



# Implementing Best Practice Models of Return to Work

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**Abstract**

Over the last few decades, we have seen a considerable number of models of return to work (RTW) and work disability. The majority of these are conceptual models developed from research on musculoskeletal disorders. The aim of this chapter is to develop a new practice-based model of RTW implementation, compare it to existing practice-based models, demonstrate the application of the new model using a case scenario, and indicate how it fits with recommendations for best practices from those engaged in RTW on a daily basis. The “Best Practices for RTW Implementation Model” has a holistic approach and identifies three stages involved in best practices for RTW, Stay-at-Work, early RTW, and prolonged RTW and takes into account the workplace’s organizational culture and structure. Keys to staying at work are positive supervisor and co-worker relations to enable early identification and action to solve problems. For early RTW, the role of the RTW coordinator is key, and workplace adjustments that may be both formal and informal are an important mechanism to get absent workers back into the workplace as soon as possible. Prolonged RTW follows from an unsuccessful RTW, and optimizing the work environment to match the (remaining) capacities of the employee is central. The model has the capacity to be of value to both researchers and practitioners focusing on the RTW process regardless of reason for employee absence or jurisdiction.

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**Keywords**

Return to work · Implementation · Practice models · Work disability

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**Introduction**

Over the last few decades, we have seen a considerable number of conceptual models of return to work (RTW) and work disability. Many of these models were developed from research evidence on musculoskeletal disorders, in particular, low back pain (Costa-Black et al. 2013; Knauf and Schultz 2016). More recently, research evidence in the area of RTW for cancer survivors led to the development of a model specific to cancer (Feuerstein et al. 2010). Studies of RTW specific to other diseases and disorders, such as common mental health disorders, spinal cord injury, stroke, etc., have elucidated that many factors related to RTW, especially workplace factors, are generic across disorders (Shaw et al. 2013). Although we now have multiple conceptual models for RTW, only a handful of models exist to guide the practice and implementation of RTW (Bourbonnais et al. 2006; Dyck 2017; IWH 2007).

Therefore, the objective of this chapter is to review existing best practice models of RTW. First, we define RTW as conceptualized in this chapter. Next, we briefly review the conceptual literature on RTW and work disability to develop a new practice-oriented model of RTW. Then we compare our proposed new model to existing practice-oriented models to identify model strengths and limitations. The

barriers and facilitators to the implementation of RTW are highlighted through the application of our new proposed model to a typical case of work absence. We conclude with best practice recommendations.

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## Return to Work Definition

Successful RTW is a key factor for the prevention of work disability in workers with chronic disease or disability. Although workers with chronic disease or disability are less likely to participate in work or employment, a large part of their work is in active paid work. Moreover, given the increase in the average age of the working population, the number of older workers with a chronic disease is likely to increase. Generally, work is considered to have a positive influence on health, as it gives meaning to life, social relationships, and opportunities for personal development, that is, when working conditions are healthy. A healthy work environment is even more important for the large and growing group of workers with chronic disease or disability as they have different requirements and their work capacity might differ from healthy co-workers. Working with a chronic disease or disability often goes along with difficulties in work functioning that may change over time depending on the progressive nature of the disease or changes in working conditions. This may lead to intermittent work absence. The key to preventing work disability is the RTW process.

In the field of work disability prevention, there has been a plethora of research conducted on RTW, both as an outcome and as a process. Although it may seem simple to distinguish RTW from not returning to work following an episode of work absence, the definition of RTW requires more than the answer to the question “Have you returned to work?”. Young and colleagues described RTW as a developmental and dynamic process involving multiple phases (Young et al. 2005) from off work to reentry, maintenance, and advancement.

Important aspects of successful RTW vary by stakeholder perspective (Hees et al. 2012). Here, we mention a few of the common outcomes considered in defining successful RTW: (1) duration, (2) number of hours, (3) location, and (4) task. With regard to the duration of RTW, successful RTW is often defined as a minimum number of days between the 1st day of absence and the 1st day of RTW. For example, in the Netherlands, successful RTW is defined as RTW within at least 28 days which is in line with work disability compensation policies (a RTW episode of fewer than 28 days is considered as a continuation of the previous episode). The number of hours of RTW is another important aspect of the definition of successful RTW. Successful RTW may be considered working the same number of hours as before the episode of work absence. Location is of relevance as RTW in the workers’ own job or at the same employer is considered more successful than RTW at a different employer or in a different job within the same employer. Tasks are also of relevance as they relate to changes compared to the job before the work absence episode as a change of tasks may promote RTW but may have consequences for career opportunities in the longer run.

Overall, many definitions of successful RTW include aspects of duration, number of hours and location, and seldom aspects of at-work productivity (Hees et al. 2012). Often, RTW is a process from being work disabled to taking up job tasks and maintenance of employment and sometimes even continuation of the working career path. Different stakeholders involved in the RTW process have different ideas about successful RTW (Hees et al. 2012). For an employer, successful RTW may relate to costs or duration until RTW, staff turnover, or at-work functioning (Hees et al. 2012). For employees, job satisfaction, work-home balance, and mental functioning have shown to be important outcomes of the RTW process (Hees et al. 2012), whereas professionals relate to restoration of functional abilities needed for specific tasks (Hees et al. 2012). This chapter focuses on best practices in the implementation of RTW with the objective of achieving RTW success and minimizing work disability. Differences in the definition of RTW may help to understand and explain differences between best practices in implementing RTW. These four aspects of defining successful RTW (i.e., duration, location, number of hours, and task) as outcomes can be used as targets for implementing best practices in the process of RTW.

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## Overview of Conceptual Models of Return to Work

Many books, book chapters (Costa-Black et al. 2013; Knauf and Schultz 2016; Schultz et al. 2015), and journal articles (Kristman et al. 2016; Schultz et al. 2007) have addressed conceptual models of RTW and work disability. Most models were developed from research findings related to musculoskeletal disorders. Over the last decade, research evidence suggests that many aspects of RTW are common to various diseases and disorders (Shaw et al. 2013). Yet, few models of RTW and work disability have taken a holistic approach to conceptualizing the problem.

