

# Injury/Illness and Return to Work/Function

APPENDIX 3

Institute for Work & Health

*Work-Ready. Return-To-Work Approaches  
For People with Soft-Tissue Injuries*

*Return-to-Work Approaches*

# WORK-READY

*For People with Soft-Tissue Injuries*

---

**Workshop**

---

**Participant's**

---

**Booklet**

---

# The Work-Ready Project

## Project Sponsorship:

This work was co-sponsored by the Health Evidence Application and Linkage Network (HEALNet), the Institute for Work & Health (IWH), and the National Institute of Disability Management and Research (NIDMAR). HEALNet is a member of the Networks of Centres of Excellence Program, which is a unique partnership among Canadian universities, Industry Canada and the federal research granting councils. The Institute for Work & Health is an independent not-for-profit research organization that receives support from the Workplace Safety & Insurance Board (WSIB) of Ontario. NIDMAR is a labour-management initiative based in British Columbia whose mandate includes education and training, research and policy development. The views expressed in this manual are those of The Editors and not necessarily those of the sponsoring organizations.

## Acknowledgments:

The Editors wish to acknowledge the contribution of the HEALNet Work-Ready Research Group, comprised of the provincial working groups listed below, and Arlene Ward in the creation of the three-part teaching package *Return-to-Work Approaches for People with Soft-Tissue Injuries*. The Editors also wish to thank the stakeholders who shared their thoughts with us; their wisdom and candour enriched our understanding of the issues and, we think, the quality of the product.

## Ontario Project Working Group

John Frank - family physician/epidemiologist  
Claire Bombardier - rheumatologist/epidemiologist  
Judy Clarke - psychometrist/anthropologist  
Donald Cole - occupational physician/epidemiologist  
Pierre Côté - chiropractor/epidemiologist  
Jaime Guzmán - rheumatologist/epidemiologist  
Deirdre McKenzie - physiotherapist/program evaluator  
Vicki Pennick - occupational health/community health nurse

## Quebec Project Working Group

Susan Stock - occupational physician/epidemiologist  
Raymond Baril - anthropologist  
Suzanne Deguire - sociologist  
Marie-José Durand - occupational therapist/epidemiologist  
Patrick Loisel - orthopaedic surgeon/epidemiologist  
Michel Rossignol - occupational physician/epidemiologist

## Manitoba Project Working Group

Annalee Yassi - occupational physician/epidemiologist  
Juliette Cooper - occupational therapist/rehabilitation research  
Margaret Friesen - occupational therapist/adult educator

## Canadian Workshop Facilitator

Arlene Ward - vocational rehabilitation specialist/adult educator

## Address correspondence to:

Institute for Work & Health, 250 Bloor Street East, Suite 702, Toronto, ON M4W 1E6 or  
National Institute of Disability Management and Research, 3699 Roger Street, Port Alberni, BC V9Y 8E3  
Web sites: <http://iwh.on.ca> <http://nidmar.ca>

© 2000 Institute for Work & Health and National Institute of Disability Management and Research for John Frank, Annalee Yassi, Susan Stock, Jaime Guzmán, Judy Clarke, Margaret Friesen, and Donald Cole (The Editors)

Figure 1 reproduced with permission ©1998 The Scarecrow Press, Inc.

Figure 2 reproduced with permission ©1996 Lippincott Williams & Wilkins, Inc.

Table 1 reproduced with permission ©1998 Canadian Medical Association

# Contents

<b>Introduction</b> .....	<b>1</b>
<b>What Did We Learn from Published Research?</b> .....	<b>3</b>
<b>What Did People at the Front Line Tell Us?</b> .....	<b>8</b>
<b>So What Is the Next Step?</b> .....	<b>11</b>

# Introduction

## What's Work-Ready all about?

Sprains and strains (soft-tissue injuries), such as low-back pain and repetitive strain injuries, have become by far the most common cause of workers' disability and compensation claims in North America, accounting for 50% to 70% of all lost-time claims. Work-Ready is a multi-disciplinary applied research project involving researchers in occupational health and rehabilitation in three Canadian provinces. These experts have summarized current scientific knowledge, and studied community "best practices," concerning the optimum management of these occupational soft-tissue disorders to facilitate prompt recovery and return-to-work (RTW).

