
The benefits to the employee of return to work	1.04
Organisational case management activities	1.02
Assistive technology available in the organisation	0.94
Organisational policies/practices/systems in place to facilitate return to work	0.99
Transitional work arrangements	0.83
Organisational procedure in place for communicating with employee(s) absent due to illness/accident	0.81
Job re-design/ alternative job possibilities	0.69
Job out-placement practice/ in place/familiar with	0.66
The business case for return to work (for the employer)	0.66

The above table shows that based on responses there seems to be a higher training need in the area of retention/reintegration rather than in prevention/intervention. The one area under prevention/intervention that seems to have a high training need is 'Organisational early intervention practices'. For all the other elements in this area it seems that respondents either felt that knowledge levels were high or the element was not of significant importance.

However under retention/reintegration there seems to be number of areas requiring attention. The 4 areas with the highest need are:

1. Organisational communications with all employees on all aspects of organisational return to work practices
2. Organisational training and development facilities for employees
3. The support of management and employees for return to work practices
4. The employer having a resource person who is responsible for ensuring safe return to work

It is somewhat surprising that 'the business case for return to work' has a low training need (due to it scoring very low in 'importance') given that the 'support of management' (and employees) scored second in terms of highest training need.

Table 5b: Training Needs –Means for OSH students, European Rehabilitation Agencies and Irish Employers

Prevention / Intervention	OSH Students	Rehab Agencies	Employers
Employer awareness of relevant legislation	-0.5	0.5	1.1
Social services available to help employees and employers	-0.1	1.2	0.6
Grants and financial supports for employers and employees	0.4	0.0	0.7
Employer knowledge of pay and social welfare entitlements	-0.2	0.0	0.0
Employer knowledge of medical rehabilitation services	0.5	1.2	0.8
Employer knowledge of vocational training services	0.2	1.3	0.0
Employer knowledge of external occupational health services available	0.1	0.6	0.4
Organisational accident prevention and safety activities	0.0	0.0	0.8
Organisational workplace health promotion	0.6	0.2	-0.5
Organisational occupational health services	0.7	-0.3	1.0
Organisational early intervention practices	1.3	1.2	1.7
The nature of the employee's illness or injury	1.0	0.5	0.5

Prevention / Intervention	OSH Students	Rehab Agencies	Employers
Organisational policies/practices/systems in place to facilitate return to work	1.0	1.2	1.0
Organisational case management activities	0.6	1.8	1.0
The employer having a resource person who is responsible for ensuring safe return to work	0.7	1.5	1.2
Job re-design/ alternative job possibilities	0.7	1.0	0.6
Job out-placement practice/in place/familiar with	0.6	0.5	0.7
Transitional work arrangements	0.9	0.8	0.8
Assistive technology available in the organisation	0.1	0.7	1.4
Organisational training and development facilities for employees	0.4	0.8	1.8
Organisational procedure in place for communicating with employee(s) absent due to illness/accident	0.5	1.3	0.8
Organisational communications with all employees on all aspects of organisational return to work practices	1.3	1.2	1.6
The support of management and employees for return to work practices	0.8	1.5	1.4
Organisational absenteeism (ill or injured) information management system in place	0.5	1.2	1.2
The business case for return to work (for the employer)	0.6	1.0	0.2
The benefits to the employee of return to work	1.3	0.6	1.0

The table above shows that there are some relative differences between the different groups' training needs. Employers indicated that they have a high training need with regard to legislation, while the other groups didn't. Rehab agencies indicated that they need to know more about available social services and vocational training, while they were the only group who didn't seem to need to learn more about in house occupational health services.

Rehab agencies also indicated a high training need in the area of case management (1.8), while the students indicated a much lower need (0.6).

Two other areas in which employers alone seem to have a high learning need were that of assistive technology and training and development.

3.3.1.d Length of Training

Table 6: Length of Training - Means

	Mean Number of Hours
Length of training	9.32
Face-to-face training	4.00
Using the e-learning environment	2.45
Practical homework	2.26
Reporting	1.85

Respondents were asked how long they thought each element of training should take. In overall terms, respondents thought that the training should take 9 hours (hrs) 20 minutes (mins), with the Face-to-face training taking up the most time (4 hours), followed by 2 hrs 30 mins for online work. 2 hrs 15 mins were allotted for homework and 1 hr 50 mins for reporting.

3.3.2 Qualitative

This section outlines the results from Section 1 of the questionnaire. There are six tables in total each corresponding to a particular question on the questionnaire. Within each table, responses are grouped under appropriate headings.