In fact, there is no single parsimonious multivariable model that describes best practices in the implementation of RTW. Therefore, the purpose here is to briefly review theoretical models that contribute to RTW best practices. Table 1 highlights the features of relevant conceptual models and indicates their contribution to the implementation of best practices of RTW. In the next section, we use this information to develop a new practice-based model, based on these existing conceptual models.

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## Proposed New Practice-Oriented Model

Since existing theoretical models do not provide a holistic view of the implementation of the RTW process, we developed a new practice-oriented holistic RTW model (Fig. 1) based on the contributions of the conceptual models listed in Table 1: “Best Practices for RTW Implementation Model.” Although return to work is traditionally accepted as the process involved following a work absence due to injury or illness,

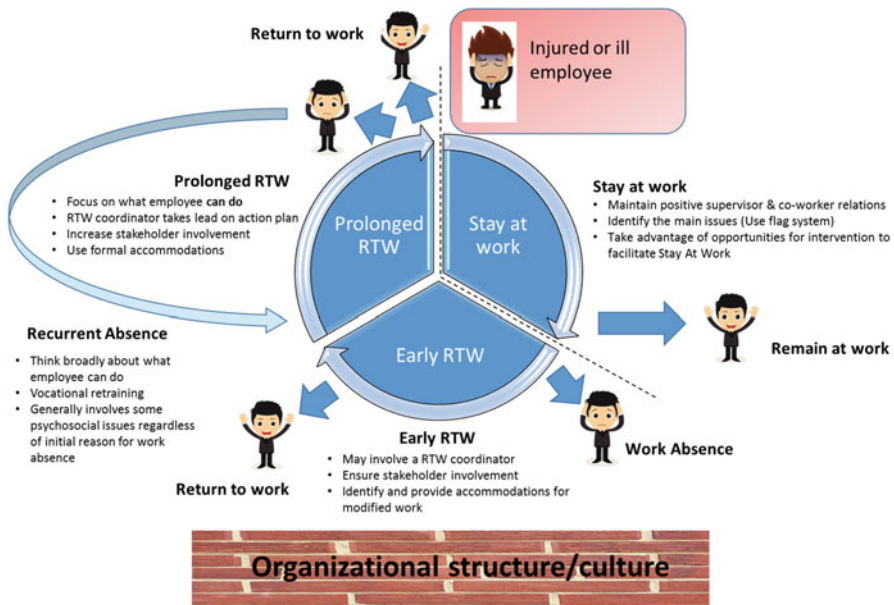
**Table 1** Conceptual models of RTW and work disability

Conceptual model	Model features	Contribution to implementation
Karasek job demand-control model (JDC) (Karasek Jr 1979)	Job demands should be balanced by control (e.g., social support) over how to do the work to avoid job strain	Suggests RTW is dependent on control over work, social support, and a reduction of job demands; high job demands or low control may be barriers to RTW
Biopsychosocial model (Waddell 1987)	Many factors can contribute to work disability including biology, behavioral, and social factors	Behavioral and social factors contribute to RTW
Biomedical model (Leibowitz 1991)	Focuses on the individual impairment and clinical response	The health issue is an important consideration in RTW
Feuerstein model (Feuerstein 1991)	RTW results from interactions between behavior, medical status, physical capabilities, and work demands	Considers psychological/behavioral resources as a modifier of the medical status, physical capabilities, and work demands on RTW
Effort-reward imbalance model (ERI) (Siegrist 1996)	Work stress occurs due to an imbalance between the employee efforts and rewards received	Efforts and rewards should be considered in RTW
International Classification of Functioning (ICF) (WHO 2001)	Social participation, including work, depends on biology and life activities and is influenced by environmental and personal factors	Health, psychosocial, and environmental factors are important considerations for RTW
Institute of Medicine (IOM 2001)	The workplace interacts with the person to explain health	It is important to consider both personal and workplace factors in RTW
Case-management ecological model (Loisel et al. 2001)	Identifies important systems and stakeholders in work disability: Insurance, workplace, healthcare, and personal system operate within a societal context	It is important to consider all stakeholders in the RTW process
Faucett's integrated model (Faucett 2005)	Disability is a result of the physical work environment and management that lead to worker strain; the model separates individual and external factors	Workplace management, the physical work environment, and worker perceptions of these are important factors to consider in RTW
Cancer and work model (Feuerstein et al. 2010)	This is a comprehensive model for disability in cancer survivors including influences of health, symptoms, function, work demands, and environment within an organizational, legal, and financial context; also provides considerations for characteristics of cancer survivors	Many important RTW factors overlap across health conditions; special considerations should be given to symptoms specific to some conditions, such as cancer, in the process of RTW

(continued)

**Table 1** (continued)

Conceptual model	Model features	Contribution to implementation
Perceived uncertainty model (Stewart et al. 2012)	An awareness of not knowing what will happen in relation to health, work, and life in general can influence RTW	Worker perceived uncertainty, along with expectations, and coping ability can influence RTW
Workplace factors model (Kristman et al. 2016)	This model presents the three basic principles for workplace factors influencing RTW	Consider workplace factors at reentry, aversive, and appetitive workplace factors when attempting a RTW