The project team has:

- systematically reviewed the published literature on interventions to optimize recovery and return-to-work after low-back pain (the most common single cause of compensable lost time from work, and by far the best-researched soft-tissue injury).
- conducted in-depth interviews with employees, employers, insurers/workers compensation boards, health-care practitioners, and disability management specialists in the community about what works and does not work in return-to-work after soft-tissue injury; these interviews focused on what these knowledgeable informants believe are the most frequent barriers to recovery and RTW, and what possible solutions they have seen applied, or can suggest, based on their extensive experience.
- tested and refined Work-Ready materials in a series of workshops with occupational health stakeholders across Canada.

These activities have led to the publication of this booklet and case studies, designed as a practical guide and "toolbox" of ideas and approaches for improving injured worker recovery and RTW. It is intended for use by all stakeholders in the workplace and health-care system, to assist them, through dialogue together, in achieving better outcomes for injured workers.

## What does HEALNet have to do with it?

The Work-Ready research team was brought together under the auspices of the federal Networks of Centres of Excellence initiative (NCE). Work-Ready researchers are part of HEALNet, an NCE-funded research network devoted to enhance the health of Canadians through improved use of the most relevant research evidence in health decision-making. HEALNet stands for Health Evidence Application and Linkage Network. HEALNet researchers collaborate with private and public sector partners to promote the use of research results in the prevention of work-related disability.

Work-Ready and other HEALNet researchers are working in settings ranging from assembly lines to hospital wards to test prevention and rehabilitation programs in order to determine the most appropriate approaches for specific workplace needs.

## What exactly is in this booklet?

This booklet contains brief summaries of the published literature on interventions to optimize recovery and return-to-work, and of the in-depth interviews conducted with people directly involved in return-to-work. The booklet is complemented by a series of case studies used in Work-Ready workshops. These case studies illustrate common situations in which return-to-work is delayed. Each case-study is accompanied by an analysis of what went right or wrong, and recommendations on what could have improved the final outcome. Finally, there are selected references for those who wish to do further reading around the issues raised in each case study.

The booklet and case studies are designed for use in workshops and other in-service educational offerings to be held with stakeholders – either from one organization, or where possible, more than one – to facilitate improved understanding of the co-ordinated roles that employer, employee, insurer, and various health-care professionals must play to achieve successful outcomes in these cases.

The case studies are representative of delayed recovery and RTW situations typical of present-day Canada, in which various factors have contributed to the delay, in accordance with the findings of our fieldwork. The analysis is based on the available scientific literature, our in-depth fieldwork in three Canadian provinces, and our collective professional experience as researchers and practitioners. All this evidence is distilled into some concrete suggestions to improve the outcome.

### **In conclusion...**

By combining information from practising experts in the field with the best current research knowledge, we hope to help stakeholders develop their own local, evidence-based, disability prevention and return-to-work programs. The information contained in this booklet is designed to be useful for workers' compensation boards, other disability insurers, businesses, labour, and health-care providers in facilitating safe and early return-to-work after soft-tissue injuries such as low-back pain.

We are specifically looking for feedback from all these constituencies to ensure that this booklet remains current, and becomes a useful tool to reduce the burden of occupational soft-tissue disorders.

# What Did We Learn From Published Research?\*

Work-Ready researchers have reviewed recent research, particularly that done after the 1994 release by the U.S.-based Agency for Health Care Policy and Research (AHCPR) of comprehensive guidelines on an appropriate clinical response to acute low-back pain, that describes interventions and approaches aimed at facilitating early and safe return-to-work.