Table 7 below shows the responses to the question, what do you think are the three most common reasons for long-term absence from work? From this table we see that answers fall into 2 main categories, health reasons and organisation reasons. In the first category we have musculoskeletal disorders, mental health, accidents and chronic illness/disease. The latter category is mainly made up of poor workplace morale issues and poor return to work practices in the organisation and externally.

Table 7: Reasons for Work Absence

Musculoskeletal Disorders	Mental Health Related Issues	Accidents
• Musculoskeletal disorders • Back pain • Back injury • Muscular injury	• Psychosocial problems • Stress • Psychiatric problems • mental health/ stress • Depression • Skills – work mismatch	• Work accident • Injury • Manual handling • Machinery & hand tools
RTW Practices	**Workplace Morale**	**Chronic Illness/Disease**
• Poor HRM re RTW • Lack of RTW management • Incompetence/lack of technical knowledge or inability to acquire it • National Insurance does not emphasise enough Return to Work as an objective • Rehabilitation treatment and training do not emphasize enough RTW as an objective • Lack of follow-up from the rehabilitation planning made by the occupational doctor in charge of the patient (In the Netherlands, occupational doctors are hired by the companies to protect employees needs) • Lack of attention and adaptation to the employees needs/abilities in general	• Poor morale • Bad relationships between workers and employers • Alienation from workplace • Conflicts at workplace* or family/personal reasons	• Illness • Health problems • Chronic Illness • The severity/type of illness or injury (some just prevents Return to Work)
Other Illness	**Organisational Factors**	**Other**
• Occupational diseases • Spinal cord injuries • Respiratory disorders • Hysterectomy • Severe diseases such as cancer	• Training • Lack of adequate job possibilities	• Age • discrimination • Inability to cope with changes at work

Table 8 below outlines respondents' opinions on what are the three most important services currently available that can help ensure a safe and early return to work. Responses have been grouped and the 4 main categories are:

- rehabilitation - timely and effective services e.g. A timely medical rehabilitation process with the participation of employer and client
- communications - between interested parties e.g. Dialogue between medical staff, employers and employees,
- workplace response - e.g. flexible return policy
- primary care – e.g. quick diagnosis

Table 8: Most Important Services for RTW

Communications	Rehabilitation	Primary care
• Employer contact • Dialogue between medical staff, employers and employees • Contact with employer • Information services at regional level and within the rehabilitation centre	• rehabilitation • Phsyiotherapy • Rehabilitation services promoting RTW • Services provided by rehabilitation centres (facilitating the return to work process, contact with the employer, etc) • Proper intervention by doctor (rehab. prog.) or the company (workplace adaptation) • Case management • A timely vocational rehabilitation process with the participation of employer and client • Vocational rehabilitation • A timely Medical Rehabilitation process with the participation of employer and client	• A Quick diagnosis after the accident or beginning of illness • Primary Health care services with the view to facilitate the return to work • Cognitive therapy (Focusing on the behavioural issues to enhance the person's ability to apply for a new job)
Workplace response	**OSH**	**Other**
• Return to work interviews • EAP • Flexible return policy • Support • Redeployment • Work place adaptation • HR • Phasing employee back • Reduced work activities • Job redesign • empowerment of employee	• The existence of a health and safety department in the company • OH • Competent assessment by company doctor	• Staying in work • Job retention • Bradford factor • The obligation by law to have a physician working for company • Subsidies to finance necessary interventions

Table 9 shows the responses to the question, *What are the three largest barriers that currently hinder a safe and timely return to work process*? The table indicated that answers fall into 4 main categories:

1) Communications/support,
2) Attitudes and knowledge (e.g. Management reluctance, prejudice),
3) Employee characteristics and
4) System failures (e.g. Cannot access early treatment, Lack of support from public authorities in terms of policies/guidance/subsidies)

Table 9: Barriers to RTW

Communications/Support	Lack of System	Attitudes and Knowledge
• Lack of support • Lack of communication between the employer and employee • Relations between employer/employee	• No intervention by management • Work no longer suitable • Hours too long • National legislation (no promotion of Return to Work, no funds available for it)	• Management reluctance • Ignorance of employers of real costs and benefits of RTW • The behavior of the employers (not aware of their role, don't see work possible) • Prejudice: ageism/fear of rehab worker • Personalities • Lack of information on legislation and of grants for employers and employees • Fear of litigation
Employee Characteristics	**System Failures**	**Other**
• Employee perceptions • Worries about getting back into the swing of it • Alienation from workplace • Employee apprehension • Fear • Fear of not being accepted - harassment • The fear of failure from the employee's side (and sometimes from the service providers side as well) • Psychological barriers	• Lack of information/analysis processes on the real causes of absenteeism • Rigid and bureaucratic national insurance system • Lack of coordination between actors • Insurance • Lack of support from public authorities in terms of policies/guidance/subsidies • Cannot access early treatment • Strict delimitation between healthy and sick state (if an employee is declared sick, they must stay home and can only go back to work/training when the doctor declares they are fully recovered) • GPs • Lack of support for the individual • Poor work-based interventions and workplace adaptations • Short-term perspective & inflexibility of health services • No focus on early intervention/RTW • The bulk of administrative procedures • Poor recovery due to lack of OH	• Stress • The payment of the services/interventions by the employers • No incentives to return • Cost • Compensation system – role of medical and legal professions • Lack of alternative work