**Fig. 1** Best Practices for RTW Implementation Model

there is emphasis by employers and insurers to encourage “Stay-at-Work.” Stay-at-Work is initiated when a worker has reported an injury and/or illness. The employer is then tasked to engage with the employee in developing strategies that accommodate limitations resulting from the injury or illness with the goal of retaining the employee’s status at work. Although timing in the employee absence is different, there is overlap in the methodological approaches as well as associated barriers and facilitators between return to work and Stay-at-Work. Consequently, our model highlights the stages involved in the best practices of RTW (Durand et al. 2014): (1) Stay-at-Work, (2) early RTW, and (3) prolonged RTW. The model also highlights the importance of the workplace’s organizational structure and culture as the pillar

upon which the implementation of RTW occurs. This final point is key, and the success or failure of RTW implementation hinges on the organizational structure and culture established at the workplace where the RTW is being attempted (Franche et al. 2005a; Friesen et al. 2001; MacEachen et al. 2006; Schultz et al. 2007). Organizational structure is the arrangement of authority, communication, rights, and duties of an organization (Ashkenas 1995). It often defines how activities in the workplace are coordinated and supervised to achieve the aims of the organization. For example, developing corporate policies and procedures that outline internal and external stakeholder roles and responsibilities as well as flow of information relative to the RTW is critical to success of RTW implementation. Organizational culture reflects the values and behaviors that contribute to the social and psychological environment of an organization (Schein 1984). Organizational cultures that are people- and safety-oriented are associated with improved RTW (Franche et al. 2005b).

In practice, the best way to ensure a RTW is to prevent an absence in the first place. We label this the Stay-at-Work stage. The primary goal is to identify the main issue(s) that a worker or workers may be facing that could lead to work disability and implement any changes that may allow the worker(s) to remain at work. Although RTW is often conceptualized as starting from an absence, in reality RTW is a process that does not necessarily have to start with an absence but rather begins with an illness or injury. Having a worker stay in the workplace to recover, rather than having the worker recover at home, will maximize some of the important “successful RTW” outcomes: duration, zero days lost; number of hours, workers may or may not be able to work the same number of hours as before the injury or illness, but a gradual return to normal hours may be accelerated if the employee is still at work; location, will help the worker maintain job with the same employer; and tasks, tasks may need to vary to accommodate the abilities of the injured or ill worker, but as the worker recovers, the tasks can gradually return to the pre-injured state.

The Stay-at-Work stage should involve an examination of the workplace to identify issues or changes that can help an injured or ill worker remain at the workplace. Within a people- and safety-oriented culture, maintaining positive supervisor and co-worker relations will ensure that everyone in the workplace is promoting worker well-being (Lysaght and Larmour-Trode 2008; Shaw et al. 2006). Issues that a worker or workers are dealing with can be identified early, and an attempt can be made to rectify any problems prior to an absence occurring. We recommend using the flag system to identify the main issues (Shaw et al. 2009). This system involves the identification of healthcare, psychosocial, and employee’s perception of workplace factors and the actual workplace factors that may be leading to a possible work absence. Some solutions to keep a worker at work may involve allowing the worker time to attend healthcare appointments, repairing broken workplace relations, or rectifying employees’ misguided perceptions. Workplace factors are broad and are often conceptualized into four categories including (1) physical job demands, (2) psychosocial job demands, (3) work organization and support, and (4) workplace beliefs and attitudes (Kristman et al. 2016; Shaw et al. 2013). Opportunities for workplace intervention include the use of informal accommodations that allow the employee to control work intensity or rest periods (Tjulin et al. 2010), the

modification of job demands (Janssen 2000; Karasek Jr 1979), increasing the amount of control in the job (Gimeno et al. 2005), increasing the amount of reward related to the job (Janssen 2000), or the use of employee assistance programs (Jacobson Frey and Attridge 2010). Developing a written “Stay-at-Work” plan (SAWP) provides a reference document that all stakeholders can use throughout the process. This can become the cornerstone of the Stay-at-Work initiative. Often, relatively easy fixes addressing the worker’s primary concerns can allow the worker to remain at work and prevent an absence altogether (Amick et al. 2000; Shaw et al. 2006).

The early RTW stage begins once the worker is absent from work, with or without compensation. In this stage, it is important to repeat all aspects of the Stay-at-Work stage, especially if these were not done before the worker went on leave. At this stage, it may be important to involve an individual with expertise in disability management and RTW such as a RTW coordinator (Franche et al. 2005a; Gardner et al. 2010; Pransky et al. 2010; van Oostrom et al. 2007) or an occupational health physician. In some jurisdictions, involving experts in disability management and RTW may only occur when the duration of work absence has exceeded a threshold of time. For example, in the Netherlands, a problem analysis has to be performed when work absence lasts more than 6 weeks. Employers arrange a meeting between the occupational physician and the worker before the 6th week of absence, often after 4 weeks (Bockting 2007) to facilitate a RTW solution. Additionally, RTW coordinators will often conduct a case review, including ergonomic and workplace assessments, social problem-solving, and workplace mediation (Shaw et al. 2008). Effective communication and collaboration between all stakeholders, including the worker, the supervisor, the healthcare provider, the worker’s union (if existing), and any insurers, is vital (Franche et al. 2005a; Friesen et al. 2001; Young et al. 2005). This communication and collaboration is easier when the RTW process occurs in an organization where a strong organizational culture exists, an organizational culture that is understood to have particularly strong effects on the ways in which organization members think and behave; it is usually contrasted with competing influences on organization members other than culture, including direct supervisory oversight, rules such as job descriptions and budgets, and explicit contracts (Peterson and Fischer 2004). Stakeholders should discuss all the potential barriers and facilitators to RTW. These barriers may include access to appropriate healthcare, personal issues with the worker, aversive workplace factors, and difficulties working through the compensation process. A written return to work plan (RTWP) becomes critical to facilitate this process. A RTWP is similar to the SAWP in that it provides a cornerstone document that outlines stakeholder roles and responsibilities. It differs in that modifications to work, appointments, rehabilitation strategies, and gradual increases in modifications to work (i.e., duration and tasks) are clearly outlined. The RTWP should be developed in collaboration with all stakeholders including the worker, supervisor, RTW coordinator, and, where applicable, healthcare professional.