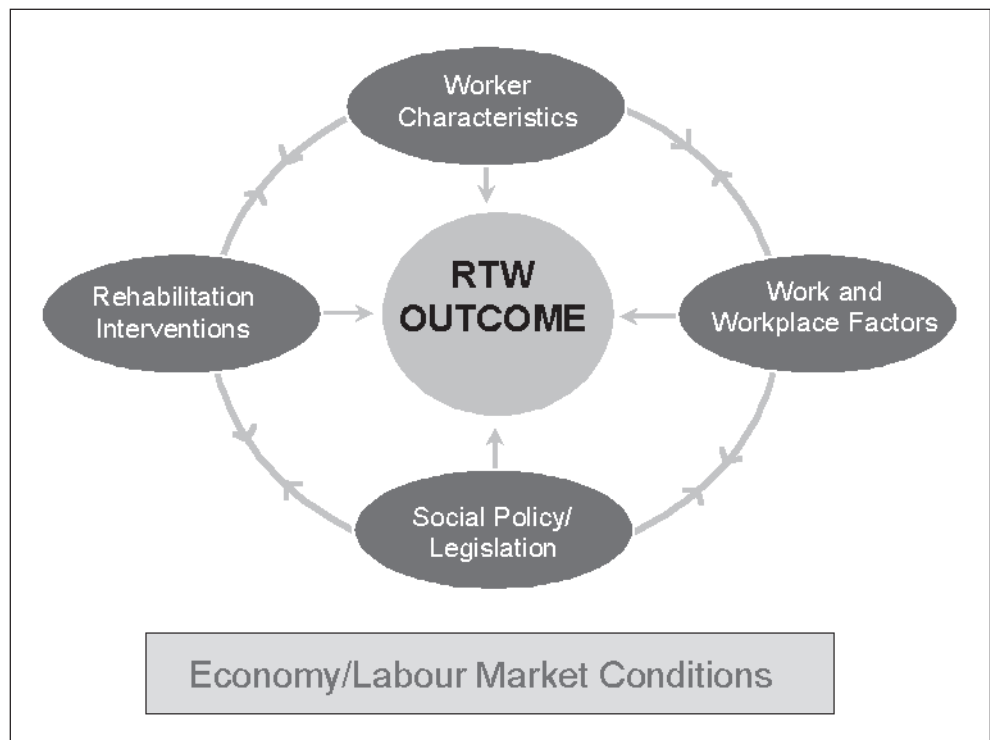
The size of the problem, in terms of lost time from work and health-care costs, has been well documented in studies around the world. In the United States and Canada, musculoskeletal disorders, including soft-tissue injuries such as low-back pain, represent the single largest category of work disability. In Ontario, between 60% and 65% of all lost-time claims are from soft-tissue injuries, at a cost of about \$2 billion. And injuries to the back account for about 40% of the costs for soft-tissue injuries – the largest single group of such injuries.

Researchers agree that disability is the result of a complex interaction of factors. The goal of return-to-work is at the centre of efforts to treat an injured worker, influenced by four groups of factors, which are not always mutually supportive. These factors are: worker characteristics such as age, gender, and clinical manifestations of the injury; rehabilitation interventions; work and workplace characteristics such as the work itself and how the workplace is organized; and social policy and legislation such as the characteristics of the compensation system and factors influencing job prospects for injured workers (Figure 1).

## The importance of stage and site

It turns out that the old saying “timing is everything” is particularly applicable in how we treat sprains and strains. New research on how health professionals respond to a worker who reports low-back pain suggests that “when” is as impor-

**FIGURE 1:**  
Factors Influencing  
Return-to-Work



*Modified from Sinclair, S.J., et al., "A Framework for Examining Return to Work in Workers' Compensation: A View from One North American Jurisdiction." Yates, E.H., and J.F. Burton, Jr. International Examination of Medical-Legal Aspects of Work Injuries. Lanham, Md., and London: Scarecrow Press, 1998. Reproduced with permission.*

\* N.B. This section has been adapted from Frank, J.W. et al., "Preventing Disability from Occupational Low Back-Pain: New Evidence Gives New Hope - If We Can Just Get All the Players Onside." *Canadian Medical Association Journal* 158 (1998):1625-31.

tant as “what” in applying treatment. And if the provider gets the timing wrong, it can increase the risk of the injury becoming a chronic condition, perhaps by unnecessarily focusing the injured worker on the disability and inducing a “sick role behaviour.”

The key finding in recent research is that there are three fairly distinct clinical stages in low-back pain, each requiring a specific approach if prolonged disability is to be avoided. The three stages are: the *acute* stage, up to four weeks after the worker experiences onset of symptoms affecting the lower back; the *sub-acute* stage, from about four to 12 weeks when health professionals need to be concerned if the patient’s injury is not healing; and the *chronic* stage, starting after 12 weeks, when disability starts to become difficult to reverse.