Table 10: Most important RTW factors

Communication	Quality Services	RTW Activities
• Communication between employer and employee • Coordination between employers and doctors • Communication with all parties • Feedback loop • A good relationship with employers • Management/colleague support.	• Retraining/reintegration • Rehabilitation programme promoting Return to Work • Going back to a good health state • Timely and appropriate health care and vocational rehabilitation • Sensitivity • The internal and external services supporting the process • Chief Medical Officer • Involvement of independent service providers	• Return to work interviews • Structure • Early intervention • The employer's cooperation • Job redesign • Case management • The existence of RTW or disability management services in the company • Adequate work possibilities • Risk assessment • Light duties • Early intervention
Attitude / Approach	**Organisational Capacity**	**Other**
• Realism • Active participation of all stakeholders • Empowering way of thinking • The attitude of the employee • Attitude of returnee	• Job-adjustment to individual capacity • Capability of the enterprise to facilitate re-integration	• Bradford factor • Money • Consistence and coherence between health, social, labour and insurance systems at legislative levels

Table 10 above shows the list of the most important factors in ensuring a safe and timely return to work process, according to respondents. Most of the categories and their elements have been seen elsewhere already e.g.

- Communications (Communication between employer and employee, Coordination between employers and doctors)
- Services/systems (Rehabilitation programme promoting RTW, Timely and appropriate health care and vocational rehabilitation)
- RTW activities/workplace response (RTW interviews, Early intervention, Case management)
- Attitude (The attitude of the employee, Active participation of all stakeholders (e.g. management participation not reluctance)
- Organisational capacity/workplace response (Job-adjustment. facilitate re-integration e.g. Work place adaptation, flexible working)

Table 11 shows the responses to the question, w*hat do you think are the three most important things that HR managers need to know about good return to work practices?* While Table 12 outlines respondents' opinions on what are the most important skills needed by HR managers to assist an employee to return to work?

Table 11: HR Managers' Knowledge Needs

Legislation	Services	RTW activities
• Legislation related to early intervention practices and grants possibilities • Good knowledge of legislation • rights and duties of the employer according to the law • Legislative knowledge	• Rehabilitation practices • Available services • How to find service providers • the type of services offered • Knowledge of training options • Knowledge of rehabilitation	• Communication • Return to work interviews • Project management • Stages/gradual rehabilitation • Keep in contact • Disability management before & after RTW • Alternative available work • Monitor sickness absence • Sick leave management • The importance of a good atmosphere and of flexibility in work methodologies • The job position must be adapted to the employee and not the opposite • Likely work abilities/assessment of fitness • Knowledge of work demands/job – skill alignment • Knowledge of processes
RTW approach	**Benefits of RTW**	**Other**
• Emotional support • Do not rush things • Empathy with employee • The importance of workers satisfaction and motivation + their role in this	• Value of process • Benefits of job retention/reintegration • The added-value of job retention related to continuous competitiveness	• Psychological concerns of the employee • mental health issues are special and do not fit in ordinary framework • Educate line managers • Prevention and awareness of potential disabilities and health problems • Knowledge of illness • Disability awareness • Worker involvement

Table 12: HR Managers Skills Needed

Communications	Approach	Organisational Supports
• Negotiation/mediation skills • Communication (the ability to listen and understand the employees) • Advocating and promoting good practices • Trouble-shooting • Ability to convince the managers • Disability management • Manage expectations • Trouble-shooting • Ability to coordinate the different actions and actors (inside and outside the company) for reintegrating an employee	• Openness • Tact & Patience • Encouraging attitude • Sense of responsibility : HR managers should do adequate follow-up • Motivation • Understanding • Empathy with employee • Demonstrate an interest in the employee • Enthusiasm • Tolerance • Positive energy: Should stimulate the process of reintegration • Support • Listening • flexibility • HR managers should create the right atmosphere to continue process until end • Knowledge of RTW	• Corporate social responsibility • Retraining • Case management competences

Taking the two tables together it can be seen that there is little overlap between the two i.e. between what HR managers need to know and what they need to be able to do. This makes sense in relation to most categories e.g. they need to KNOW about legislation but they need to be ABLE to communicate.