We have identified prolonged RTW as the period of time when a worker's absence results following an initial failed RTW attempt (Frank et al. 1996). Examples that may contribute to the failed RTW include recurrence/exacerbation of injury/illness, contextual barriers experienced by the worker requiring resolution before continued return to work, and/or a new injury/illness (Frank et al. 1996). During the prolonged RTW stage, the focus should be on what an employee can do (i.e., capabilities). The stakeholders should develop a RTWP (Tjulin et al. 2010), outlining the roles and responsibilities of all involved with timelines attached. Formal accommodations can help to remove or modify barriers (Franche et al. 2005b; Krause et al. 1998). The supervisor or workplace personnel involved in day-to-day operations should be involved (Franche et al. 2005a, b) and the absent worker. Depending on context and jurisdiction, it may be required to include additional employer stakeholders such as union, management, and other co-workers (MacEachen et al. 2006). The workplace should provide paid time for medical appointments, if needed (Pryce et al. 2007). Most importantly, continued communication and collaboration between all parties will help to achieve a timely and successful RTW (Nieuwenhuijsen et al. 2004; Yarker et al. 2010).

If RTW is not achieved according to the RTWP, this stage should be repeated with ideas for new interventions, increased social support, and increased participation. If this is still unsuccessful, the absence may become recurrent (ongoing long-term absence). At this stage, there are generally psychosocial issues regardless of the initial reason for work absence. Modifiable psychosocial risk factors associated with prolonged absence from work include fear of reinjury with movement, pain catastrophizing, personal beliefs regarding perceived degree of disability, and depressive disorders (Sullivan et al. 2005). Vocational retraining or assistance with a job search for a new position may need to be considered. Research has shown some evidence for the success of community-based psychosocial interventions (Sullivan et al. 2005). However, early, multidisciplinary, and time-contingent, activating interventions appear to be the most effective to support RTW (Hoefsmit et al. 2012), but more research is needed to evaluate interventions used at the recurrent stage.

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## Comparison of Practice-Oriented Models

Previously, the development of conceptual models highlighted the progression and growth of knowledge related to RTW factors and interventions. However, in order to facilitate RTW, supervisors or RTW coordinators need practical tools to guide the complex process of accommodating and reintegrating a worker following an absence.

The sheer variety of considerations for RTW make the development and implementation of a practice-oriented model difficult. Successful RTW is dependent upon an extensive list of factors, which include but are not limited to the structure and culture of the organization, industry, type of work, required modifications, social influences, and job demands. As a result, a fully comprehensive model becomes

overwhelming to implement, and a simpler model does not capture the essential components of a RTW plan.

Implementing any type of RTW comes with a host of barriers. As each individual situation will eventually reveal, there is far more to a successful RTW than what can be easily captured in a “one-size-fits-all” solution. There are, however, some common barriers to RTW that are significant and should be addressed. First, RTW inherently begins once a worker has reported an injury or illness that results in absence from work; however, developing a strategy to facilitate the worker staying at work to enable recovery will enhance RTW outcomes. Consequently, current models that begin the RTW process once the worker has experienced absence result in sub-optimal conditions for vital relationship development: conveying support, building trust, and negotiating expectations. Second, much of the RTW research has focused on physical conditions which require modified duties, and as a result, the mental and emotional aspects of RTW are often neglected or become secondary to the physical condition. While the models are intended to be inclusive, the specific needs of mental health in RTW considerations are lacking. This is important for two reasons: the absence frequency and duration for employees with stress and mental health concerns continue to increase (Mental Health Commission of Canada 2015), and many physical health issues are related, or compounded, by mental health issues (Scott et al. 2007). Third, the models assume a level of competence in RTW for the facilitator and/or supervisor. For many small- and medium-sized organizations, the RTWP is highly dependent upon the direct supervisor, due to lack of other organizational supports. The process of planning and implementing a RTWP can become overwhelming and confusing. Therefore, theoretical models themselves are often a barrier for organizations as they lack in lay-application, and the practical implications of the constructs within the model are unclear. Finally, RTW is rarely a linear process. Models need to include and anticipate trial and error, relapse, and regression.

Table 2 contains a description of three of the most widely used practice-oriented models, as well as a description of the newly proposed “Best Practices for RTW Implementation Model.” This comparison is designed to highlight key aspects of the models without attempting to be exhaustive. However, comparing the models and the inherent strengths provides an overview of how the models are intended to guide the RTW facilitator.

While all of the three existing practice models have clear strengths, they also possess limitations, many of which are addressed within the Best Practices for RTW Implementation Model. The new model was designed with features to increase ease of use as well as including a process that encourages accommodation prior to the worker being absent from work due to injury or illness (i.e., Stay-at-Work). Also integral to the model is the recognition that organizational climate, context, and structure will influence and inform the RTW process. These factors are situational and company specific.

The process model, while extremely comprehensive, creates a series of steps that easily become overwhelming for the non-RTW specialist. For large organizations with RTW staff, this model may capture the complexity of RTW. However, without