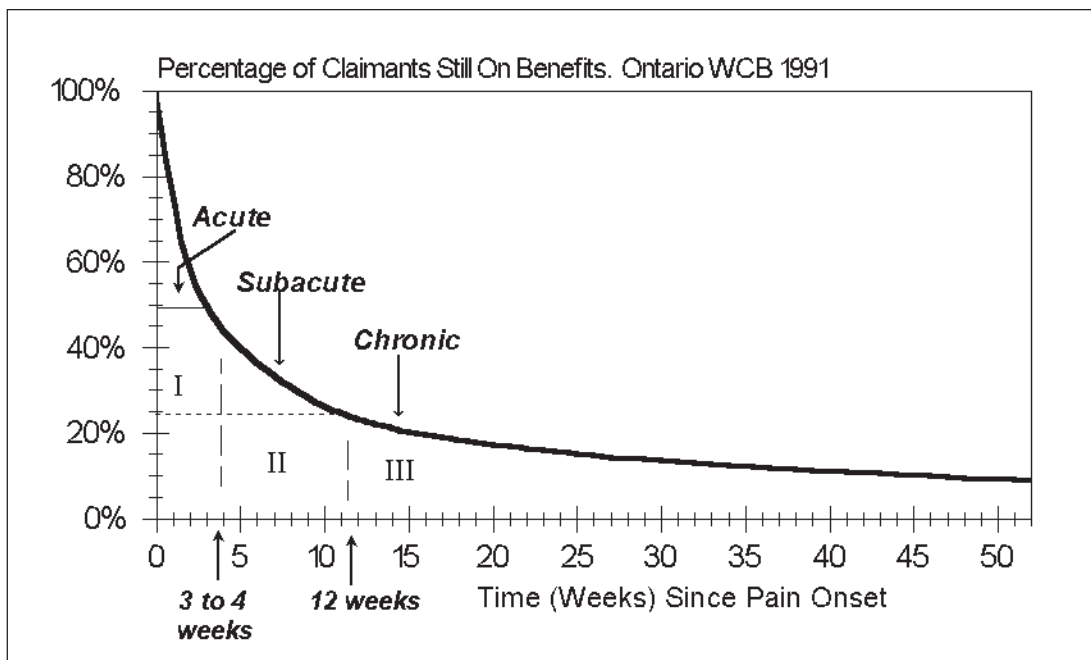
The vast majority of those suffering from a low-back problem will recover reasonably quickly and in an uncomplicated way during the early, acute stage. A smaller number of injured workers are still off work and suffering during the sub-acute stage. Only about 10% of those with

back pain continue on to the chronic phase, but these cases are the most costly to the health-care system and to society as a whole.

Figure 2 provides a graphic illustration of the three-phase model, showing that most injured workers are back at work within a month of reporting low-back pain.

The AHCPR experts, whose focus was health care, did not pay any attention to workplace intervention studies that have consistently shown major reductions in vocational disability due to low-back pain. These impacts include a 30% to 45% reduction in the duration of lost time per reported lost-time injury, often with significant additional reductions attributable to “spin-off” declines in lost-time frequency. These spinoffs occur as workers with less severe injuries voluntarily choose modified duties immediately, rather than take any time off, and as deeper changes in workplace culture are brought about by accommodative responses to reports of health problems. Although many of the individual studies have design flaws, the overall body of evidence has now become convincing by virtue of the large effects reported and their consistency.

**FIGURE 2:** Three-Phase Model of Low-back Pain Natural History/  
Duration of Lost-Time Claims from Back Injury to Return-to-Work



From Frank, J.W., et al. “Disability Resulting from Occupational Low Back Pain, Part II: What Do We Know About Secondary Prevention? A Review of the Scientific Evidence on Prevention After Disability Begins.” *Spine* 21 (1996): 2918-29. Reproduced with permission.

## Right after the injury

Until recently, the bio-medical approach has dominated the response to sprains and strains. In the first stage of recovery, intervention has tended to be oriented towards diagnosis and pain relief, but not always consistent with the current research evidence and practice guidelines. Guidelines now stress that aggressive early clinical interventions – such as prescribed bed rest or prompt referral for physiotherapy-led exercise instruction – are largely ineffective in this early phase. Instead, assuming that no rare “red flags” are identified (following a physical exam and review of the patient’s medical history) that suggest a more serious underlying condition such as cancer, infection or fractures, health-care professionals should provide education and assurance to the patient, accompanied by conservative use of over-the-counter analgesics and other straightforward strategies to manage pain. Encouragement for patients to continue their usual activities as much as possible is key to managing low-back pain in the acute stage to facilitate prompt recovery and return-to-work.

Several studies suggest that constructive workplace involvement from day one – including increased utilization of modified work – can reduce both the incidence (by about 50%) and the duration (by about 40%) of lost-time disability secondary to sprains and strains.

## One to three months after injury

During the sub-acute phase, research evidence suggests that treatment should be more aggressive. Workers who have been off more than a month are more appropriate subjects for active interventions than those given the same treatment within the first few weeks of injury. After the initial four-week period, intensive physiotherapy, particularly supervised exercise instruction combined with ergonomic intervention at the work site, is more likely to be successful in preventing long-term disability and promoting timely return-to-work than the same measures applied too early in the rehabilitation process.