Respondents felt that it was important to know about available services e.g. rehabilitation practices and to have a knowledge of return to work in terms of activities (e.g. return to work interviews, sick leave management and knowledge of work demands/job –skills alignment), approach (emotional support, empathy) and benefits (value of process, added-value).

In terms of skills needed, responses were nearly entirely communications related, both hard skills (e.g. Negotiation mediation skills, ability to convince managers, disability management) and soft skills (openness, patience, understanding).

4. Conclusion

4.1 Literature Review

The literature review findings (presented in Section 3.1) show that the need for integrated approaches to address the absence threshold is now regarded as a given for better return to work. The Finnish Maintenance of Work Ability programme provides a good example of such an approach, with its emphasis on a range of health and non-health related preventive measures. In addition, there is also an emphasis on the promotion of good working conditions and health and wellbeing as an incentive to remain at work.

There is an EU trend towards changing responsibility for return to work from social insurance providers and social protections agencies to the employer. This is having the effect of producing a more coherent response to absence and of encouraging a more proactive approach to return to work.

In addition, there is evidence of a move towards joint initiatives to combat long term absence which include inter-agency working and in particular between labour, health and social protection agencies.

The need to develop proactive approaches has been acknowledged in many jurisdictions and is considered to be a keystone of good practice in relation to return to work in some. In particular, the Disability Management approach is becoming more widespread and has been adapted to suit European systems and companies.

The fundamental conclusion of the literature review is that there is a decade and a half of practice and research to inform the development of a useful training course for HR professionals which spans a variety of jurisdictions. On the basis of the review it is possible to specify the key elements of a training programme for those who have responsibility for assisting long-term absent employees to return to work.

The overall structure of such a training programme should include:

- What is needed to get started
  - This requires information on the impact of the external context on the behaviour of organisations; an understanding of the principles that underpin effective return to work; the business case for return to work; strategies for persuading an organisation to take on board return to work as a priority objective and ways to overcome the challenges that will inevitably arise.
- What are the policies that need to be developed:
  - This includes not only the development of a specific return to work policy but also the integration of return to work into other key policies including Health and Safety, Occupational Health, Health Promotion, HR and Quality policy.
- How to build and maintain the organisational capacity to sustain an effective return to work programme.
- The processes and procedures required to ensure a successful return to work including:

  - Maintaining Workability
  - Assessing the return to work threshold
  - Implementing early intervention
  - Case Management
  - Appropriate interventions
  - Follow up and job retention
- How to maintain and improve the return to work system.

4.2 Other Training

It can be seen, from the internet search results (outlined in Section 3.2) which was conducted to identify any potential competing or complementary training courses in the area, that there seems to be a need for a 'return-to-work' programme which is accessible to employers, given that the main course we found (the Brunel/NIDMAR collaboration in the UK which is an internationally certified academic course) would be too long a commitment in general for organisations interested in improving their Return to Work practices. A further point, as mentioned previously, is that no online Return to Work programmes were found in Europe which would suggest that we should consider developing an integrated e-learning environment to significantly improve the available return to work training materials in Europe.

4.3 Survey

The quantitative data suggests that there is a higher training need in the area of retention/reintegration than in prevention/intervention.

Overall, the 5 top areas requiring training input are:

- Organisational early intervention practices
- Organisational communications with all employees on all aspects of organisational return to work practices
- Organisational training and development facilities for employees
- The support of management and employees for return to work practices
- The employer having a resource person who is responsible for ensuring safe return to work

The qualitative results indicate that the target group need to know about:

- Legislation
- Available services
- RTW – activities, approach, benefits

While they need to have both hard and soft communication skills.

In terms of the important areas or issues in the area of return to work various topics consistently came through:

- Communications – internally and externally

-
- Organisational RTW activities & practices/workplace response
- Attitudes of stakeholders (management/employees/returnee)
- Available services/systems (including rehab services/primary care)

It should be noted that there is also a case for creating a general management "training/awareness-raising" on-line tool, for example for general practitioners who are also instrumental in the Return to Work process. However this project has been set up to concentrate on producing materials to educate the target groups as outlined in Section 1.

4.4 Training Specification Diagram

Once all the above results had been collated, as mentioned in Section 2.4, a Needs Analysis workshop was held in Athens to review all the available material (literature review, internet search for other training and the survey results) to construct a framework, in the form of a matrix, for organizing the potential content material for the various training courses and treatments (See Appendix 5.2). This framework was then scrutinized and the most important categories were selected and input into the Training Specification Diagram below. The Training Specification Diagram will form the basis of all the material that will be developed for training and tool supports.