**Table 2** Comparison of Return to Work Practice Models

	Process model <sup>a,b</sup>	Participative model <sup>c-g</sup>	IWH 7 Principles <sup>h</sup>	Best Practices for RTW Implementation Model
Overview	Within a disability management framework, this graduated RTW process of shared responsibility considers social issues and fairness to all parties	A stepwise process from sick leave to return to work involving all stakeholders in the development of a RTW plan designed to fit specific workers or organizational needs	A set of steps which ensures an individualized RTW plan is developed to reintegrate workers in a safe and timely manner	A three-component model which is engaged prior to the work absence. Each phase builds upon the prior with a holistic biopsychosocial focus
Model in brief	<ol style="list-style-type: none"> <li>1. Collaboration and cooperation between stakeholders</li> <li>2. Focus on a safe and timely RTW with early intervention</li> <li>3. Active involvement of supervisors and unions with clear roles</li> <li>4. One person responsible for case management</li> <li>5. Develop individual RTW plans:                             <ol style="list-style-type: none"> <li>1. Assess capabilities of employee</li> <li>2. Tasks and duration suitable for RTW</li> <li>3. Determine accommodation</li> <li>4. Monitor progress</li> <li>documentation</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Creating conditions: assign a process manager, check the key stakeholders, prepare the organization</li> <li>2. Problem analysis: aim to reach consensus about problems to be solved</li> <li>3. Solutions analysis: aim to reach consensus about solutions between key stakeholders</li> <li>4. Action plan: define a protocol for implementation</li> <li>5. Implementation: support the implementation process and plan an evaluation</li> <li>6. Evaluation: check if the targets are met, the solutions implemented, and that the</li> </ol>	<ol style="list-style-type: none"> <li>1. Workplace committed to health and safety</li> <li>2. Accommodation offered to encourage early and safe RTW</li> <li>3. RTW planner as lead considers worker, supervisor, and co-worker needs</li> <li>4. Supervisors provided training on RTW planning and disability prevention</li> <li>5. Early and considerate contact with worker by supervisor</li> <li>6. RTW coordination assigned</li> <li>7. Communication between healthcare providers, worker, and supervisors essential</li> </ol>	<ol style="list-style-type: none"> <li>1. Stay-At-Work – issue identification with informal supports, work modifications jointly decided with the worker and supervisor.</li> <li>2. Early RTW – formal case review with all stakeholders which identifies challenges and opportunities for RTW</li> <li>3. Gradual RTW – action plan developed with a focus on worker’s capabilities and implementing a range of RTW strategies</li> </ol>

(continued)

**Table 2** (continued)

	Process model <sup>a,b</sup>	Participative model <sup>c-g</sup>	IWH 7 Principles <sup>h</sup>	Best Practices for RTW Implementation Model
		problems are solved. Advise about next steps if needed 7. Problems are prioritized		
Strengths	Comprehensive view of RTW Social aspects including supervisor and co-worker attitude recognized as factors effecting outcomes Clear connection with job description and duties Fits well with physical and mental disabilities	Focus is on worker voice Proactive approach Can be used to address both individual worker level and organizational level RTW issues Feasibility of implementing solutions is high as this is taken into account as prioritizing factor	Focus on safety commitment Early worker communication essential Highlights union involvement and role of collective agreement Red flags/green lights cards and guidelines to identify what to watch for and behaviors that enable RTW	Priority given to building relationships and communication expectations prior to work absence Views the worker as a whole person, instead of focusing on what is “wrong” Identifies other issues related to RTW such as organizational context and co-worker support Includes informal, formal, and creative interventions to address psychosocial needs
Situational strength	Physical disabilities and injuries with easily quantifiable measures	Highly applicable for RTW issues of psychological safety	Generic steps that could fit any model, however not enough as a stand-alone RTW solution	Any RTW situations with complex physical and/or mental/ social needs

<sup>a</sup>(Dyck 2017)<sup>b</sup>(Cullen et al. 2018)<sup>c</sup>(Bourbonnais et al. 2006)<sup>d</sup>(Driessen et al. 2010)<sup>e</sup>(Kraaijeveld et al. 2016)<sup>f</sup>(Rivilis et al. 2008)<sup>g</sup>(van Oostrom et al. 2009)<sup>h</sup>(IWH 2007)

significant dedicated resources, it becomes unmanageable. Small- to medium-sized organizations may struggle with the complexity of steps and procedures. While this model strongly addresses physical and mental health injury and illness, it lacks in psychosocial considerations. This is one of the key and unique strengths of the participative model.

Prioritizing the need for the employee's voice is one of the hallmarks of the participative model. As with the process model, a high degree of RTW competence is required, albeit in different areas. The participative model is built on a foundation of communication, inclusion, and cooperation, which requires an expertise in itself, as well as a parallel organizational culture. In situations where relationships are strained or the structure is more competitive, this model may not be an appropriate approach.

The IWH 7 Principles are perhaps less of a model and more of a practice guide. The principles set the philosophical base for a RTW plan that focuses on safety. The well-known red flags/green light cards are extremely approachable regardless of practitioner background, yet they do not present a flow or structure to the RTW plan. The cards do however raise many important considerations for overcoming road-blocks, which can easily be incorporated in the other three models. It therefore may be more accurate to classify the IWH 7 Principles as a toolkit, than a RTW model.

The design of the Best Practices for RTW Implementation Model (see Fig. 1) was deliberate in the recognition of the need to address the dynamics and accommodations resulting from injury or illness, before an absence occurs (i.e., Stay-at-Work). This allows practitioners to begin a dialogue on essential RTW factors: health interventions, supervisor/employee relationships, and proactive work modifications. This also sets the tone for a cooperative RTW planning process, should it be required. The new model also allows for flexibility in involvement, as it suggests, but does not require a RTW facilitator. This model presents a flow to the RTW activities that can be understood and implemented by various organizational members, which may be more feasible in smaller organizations. The importance of flexibility and the need to consider the psychosocial are essential as many RTW processes cannot follow a firm set of prescribed steps, due to the complexity of the RTW requirements and/or co-occurring injury and illness.

The method by which this new model can assist in RTW planning and implementation is illustrated in the following section.

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## **Application of the Best Practices for RTW Implementation Model**

The following provides an overview of the application of our newly formed conceptual model for facilitating RTW. The model is applied to a hypothetical clinical case (Box A). Application of the model begins in phase 1 with the injured worker and progresses through each subsequent phase to demonstrate feasibility of identified key constructs to resolve the RTW barriers and establish successful RTW.

**Box A Case Scenario**

Client: Male, 45 yo; married; one child

DOI: January 6, 2018

Injury: left upper extremity; depression

Injury category: Work-related

Occupation: Cafeteria worker

RTW: Currently off work; two previous failed RTW

**Context:** The injured person is a cafeteria worker; the cafeteria is located in an office building and is owned by a food service company.