Intensive interventions that begin at six to eight weeks after onset, with patients who are still off work, can reduce subsequent lost time by up to 50%. Interestingly, although the interventions studied were very different, the results were the

same, suggesting that it may be less important what kind of treatment is given, so long as something intensive is done and that it is designed specifically to get the worker back on the job.

## The chronic stage

By three months after injury, most authorities consider early chronic pain syndrome to have set in. This syndrome implies the existence of psychosocial and perhaps also biological “vicious circles” that make successful treatment at this stage a more elusive goal. Here we know much less for certain; there are few high-quality studies of the many chronic pain syndrome treatments currently in vogue.

A recent attempt by Work-Ready researchers to systematically appraise the studies to date suggests that co-ordinated multidisciplinary treatment that includes modified work or a participatory ergonomic component gets more of these workers back to work than just leaving them to their own resources does. There is however, little consensus on who benefits from such intensive programs, which usually last several weeks and entail significant expense.

Thus, we are left with all the more reason to invest in strategies to identify workers most at risk for chronicity and recurrence. The workers thus identified could receive less intensive workplace-linked treatments during the acute or sub-acute stages to avoid “the dreadful chronic stage.”

## Putting it all together

One is forced to conclude that much of the disability secondary to sprains and strains is preventable. In fact, a good portion of it seems to be brought on by long-lasting patterns of non-accommodative workplace response and sub-optimal primary care – such as those practices discouraged by the AHCPR Guidelines.

Table 1 (page 6) summarizes the three underlying factors contributing to the genesis of potentially preventable disability from occupational low-back pain – the targets, as it were, of the successful interventions evaluated in the studies described above. Also set out are the solutions evaluated, impacts on lost-time demonstrated, and the societal stakeholders necessarily involved in addressing each factor.

**TABLE 1: Factors Contributing to Onset of Chronic Disability from Low-back Pain at Work and Recommended Solutions.**

	<b>Acute Stage</b> (first 3 or 4 weeks)		<b>Subacute Stage</b> (3 or 4 to 12 weeks)
<b>Key contributors to disability</b>	Clinical Iatrogenesis	Inappropriate workplace response	Mind-body processes leading to chronic pain syndrome
<b>Recommended solution</b>	Guidelines-based care by primary providers (e.g., via decision aids, education materials, academic detailing)	Workplace interventions focused on prompt accommodation (e.g., modified work)	Intensive, work-related case management <ul style="list-style-type: none"> <li>• quota-based exercise program</li> <li>• comprehensive case review</li> <li>• ergonomic work adjustment</li> </ul>
<b>Potential reduction in time lost from work (after intervention)</b>	50%	30%	35-50%
<b>Key stakeholders (players) to “get onside”</b>	Patients, care providers, payers	Patients, employers, labour unions, payers	Patients, care providers, employers, labour unions, payers

*Adapted from Frank, J.W. et al., “Preventing Disability from Work-Related Low-Back Pain: New Evidence Gives New Hope – If We Can Just Get All the Players Onside.” Canadian Medical Association Journal 158 (1998):1625-31. Reproduced with permission.*

All listed stakeholders need to be “onside” in order for the recommended solution to work well.

While the picture painted here is encouraging, there is a thorny practical problem: how can all the relevant societal players be brought together and their roles co-ordinated, so as to bring reason to bear on this multifactorial problem? This is a challenge, given that some of these players have historically taken a narrow self-interested view, seeking to push off the costs and difficulties onto others. For example, some insurers/ third-party payers have little incentive to reduce disability, because their own volume of business or profit-margin depends on both the volume of cases and their duration of disability, i.e., total payouts.

One suspects there is no easy answer here. Each setting must look for opportunities to convince these diverse interests that they can all gain from

collaborative problem-solving to reduce occupational disability from back pain. Furthermore, the evidence now accumulating, summarized above, suggests strongly that piecemeal approaches – based in only one stakeholder site or one phase of disability, and targeted to only one of the underlying factors described above – won’t work well. Such approaches are far less likely to efficiently prevent disability than conjoint efforts spanning groups of stakeholders, and tackling both the acute and subacute phases.

In other words, like the preservation of the English commons of two centuries ago, it is only by engaging all those with a common stake in the issue, and obtaining their active collaboration, that soft-tissue injuries can be successfully controlled as a major cause of disability in our time.