The diagram is a process flow diagram with 5 main central boxes:

- Getting Started
- Policy Development
- Building and maintaining capacity
- Getting employee back to work
- System maintenance/ monitoring

It is designed both to reflect the main findings of the literature review and to lead the employer logically through the steps necessary to put an efficient return to work system in place in order to ensure the successful return to work of absent employees.

In essence, the conclusions of the needs analysis, in its entirety, has been summed up in the Training Specification Diagram. This is illustrated by the examples below:

a) 'marketing/persuasion' elements which were raised in both the literature review and survey will be incorporated into Box 1 - The support of management and employees for return to work practices (survey) and strategies for persuading an organisation to take on board return to work as a priority objective (literature review)*

b) 'Communications' which was indicted in the survey results as a training need is listed in both the 2nd and 3rd box

c) RTW – activities, approach, benefits (survey) and the processes and procedures required to ensure a successful return to work (literature lit. review) will be addressed in Box 4.

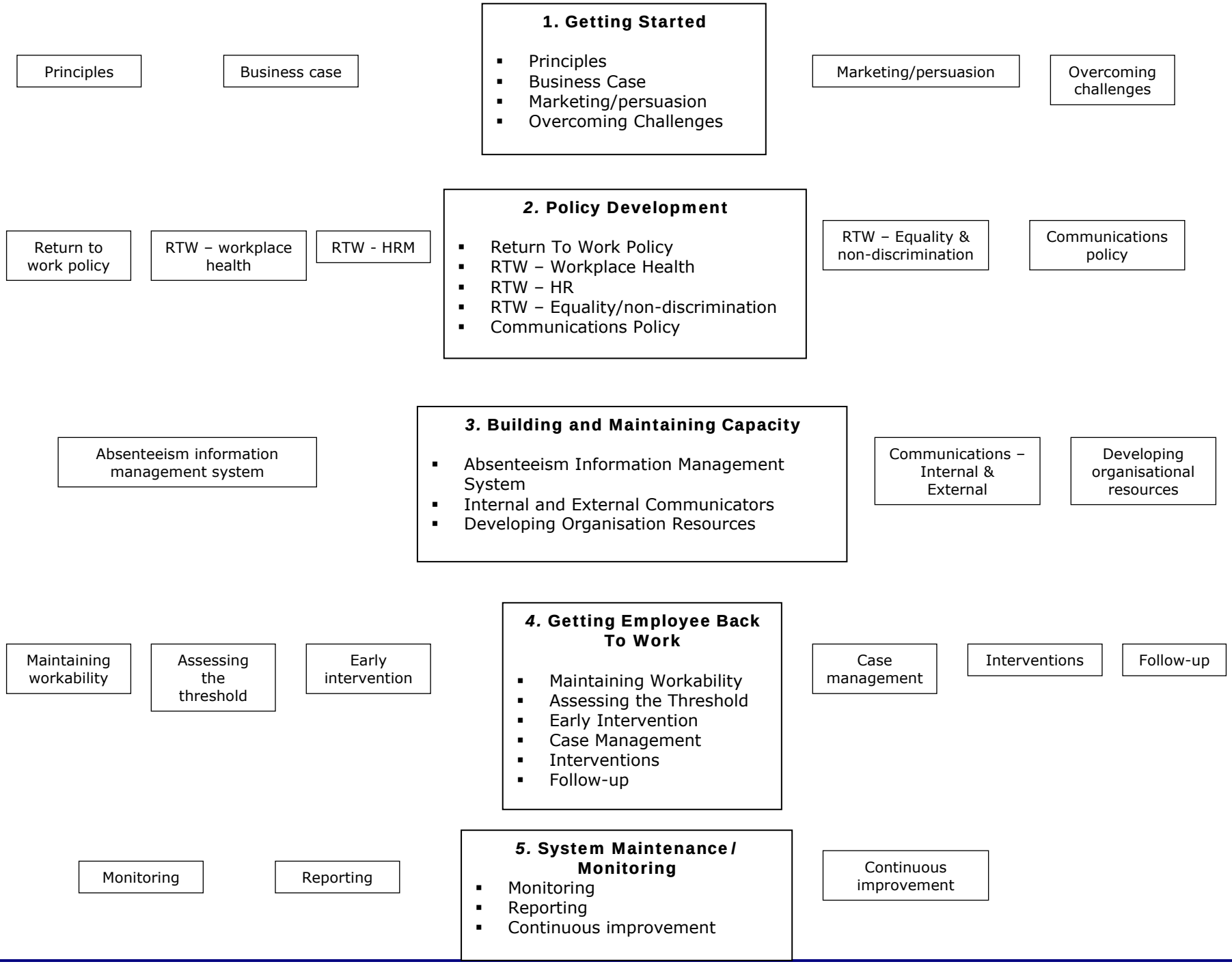
d) 'Early intervention' indicated in both the literature review and survey will be covered in Box 4.

e) 'How to maintain and improve the return to work system' indicated by the literature review as an important area will be addressed in Box 5.