**Current Status:** The worker has experienced a left upper extremity injury (rotator cuff and biceps tear) while reaching overhead to obtain a large container of food product at work. He is unable to perform sustained work involving the upper extremity without experiencing increased, localized pain. In addition to musculoskeletal complaints, the worker was diagnosed with depression in September 2018 and has been receiving treatment under the supervision of a psychiatrist. It has been 10 months since the initial incident, and the worker is reporting increased pain and is uncertain about his ability to RTW.

In addition to the issues related to implementation of developing a suitable RTW plan for the injured worker, the organization has failed to establish a corporate Return-to-Work program including policies and procedures that clearly outlines roles/responsibilities and process for the involved stakeholders (i.e., injured worker, supervisor, co-workers). This has left all workplace parties including the injured worker feeling lost in the process. The primary contact for the RTW is the company's HR Manager; this person has been tasked to establish a suitable RTW plan that is agreed upon by all stakeholders.

**Capabilities.** The injured workers' abilities from their family physician include minimal lifting overhead and minimal repetitive movements involving the left upper extremity. The psychiatrist has recommended a graduated RTW starting at 2 h per day in a supported environment.

**Medication:** A series of medications for both pain and anxiety. Gabapentin (400 mg 3×/day), Flexeril (10 mg/day), and Paxil (20 mg/day).

**History:** The worker was injured on January 6, 2018, while lifting a 20 lb. container of food product. The injury report indicates the container was on a high shelf, and, while reaching up to pick up the container to carry to their workstation, he felt a twinge in his low back and left upper extremity in the area of their shoulder and upper arm.

When the worker reported the injury to the supervisor, the supervisor attempted to create a Stay-at-Work plan by providing modified duties. However, the worker felt the duties were not meaningful and were demeaning. Furthermore, co-workers who were considered friends by the worker openly questioned the worker's integrity and pointedly asked when he would be back

(continued)

to “helping the team” again. The worker did not RTW the following day, and the plan failed.

Two weeks later, the supervisor attempted to implement an early RTW plan. The supervisor contacted the worker and obtained information about his capabilities to better identify appropriate modified duties. However, the duties extended beyond the worker’s outlined functional capabilities and exacerbated their condition. The worker tolerated the plan for 1 week before “calling in sick.” During a follow-up telephone conversation with the worker, he mentioned that the 30-min commute was too long and exacerbated his shoulder pain. The supervisor indicated that he was frustrated and suggested that the worker try another form of work because it seems like this work is too difficult for him. This left the worker feeling isolated and unwelcome in the workplace; gradually the worker began feeling depressed and experiencing episodic anxiety. The supervisor didn’t know how to proceed after this, and although attempted to contact the worker a couple of times following the failed RTW, there was no response. The worker has remained off work but is now in a position where both the insurer and employer are seeking an update and asking for a RTW plan to be implemented.

**Treatment History:** After the first day of work, the worker followed up with their family physician. He was referred and initially treated by a chiropractor with no improvement; the worker was then referred to orthopedic specialist and was not found to be a surgical candidate. MRI revealed a bulging disc at L5-S1 and a rotator cuff w/ biceps tear. The worker completed two rounds of physical therapy, first in February 2018, was released to work, then progressively got worse, and was referred to physical therapy again in May 2018. During August 2018, the worker became more frustrated with ongoing pain and became despondent; family members suggested follow-up with his family physician who recommended that he seeks treatment from a psychiatrist. He has been receiving appropriate treatment under a psychiatrist for depression since the beginning of September 2018 and has reported benefit from same.

## Phase I: Stay-at-Work

*What Happened:* Despite lacking a formal, corporate RTW policy and procedure, the worker’s supervisor developed a SAWP immediately following the incident to support the worker following his injury. However, the duties provided were unsuitable and considered demeaning by the worker. Furthermore, co-workers were unsupportive of the RTW and questioned the worker about the length of the modified RTW. Subsequently the worker terminated the RTW plan and remained off work for an additional 6 months.

*Applying the Best Practices for RTW Implementation Model:* The following three constructs reflect critical steps in facilitating Stay-at-Work: (i) maintaining positive supervisor and co-worker relations, (ii) identifying the main issues, and (iii) taking advantage of opportunities to facilitate Stay-at-Work. Failure of the initial Stay-at-Work plan might have been avoided if the workplace had facilitated a coordinated RTW with all stakeholders, ensured ongoing monitoring and collaboration with the injured worker, and educated workplace parties about the RTW. In particular, the supervisor should have better coordinated the plan with the worker and ensured the worker was returning to a positive, supportive environment among his colleagues. Furthermore, developing a clear SAWP that articulated roles, responsibilities, and duties would have ensured a cohesive approach. These activities are critical to supporting RTW and would also have been enforced had the organization established stakeholder roles and responsibilities with a clear RTW policy and procedures aligned with a positive, worker-centered environment.

## **Phase II: Early Return to Work**

*What Happened:* The worker remained off work for 2 weeks before the supervisor attempted contact. Although the supervisor obtained updated capability information, the provided modified work was not appropriate and reinjured the worker. The RTW was successful for 1 week after which the worker terminated the plan. The supervisor followed up with the worker but became frustrated and suggested the worker seek alternative employment. This isolated the worker who eventually became anxious and depressed.

*Applying the Best Practices for RTW Implementation Model:* The following three constructs are critical to supporting early RTW and have been reviewed in the context of the case scenario: (1) involve a RTW coordinator, (2) ensure stakeholder engagement, and (3) identify and provide suitable accommodations for modified work.

A RTW coordinator is an individual with expertise in facilitating RTW and expertise in disability management; examples of professions that often become RTW coordinators include occupational therapists, kinesiologists, physical therapists, and nurses (Pransky et al. 2010). Furthermore, the RTW coordinator is a designated individual who can provide an unbiased perspective on the RTW strategy, independent from workers' direct supervisor and/or workplace. Within the context of the case scenario, the supervisor should have recognized personal limitations associated with supporting the worker through their recovery and involved a RTW coordinator. The RTW coordinator would have provided a more supportive interaction between the worker and their supervisor resulting in a RTWP that was more suitable based on functional abilities information. Furthermore, the RTW coordinator would have developed a RTWP based on the capability information which clearly outlined required modifications to tasks/duties and duration to ensure suitability of the work.