## Bibliography

- Bigos, S., et al. Agency for Health Care Policy and Research. *Clinical Practice Guideline Number 14: Acute Low Back Problems in Adults*. Rockville, Maryland: U.S. Department of Health and Human Services, 1994.
- Brooker, A.S., et al. "Effective Disability Management and Return-to-Work Practices." *Injury and the New World of Work*. Ed. T.J. Sullivan. Vancouver: University of British Columbia Press, 2000. 246-61.
- Frank, J.W., et al. "Disability Resulting from Occupational Low Back Pain, Part II: What Do We Know about Secondary Prevention? A Review of the Scientific Evidence on Prevention after Disability Begins." *Spine* 21 (1996): 2918-29.
- Frank, J.W., et al. *Facilitation of Return to Work After a Soft-Tissue Injury: Synthesizing the Evidence and Experience: A HEALNet Report on the Finding of the Work-Ready Project*. Winnipeg: HEALNet, 1999.
- Frank, J.W., et al. "Preventing Disability from Work-Related Low-Back Pain. New Evidence Gives New Hope – If We Can Just Get All the Players Onside." *Canadian Medical Association Journal* 158 (1998): 1625-31.
- Indahl, A., et al. "Good Prognosis for Low Back Pain When Left Untampered: A Randomized Clinical Trial." *Spine* 20 (1995): 473-7.
- Kazimirski, J. "Helping Patients Return-to-Work." *Canadian Medical Association Journal* 156 (1997): 680-680C.
- Krause, N., et al. "Modified Work and Return-to-Work: A Review of the Literature." *Journal of Occupational Rehabilitation* 8(2) (1998), 113-139
- Loisel, P., et al. "A Population-Based, Randomized Clinical Trial on Back Pain Management." *Spine* 22 (1997): 2911-18.
- Malmivaara, A., et al. "The Treatment of Acute Low Back Pain – Bed Rest, Exercises, or Ordinary Activity?" *New England Journal of Medicine* 332(6) (1995): 351-5.
- Sinclair, S.J. et al. "A Framework for Examining Return to Work in Workers' Compensation: A View from One North American Jurisdiction." Ed. Yates, E.H., and J.F. Burton, Jr. *International Examination of Medical-Legal Aspects of Work Injuries*. Lanham, Md., and London: Scarecrow Press, 1998. 263-300.
- Sinclair, S.J., et al. "The Effectiveness of an Early Active Intervention Program for Workers with Soft-Tissue Injuries: The Early Claimant Cohort Study." *Spine* 22 (1997): 2919-31.
- Spitzer, W.O., et al. "Scientific Approach to the Assessment and Management of Activity-Related Spinal Disorders: A Monograph for Clinicians. Report of the Quebec Task Force on Spinal Disorders." *Spine* 12(7S) (1987): s4-s55.
- Stock, S., et al. *Obstacles and Factors Facilitating Return to Work of Workers with Musculoskeletal Disorders: Summary of the Report on the Quebec Qualitative Study in the Electric and Electronic Sector of Work-ready Phase 1*. Montreal: Montreal Department of Public Health, December 1999.
- Stock, S., et al. *Travailleuses et travailleurs atteints de lésions musculo-squelettiques : les stratégies de prise en charge en milieu de travail dans le secteur électrique/ électronique de l'île de Montréal. Work-Ready Phase 1 : Volet qualitatif québécois*. Montreal: Montreal Department of Public Health, June 1999.
- Van Tulder, M.W., et al. "Conservative Treatment of Acute and Chronic Non-Specific Low Back Pain: A Systematic Review of Randomized Controlled Trials of the Most Common Interventions." *Spine* 22 (1997): 2128-56.
- Yassi, A., et al. "Early Intervention for Back-Injured Nurses at a Large Canadian Tertiary Care Hospital: An Evaluation of the Effectiveness and Cost Benefits of a Two-Year Pilot Project." *Occupational Medicine* 45 (1995): 209-14.

# What Did People at the Front Line Tell Us?

Work-Ready researchers in Manitoba, Quebec, and Ontario interviewed a variety of people who are directly involved in return-to-work, in order to gain insight into the process as it is understood by those on the front line. Those interviewed included occupational health personnel, injured workers, supervisors, representatives of labour and management, health-care practitioners in the community, health and safety group members, and workers' compensation professionals. Individual interviews, focus groups, and some written surveys were included.