Additional material/weblinks on legislation and available services will be incorporated on the website.

It should be noted that:

- although business case scored low in the survey, it was decided to incorporate it into Box 1 as the literature review findings indicate that it is an essential element in winning management support.
- only Box 4) 'Getting employee back to work' has a logical sequence (left to right) to its horizontal elements.


1. Getting Started
Principles
Business case
Principles
Business Case
Marketing/persuasion
Overcoming Challenges
Marketing/persuasion
Overcoming challenges
2. Policy Development
Return to work policy
RTW – workplace health
RTW - HRM
Return To Work Policy
RTW – Workplace Health
RTW – HR
RTW – Equality/non-discrimination
Communications Policy
RTW – Equality & non-discrimination
Communications policy
3. Building and Maintaining Capacity
Absenteeism information management system
Absenteeism Information Management System
Internal and External Communicators
Developing Organisation Resources
Communications – Internal & External
Developing organisational resources
4. Getting Employee Back To Work
Maintaining workability
Assessing the threshold
Early intervention
Maintaining Workability
Assessing the Threshold
Early Intervention
Case Management
Interventions
Follow-up
Case management
Interventions
Follow-up
5. System Maintenance / Monitoring
Monitoring
Reporting
Monitoring
Reporting
Continuous improvement
Continuous improvement

5. Appendices

5.1 Appendix 1: Training Needs Questionnaire

Introduction

This questionnaire aims to examine opinions on the issue of return to work practices and policies for people who are absent from work for health reasons. The information that is collected will be used to build an e-learning system for people in workplaces such as HR personnel who are responsible managing absence from work.

The questionnaire asks questions about your views on the knowledge and skills required to ensure a safe and timely return to work for people who have gone absent for health reasons. For example, it asks about the kinds of polices that might be needed, the difficulties faced in getting an employee back to work, the kinds of information needs that companies may have and what is good practice in the area.

All of the information collected using the questionnaire will be treated in an anonymous and confidential way.

Should you have any queries about the questionnaire or its contents, you can ask Leonie Lynch for more information. She can be contacted at:

lynch.leonie@gmail.com

Many thanks for taking the time to help the Reintegrate project

PART 1 – GENERAL OPINIONS ON RETURN TO WORK

a) In general, what do you think are the three most common reasons for long-term absence from work?

b) What do you think are the three most important services currently available that can help ensure a safe and early return to work?

c) What are the three largest barriers that currently hinder a safe and timely return to work process?

d) What do you think are the three most important things that HR managers need to know about good return to work practices?

e) What do you think are the three most important skills needed by HR managers to assist an employee to return to work?

f) In general, what do you think are the three most important factors in ensuring a safe and timely return to work process?

PART 2 – SPECIFIC OPINIONS ON RETURN TO WORK

In this section we ask you to rate the importance of a number of factors that may influence the success of return to work. We also ask you to rate the level of knowledge and skills that you feel exist, in the organizations that you come in contact with, in relation to these factors.

How important do you think the following elements are in relation to return to work practices?

	Not at all	Of some import -ance	Very impor- tant	Essen- tial
PREVENTION / INTERVENTION				
1. Employer awareness of relevant legislation	☐	☐	☐	☐
2. Social services available to help employees and employers	☐	☐	☐	☐
3. Grants and financial supports for employers and employees	☐	☐	☐	☐
4. Employer knowledge of pay and social welfare entitlements	☐	☐	☐	☐
5. Employer knowledge of medical rehabilitation services	☐	☐	☐	☐
6. Employer knowledge of vocational training services	☐	☐	☐	☐
7. Employer knowledge of external occupational health services available	☐	☐	☐	☐
8. Organisational accident prevention and safety activities	☐	☐	☐	☐
9. Organisational workplace health promotion	☐	☐	☐	☐
10. Organisational occupational health services	☐	☐	☐	☐
11. Organisational early intervention practices	☐	☐	☐	☐
12. The nature of the employee's illness or injury	☐	☐	☐	☐
RETENTION / REINTEGRATION				
13. Organisational policies/practices/systems in place to facilitate return to work	☐	☐	☐	☐
14. Organisational case management activities	☐	☐	☐	☐
15. The employer having a resource person who is responsible for ensuring safe return to work	☐	☐	☐	☐
16. Job re-design/ alternative job possibilities	☐	☐	☐	☐
17. Job out-placement practice/in place/familiar with	☐	☐	☐	☐
18. Transitional work arrangements	☐	☐	☐	☐