### **Phase III: Prolonged Return to Work and Recurrence**

*What Happened:* The worker remained off work for over 10 months, and although the supervisor attempted intermittent contact, the worker avoided contact. The worker continued to receive treatment for both his musculoskeletal injury and depression; however the efforts to coordinate a RTW were less robust. Parties subsequently came together to facilitate a RTWP for the worker based on his newly acquired functional ability information from both his family physician and psychiatrist.

#### **Applying the Best Practices for RTW Implementation Model**

The following four constructs are critical to supporting RTW after a prolonged absence from work: (1) focus on employee capabilities not limitations, (2) RTW coordinator assuming lead on developing the RTWP, (3) increased stakeholder engagement, and (4) use of formal accommodations for modified work.

Because the organization did not establish a corporate return to work policy to establish stakeholder roles and responsibilities, this became a barrier in developing suitable modified duties. For example, the supervisor and worker lacked processes to provide updated information and responsibilities within the RTW planning phase, which resulted in the worker experiencing a prolonged absence from work. In this prolonged absence phase, as the RTW coordinator assumes a lead role in negotiating the RTW plan, the roles and responsibilities of each member including the worker and supervisor would become more clearly established which will facilitate development of a suitable RTWP. For example, standard practice would require that the worker's responsibilities would include providing updated functional ability information when requested, providing feedback on suitability of modified work, and immediately identifying barriers associated with the RTWP. The supervisor would be responsible for requesting updates from the worker regarding the RTWP and discussing identified barriers with the worker and the RTW coordinator to facilitate solutions.

Within this phase, it is critical to focus on facilitating workers' capabilities. For example, updated information regarding the workers' functional abilities was provided from the treatment team. A graduated RTW was supported by the worker's family physician and psychiatrist, and clear information about the worker's capabilities was provided including:

- Lifting above shoulder (restricted to 5 kg to start).
- Avoid repetitive movements involving the left upper extremity (first 2 weeks).
- Start a graduated RTW at 2 h per day in a supportive environment.
- Flexible break times during high emotion.

Within the context of the model, the RTW coordinator would take the lead and organize a meeting between the supervisor and worker to develop a RTWP based on

the worker's capabilities and establish an implementation strategy. The implementation strategy would include (i) a communication plan that ensures regular communication between the worker and supervisor and (ii) development of a formal, written RTWP based on worker's capabilities, job demands, and input from the worker and supervisor. The RTWP should act as a contract between all stakeholders where all members agree to and subsequently sign to the terms of the plan. The RTWP would clearly delineate the formal accommodations agreed upon by all stakeholders. Examples of formal accommodations may include (i) modification to duration of tasks to accommodate lifting and repetitive movement limitations; (ii) modification to workday length to accommodate the starting RTW duration of 2 h per day; (iii) modification to tasks performed at work to accommodate the lifting restriction; and (iv) modification to workflow to accommodate flexible break times. It is important to note that the RTWP should include a gradual progression of these formal accommodations over the duration of the RTWP to facilitate a return-to-full hours/duties within the parameters of the RTW goal. Furthermore, treatment strategies including exercises and modifications to work environment (i.e., ergonomic interventions) should also be included within the development and implementation of the plan.

## Summary

Several recommendations can be made following application of the model that would have reduced exposure to a prolonged absence and facilitated the worker's RTW in the initial Stay-at-Work phase:

1. Establish a corporate policy that clearly outlines individual roles and responsibilities.
2. Develop a formal RTWP based on worker's capabilities and job requirements.
3. Identify a convenient time for all stakeholders (injured worker, RTW coordinator supervisor) to meet for an initial RTW meeting to review roles/responsibilities and proposed RTWP.
4. Ensure a transparent communication strategy between all stakeholders.

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## Best Practice Recommendations

The purpose of this chapter has been to review scientific models of RTW and develop a process-based approach that can guide stakeholders who want to decrease work disability and improve the success of their RTW/Stay-at-Work programs. Therefore, it is important to understand not only how this process model fits with the scientific literature but also how it fits with recommendations for best practices that have been developed by those who are engaged in RTW on a daily basis. Recommendations for RTW best practices can be found on government websites (e.g., [https://www.ccohs.ca/products/webinars/best\\_practices\\_rtw.pdf](https://www.ccohs.ca/products/webinars/best_practices_rtw.pdf) (Pomaki et al. 2010), [https://www.worksafemt.com/media/WSMT\\_SAW-RTW\\_Best\\_Practices.pdf](https://www.worksafemt.com/media/WSMT_SAW-RTW_Best_Practices.pdf) (WorkSafeMT)),

insurer-provided toolkits (e.g., Morneau Shepell 2016), and in educational materials developed for training RTW coordinators or human resources professionals (e.g., The Conference Board of Canada 2013), among other places. These nonacademic sources are referred to as gray literature. A summary of some key recommendations from the stakeholder literature is provided in Box B.

A review of the publicly available best practices for RTW suggests there is consistency between our model (the “Best Practices for RTW Implementation Model” based in the scientific literature) and recommendations arising from field experience. For example, both the model and best practice recommendations:

- Identify key stakeholders.
- Explore opportunities for job accommodations.
- Highlight the importance of respectful and systematic communication.
- Recognize the impact of organizational culture and providing a supportive environment for employees with health challenges.
- Suggest steps to take during the RTW process.