The research protocols in the three provinces varied in data collection methods, and in industrial sector and size of population centres in which the research was conducted. Employment settings ranged from the very small (less than 50 employees) to very large (more than 1,000 employees). The diversity of methods and of actors and stakeholders who were interviewed contributes to the confidence with which we can speak of the themes that emerged from the research. Collaboration between the groups in the three provinces allowed us to compare and contrast the ideas expressed in these varied contexts (both cultural and legislative) to obtain a more comprehensive understanding of the dynamics of return-to-work.

When analyzing the interviews, we first divided the comments into two large categories: things that people told us were helpful in returning the injured worker to the job, and those that acted as barriers to the process. As would be expected, issues were often raised that could be interpreted in either way – for example, the presence of a characteristic was a facilitator and its absence was a barrier to successful return-to-work. We then further divided the comments into common themes, that is, general ideas coming out of the things people said. As appropriate, we identified the speaker as a worker, manager, health-care professional, and so on.

## **What makes successful return-to-work easier (or harder) to achieve?**

Many of the factors that people described as influencing the success of return-to-work efforts centred on the workplace itself. Whether union-

ized or non-unionized, workplaces that took the initiative to set up a modified return-to-work program and constructively deal with any problems arising, seemed to have lower compensation costs and more satisfied employees (both workers and managers).

*Occupational health nurse: “We don’t wait for [insurance] agencies to contact us – we get a plan in place and then call them to say what we’re doing.”*

One important component of such programs was early supportive contact with injured workers, and on-going follow-up. The need for good communication among the various parties involved in the return-to-work process was stressed frequently. This included the insurance company, the workplace manager, the injured worker, any occupational health professionals who were involved, and the family physician. Any gaps in these lines of communication, or other delays in the processing of the claim, could delay the entire process of return-to-work and lead to the development of secondary disability for the worker, such as chronic pain.

The need for communication and co-ordination in the workplace was emphasized, as was the inclusion of supervisors and production managers in planning and implementing return-to-work programs. Supervisors may experience considerable role conflict between their production responsibilities and the demands of modified work programs, and are more likely to collaborate when their needs are taken into account and their role in modified work programs is rewarded concretely. The most important element seems to be the presence of good integration between production and modified work activities, i.e., adjustments are made in work organization to take into account the return-to-work program as well as production demands. This is also likely to have a positive influence on co-worker attitudes toward the injured worker’s re-entry program, which contributes greatly to the process.

*Union representative: “We’re strongly fighting employers who want to put people on production-type jobs that*

*demand quotas and things. Sometimes they say 'Well, there's not really a quota here.' And officially there isn't, but there's always an underneath - a sort of self-imposed quota, where you know, crews say 'Well, we're going to do 1200 units a shift - we always have.' And so now you have someone who's thrown in there that knocks their quota down."*

Participation of individuals from different levels of the organization in working groups for quality improvement, health and safety, and return-to-work programs leads to better integration between production and the return-to-work program. This approach was usually associated with appropriate training for production supervisors and allocation of sufficient time in their work schedule to manage return-to-work re-assignments.

The manner in which the process of return-to-work unfolds is key, as buy-in from all involved parties is necessary in order for the return-to-work process to succeed.

*Union representative: "If management is sincere in that they want this worker back to get them back to full health, so that they're now a productive part of their workforce, then it does work. But when someone in the back of their mind is saying 'How are we going to get out of this claim, so we can get our experience rating,' then I think that starts the pattern of it going downhill."*

## **The challenge of modified work**

The people to whom we spoke often stressed the challenge of developing appropriate and meaningful modified work placements. This requires creative thinking and the ability to respond constructively and flexibly to any problems that arise. In some successful work re-entry programs, modified work programming was associated with identification of workplace risk factors that could then be eliminated and thus tied to injury-prevention programs. The existence of modified work programs is likely to be better accepted in the workplace setting when seen as a benefit for all, i.e., as a means of helping any-

one who is injured in the future, and not just a response to any specific injured worker's needs. Workers tended to feel that their employer was truly interested in their health and welfare and was taking steps to protect their health if it had an active prevention program to eliminate risks for musculoskeletal disorders. Both managers and worker representatives in such workplaces believed that workers who felt "they were being taken care of" and who expected preventive action following symptom complaints were more likely to participate in return-to-work programs.

Trust for the process also helps establish the buy-in on the part of all parties that is required for successful return-to-work programming. In a potentially adversarial situation, trust is often built gradually, by on-going efforts on the part of the return-to-work team. In a few cases, it is described as the result of one or two persons' vision and hard work, and their ability to initiate good communication and carry through the policies or programs that have been established. Workers and union representatives were less likely to collaborate with modified work programs if the employer had a policy of frequent and aggressive appeals of workers' compensation claims.