	Not at all	Of some import-ance	Very impor -tant	Essen -tial
19. Assistive technology available in the organisation	☐	☐	☐	☐
20. Organisational training and development facilities for employees	☐	☐	☐	☐
21. Organisational procedure in place for communicating with employee(s) absent due to illness/accident	☐	☐	☐	☐
22. Organisational communications with all employees on all aspects of organisational return to work practices	☐	☐	☐	☐
23. The support of management and employees for return to work practices	☐	☐	☐	☐
24. Organisational absenteeism (ill or injured) information management system in place	☐	☐	☐	☐
25. The business case for return to work (for the employer)	☐	☐	☐	☐
26. The benefits to the employee of return to work	☐	☐	☐	☐

What level of knowledge and skills do you feel exist, in the organisations that you come in contact with / in your organisation, in relation to the following elements?

	None	Low level	Moder-ate Level	High Level
PREVENTION / INTERVENTION				
1. Employer awareness of relevant legislation	☐	☐	☐	☐
2. Social services available to help employees and employers	☐	☐	☐	☐
3. Grants and financial supports for employers and employees	☐	☐	☐	☐
4. Employer knowledge of pay and social welfare entitlements	☐	☐	☐	☐
5. Employer knowledge of medical rehabilitation services	☐	☐	☐	☐
6. Employer knowledge of vocational training services	☐	☐	☐	☐
7. Employer knowledge of external occupational health services available	☐	☐	☐	☐
8. Organisational accident prevention and safety activities	☐	☐	☐	☐
9. Organisational workplace health promotion	☐	☐	☐	☐
10. Organisational occupational health services	☐	☐	☐	☐

	None	Low level	Moder-ate level	High Level
RETENTION/REINTEGRATION				
11. Organisational early intervention practices	☐	☐	☐	☐
12. The nature of the employee's illness or injury	☐	☐	☐	☐
13. The employer having a resource person who is responsible for ensuring safe return to work	☐	☐	☐	☐
14. Job re-design/ alternative job possibilities	☐	☐	☐	☐
15. Job out-placement practice/ in place/familiar with	☐	☐	☐	☐
16. Transitional work arrangements	☐	☐	☐	☐
17. Assistive technology available in the organisation	☐	☐	☐	☐
18. Organisational training & development for employees	☐	☐	☐	☐
19. Organisational procedure in place for communicating with employee(s) absent due to illness/accident	☐	☐	☐	☐
20. Organisational communications with all employees on all aspects of organisational return to work practices	☐	☐	☐	☐
21. The support of management and employees for return to work practices	☐	☐	☐	☐
22. Organisational absenteeism (ill or injured) information management system in place	☐	☐	☐	☐
23. The business case for return to work (for the employer)	☐	☐	☐	☐
24. The benefits to the employee of return to work	☐	☐	☐	☐

PART 3 –OPINIONS ON TRAINING

The Reintegrate project will develop training for HR and similar personnel in the area of return to work. It is intended that this training will enable trainees to direct and manage a return to work process even if they do not have all of the skills needed to implement the process on their own.

We would like to ask some questions about the organisation of the training to be provided and the balance between its different elements.

1. In total, how long do you think the training package should be?

Number of hours:	

2. The training to be developed will involve both face to face and e-learning elements. How long do you think the following elements of the training should take?

Element	Number of hours
Face to Face training	
Using the e-learning environment	
Practical homework	
Reporting	

5.2 Appendix 2: Framework of Potential Training Elements V1

GUI	Element Level 1	Element Level 2	Self-Ass Quest	F2F Course	E-learn Environ	TT Course
Case studies?						
Context						
	Employer awareness of legislation					
		equality				
		employment				
		Age/discrimination				
	claims management	-				
	Social services for employees and employers					
	Grants and financial supports					
	Knowledge of pay & social welfare entitlements					
	Knowledge of vocational training services					
	Knowledge of external health services available					
	Application of legislation, regs and incentives					
A. Getting Started						
	The business case for RTW (employer)					
	Changing organization culture					
	Management and employee support for RTW					
	Management/staff buy in					
	Active participation of all stakeholders					
	Age/discrimination issues					
	Payment of services/interventions by employer					
	Principles					
	roadblocks					
B. Policy Development						