But there are also important differences. First, the best practice recommendations from the gray literature tend to target employer practices and include organization-wide recommendations, while the model we have developed is more focused on individual cases and is useful to any stakeholder involved in RTW. The gray literature advises employers to create organization-wide systems that include employee training, work disability data analysis, and job demands analysis. There are also specific recommendations about how to create a culture that supports RTW by developing a vision/value system and demonstrating a commitment to health and safety. While these may be the appropriate steps to change culture, they are not necessarily based on empirical research in RTW. There are many reasons for this, including the difficulty of conducting research that can isolate the impact of culture interventions on RTW outcomes (Williams-Whitt et al. 2016; Woodman 2014) and questions about whether organizational culture can be engineered (Fitzgerald 1988; Harris and Ogbonna 2011) and how long it may take for a culture change initiative to become embedded in an organization (Schaubroeck et al. 2012). Organizational culture is not only the visible manifestations of a system of beliefs, like policies and procedures, but also the unconscious assumptions that influence how people in organizations solve problems (Schaubroeck et al. 2012; Schein 1984). So, it is particularly difficult to measure and to change. In other words, we know scientifically that organizational culture is important to RTW success, but we do not necessarily know how to create the right culture. This is why our model rests on a foundation of organizational culture but focuses more on specific RTW processes, barriers, and facilitators.

A second important difference is that our model incorporates different stages of RTW and demonstrates its iterative nature. It shows who should be involved at different stages or for different levels of RTW complexity. The best practice recommendations tend to be linear and do not account for the informal accommodations that often occur in smaller workplaces, or when the injury or illness has not resulted

in time off work. It also accounts for situations where there are multiple or recurring absences, as we might see with chronic illnesses or mental health conditions. The model is flexible, allowing for experimentation and gradually increasing duties.

Finally, our model incorporates the flag system as a tool to help stakeholders systematically identify potential barriers and facilitators to RTW success. There is a greater focus on employee capabilities rather than medical restrictions as well as the goal of achieving success from the perspective of multiple stakeholders (e.g., workers compensation boards, employees, healthcare providers).

#### **Box B Stakeholder Recommended Best Practices**

##### **1. Include stakeholders in planning, communications, and coordination of RTW activities.**

##### **2. Build an organizational culture that supports RTW:**

- (a) Develop a vision, values, principles, and policies based on people-centered human resources management.
- (b) Communicate with workers in a way that shows concern, empathy, and willingness to help. Treat them as more than their illness or injury.
- (c) Demonstrate a strong commitment to health and safety.
- (d) Emphasize that safe and timely RTW benefits the organization and the employee.
- (e) Acknowledge and address normal human reactions to difficult situations.
- (f) Investigate and address social and workplace realities.
- (g) Encourage supportive co-worker relationships.
- (h) Deal with discrimination and bad faith behavior.

##### **3. Develop a RTW system:**

- (a) Assign responsibilities and empower supervisors and RTW coordinators.
  - (b) Train RTW coordinators, supervisors, and workers.
  - (c) Create a communication plan.
- Simple, standardized forms for employees and healthcare workers.
  - Information sheet that can be given to workers at the start of a health-related work absence, including a description of the RTW process and contact information.
  - (d) Track organization-wide statistics on injuries, illnesses, and work disability costs.
  - (e) Conduct physical and psychological job demands analyses that can be shared with stakeholders.
  - (f) Identify jobs and tasks that are easily modified or suitable for common injuries or illnesses/work limitations.
  - (g) Develop a process for resolving disagreements or complaints about the RTW process.

(continued)

(h) Monitor systems and outcomes.

#### 4. Develop a RTW Process:

STEP 1: Make early and considerate contact to arrange a joint meeting when it is safe and appropriate to discuss limitations and possible accommodations.

STEP 2: Gather information about the duties and demands of the employee's current job.

STEP 3: Facilitate a discussion among the relevant stakeholders (employee, supervisor, human resources, OHS, etc.) to identify the tasks/duties the employee can safely perform, any barriers to performance, and other skills and abilities that may allow the employee to work outside of their current job.

STEP 4: Brainstorm how the employee's current job might be modified to enable the employee to continue in that role, or if that is not possible, consider other jobs within the organization that match the employee's medical restrictions and other abilities.

STEP 5: Evaluate options considering suitability, safety, length of accommodation, complexity, impact on other workers, resources, and costs.

STEP 6: Collaboratively reach agreement on an appropriate solution or seek additional expertise if needed.

STEP 7: Create a progressive plan for the RTW with goals, accountabilities, and review dates.

STEP 8: Monitor and manage the RTW process through regular communication, addressing social issues and adjustments as needed.

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## Conclusion

This chapter focuses on the implementation of best practice models of RTW. We reviewed existing best practice models of RTW. In contrast to the large body of evidence on RTW, models focusing on guiding the practice and implementation of RTW are sparse. Previous work has indicated that many aspects of RTW are similar for different chronic diseases and disorders, which support a generic approach regardless of the cause of RTW and a holistic approach.

Based on the existing models, we developed a new practice-oriented model for RTW. Compared to the existing models, the new model has a holistic approach and identifies three stages involved in best practices for RTW, Stay-at-Work, early RTW, and prolonged RTW and takes into account the workplace's organizational culture and structure. Keys to staying at work are positive supervisor and co-worker relations to enable early identification and action to solve problems. For early RTW, the role of the RTW coordinator is key and workplace adjustments that may be both formal and informal. Prolonged RTW follows from an unsuccessful RTW,

and optimizing the work environment to match the (remaining) capacities of the employee is central. Formal workplace adjustments are more common.

We applied our model to a case and compared it with recommendations for best practices that have been developed over time by those involved in guiding RTW. This comparison showed many similarities that strengthened the base for our model. Some differences were identified; e.g., we chose a strong basis of organizational culture because we do not (yet) know how to create the right culture for RTW.

We conclude that the Best Practices for RTW Implementation Model has the potential to be of added value for both researchers and practitioners focusing on the RTW process as it takes into account barriers identified from scientific research and is in line with recommendations for best practices.

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## Cross-References

- ▶ [Concepts of Work Ability in Rehabilitation](#)
- ▶ [Employment as a Key Rehabilitation Outcome](#)
- ▶ [Investing in Integrative Active Labour Market Policies](#)

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