Support and commitment by both top management and worker representatives (whether union or non-union) is described as basic to establishing a climate of trust. The commitment of top management to health and safety and to return-to-work programs was identified as an important factor in the success of these programs. Employers that made health and safety one of their top priorities were more likely to have a return-to-work program that was well integrated with health and safety activities to prevent musculoskeletal disorders and to have more widespread collaboration with the program by workers, supervisors and managers.

The organization's structure, particularly how the budget for the health and safety or return-to-work program is administered, can influence the resources available to modify workstations and jobs of injured workers. Often, modified work programs are administered by a human resources department that has little discretionary power to allocate money for job modifications. In workplaces where the budget for modified work programs is administered within produc-

tion or operations departments, access to funds for job modification is often easier.

The people we interviewed also spoke about the attitudes, perceptions and behaviours of the workers themselves as factors influencing the outcome of return-to-work programs. One worker noted that you “have to be persistent and ask a lot of questions. I’ve learned how to do that!”

The worker’s motivation to get back to work and to take some responsibility for the program was also mentioned by others. For example, one manager said, “A worker who blames someone else can’t get on with their life.”

Some modified work assignments require the worker to ask co-workers or supervisors for help in carrying out tasks they are unable to do. This may be difficult for workers who are reluctant to ask for such assistance. Although individual personality factors or beliefs do play a role, workplace factors mentioned above influence the motivation of workers to participate in return-to-work programs. Resistant attitudes are probably less likely in settings where trust and respect have been established.

Financial, domestic, and emotional difficulties may be associated with an injury and time off work. Some employers described employee assistance programs as one means of helping workers through times of distress. Insight into and compassion for the worker’s personal situation seemed to be a feature of the more employee-centred work settings.

We have spoken about the need for good communication among all parties. Although no group was excluded from being responsible for contributing to effective communication, when poor communication was described as a barrier the stakeholder group frequently mentioned was family physicians. Employer representatives de-

scribed extreme frustration trying to communicate with some doctors in order to develop return-to-work plans, whereas others were helpful and forthcoming with the necessary information. Both doctors and employers mentioned the physician’s unfamiliarity with the work settings as a hindrance to the process.

On-site occupational health nurses and physicians can be quite useful in this regard, where feasible. In one community, efforts had been made to establish an on-going partnership between doctors and employers. In addition, some companies provide treating physicians with videotapes of the work to help them better understand the physical demands.

### **In conclusion...**

It is clear from the experiences described by people working every day in the return-to-work effort that many factors other than the worker’s injury per se contribute to the success of return-to-work programming. Improved communication and mutual understanding by all the involved parties, about (1) the basics of successful programs and (2) the point of view and role of each of the other actors involved in modified work programs, should help programs to operate successfully. It was suggested that the themes that emerged from the interviews in this research be used as a framework for analysis, discussion, and problem-solving among groups of stakeholders.

To assist users of this booklet make the best use of their time together to improve return-to-work in their local settings, we developed a series of case studies illustrating the themes, to be used as the focus of discussions. They are packaged under separate cover and will be distributed at the Work-Ready Workshop in which we hope you will be participating.

# So What Is the Next Step?

This booklet is intended as background material for those interested in participating in Work-Ready Workshops. A Work-Ready Workshop brings together people with varied backgrounds but a common interest in safe and early return-to-work. Participants interact intensively, sharing their perspectives and views while discussing a series of injured worker case studies.

Although the overall intent of the Work-Ready case study package is to present a balanced view of the common factors contributing to increased disability after work-related injury, many of the case studies focus on the actions of one or more specific stakeholders. The purpose of this is to highlight particular types of problems and their potential solutions.

The first page of each case study describes an injured worker's situation in enough detail to set the tone for the discussion among workshop participants. We recommend that workshop participants discuss the worker's situation thor-

oughly before reading the Work-Ready researchers' comments about the case-study. We would like workshop participants to answer three questions:

- What went right in this case?
- What went wrong?
- What might have improved the outcome?

After this discussion, we suggest that participants compare their ideas to the suggestions put forward by Work-Ready researchers, which are based on published scientific evidence and field experience. Participants should not feel that their views must conform to these expert opinions in all cases. Each of us has different experiences around return-to-work, and strategies need to be tailored to the local situation.

Diversity of views should be encouraged, as long as they are compatible with scientific evidence and facilitate stakeholder collaboration to "get the job done."