GUI	Element Level 1	Element Level 2	Self-Ass Quest	F2F Course	E-learn Environ	TT Course
	RTW – definition, importance, policy					
	Workplace health services					
		Accident prevention & safety activities • Policy and procedures in place for hazards and accidents - Who is responsible - H&S involvement in DM/RTW - case example • Safety training - For workers/management - For those responsible for H&S • Presence of joint labour management committee regarding worksite and worker safety, roles • Presence of first aid, medical assistance • Strengths and weaknesses of present system, possible improvements • Internal/external examinations of the system • Rewarding good safety performance				
		Workplace health promotion • Formalised WHP? How long? • Aims and objectives • Types of activities, organisation • Who is responsible for designing and implementing • Worker participation? How? • Formal company policy, part of OHS/DM • Part of ongoing programme • Regular evaluation and updating, results • Based on workers' needs, work environment • Specific budget				
		Organisational OH services • Occupational health - Which professionals - Which services - Health examinations, what kind and how often • Monitoring sickness absenteeism, who and what is done with the information				

GUI	Element Level 1	Element Level 2	Self-Ass Quest	F2F Course	E-learn Environ	TT Course
		• Active role of OHS with RTW? How? • Surveillance of the work performance of disabled employees? How?				
		EAP				
	claims management					
	Payment of services/interventions by employer					
	Organisational comms with all employees					
		T&D in context of RTW				
	Age/discrimination issues					
c. Building Capacity						
	Absenteesim Management info system					
	Organisational Communications					
		Internal				
		external				
	Organisational comms with all employees					
		T&D in context of RTW				
	A resource/person responsible for RTW					
		approach' items openness, tact, empathy etc				
	Workplace health services					
		Accident prevention & safety activities (as above – which ones?)				
		workplace health promotion (as above – which ones?)				
		Organisational OH services (as above – which ones?)				
		EAP				
	Assessment of health service support needs					

GUI	Element Level 1	Element Level 2	Self-Ass Quest	F2F Course	E-learn Environ	TT Course
		Physio				
		CBT				
		Voc rehab				
		Med rehab				
		Interventions				
		Types of services				
d. Coordination of RTW process						
	Payment of services/interventions by employer					
	Workplace health services					
		Accident prevention & safety activities				
		workplace health promotion				
		Organisational OH services				
		EAP				
	Organisational comms with all employees					
		T&D in context of RTW				
	A resource/person responsible for RTW	'approach' items openness, tact, empathy etc				
e. Getting Employee Back to Work						
	Organisational early intervention practices					
		Recurring absences – early intervention				
		Strategy/procs consistent throughout the org				
		Evaluation and actions				
		Timeframe, time limited				
		Appropriate communication and monitoring procs				
		Coordination of prog , who/roles				
		Involvement of internal and external providers, what				
		Support of labour and management				
		Active participation of employees in RTW process				
	Organisational case management activities					

GUI	Element Level 1	Element Level 2	Self-Ass Quest	F2F Course	E-learn Environ	TT Course
		As above – which ones?				
	Job re-design/ alternative job possibilities					
		reasonable accommodation				
		ergonomics programme - presence - joint labour/management support - job analysis - regular ergonomic assessments - link to AMS				
		ergonomics committee - representatives, roles - up-to-date training - cooperation with DM and others				
		Training/information, accessible to worker, management, those responsible for ergonomics				
		Ergonomic org evaluation: who/when/how?				
		Adaptations: who?				
	Out-placement practice in place/ familiar with					
	Communications					
		Conflict resolution				
		Negotiation/medication skills				
		RTW interviews				
		Comms with docs, rehab providers etc				
		Comms with primary care profs/services				
		Comm with absent employee				
	Transitional work arrangements/ post return interventions					
		Transitional work - provision, why (not)				

GUI	Element Level 1	Element Level 2	Self-Ass Quest	F2F Course	E-learn Environ	TT Course
		- development, who/what duties - workers and management support - workplace as a therapeutic environment				
		Assessment of the worker's functional capacity				
		Formal processes for comparing the injured worker's functional abilities with the demands of the worker's current job				
		Identification of possible transitional duties, job (task) bank				
		Transitional work programmes: goals, timeframes, resources to be deployed and other significant components				
		Use of ergonomics				
		Likely work abilities/ assessment of fitness to work				
		Assistive technology				
	Maintaining workability					
		Pols & procs for voc rehab & re-deployment - case examples, sucess - joint labour management support - re-deployment at the same level of seniority or higher - responsiblity for the process - acceptance of job-trialing by labour & management				
	Assessing the threshold					
		analysing the pros & cons of RTW				
		influencing factors				
		claims management				
		employee fear				
		nature of illness/injury - mental - physical				
F. Monitoring						

GUI	Element Level 1	Element Level 2	Self-Ass Quest	F2F Course	E-learn Environ	TT Course
		Absenteesim Management info system - reporting - data - bradford factor				
G. Consolidation						
	Evaluation of RTW process					