Work and mental health: Learning from return-to-work rehabilitation programs designed for workers with musculoskeletal disorders

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Abstract

Despite the high costs associated with mental health problems in the workplace, few studies have yet been published on the design and evaluation of return-to-work rehabilitation programs for workers with mental health problems. In fact, the best-documented return-to-work rehabilitation programs concern workers with musculoskeletal disorders (MSKD). For this clientele, a disability paradigm has been adopted which explains the multicausality of work disability. Long-term work disability is no longer seen simply as the consequence of impairment, but rather as the result of interactions between the worker and three main systems: the health care, work environment and financial compensation systems. A return to work is thus influenced by a complex set of interrelated factors that must be taken into account in any intervention. Parallels can inevitably be drawn in the field of mental health in the workplace, where individual and organizational factors are involved and must be taken into account in the return-to-work process. This paper presents the first results of an exploratory study aimed at determining the possible links between work rehabilitation programs for workers with MSKD and those for workers with mental health problems. To this end, the components of a work rehabilitation program for workers with MSKD, the Therapeutic Return to Work (TRW) program which addresses psychological factors, work environmental factors and factors related to the involvement of the various stakeholders in the rehabilitation process, are described through a multiple-case analysis and mapping of interventions. The results support the relevance of adopting the disability paradigm and considering the return-to-work clinical activities conducted with workers with MSKD (and their mechanisms of action) in the design of work rehabilitation programs for workers with mental health problems.

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1. Introduction

Mental health problems are currently one of the leading causes of worker absenteeism (WHO, 2005). Forty percent (40%) of wage loss insurance costs are linked to mental health problems (Stephens & Joubert, 2001). Moreover, people affected with this type of problem are absent from work for longer periods of time than workers whose absences are due to other disorders. Also, the longer the absence, the more difficult the re-entry into the labour market (St-Arnaud, St-Jean, & Damasse, 2004a). This situation is worrying and yet very few studies have been published on the design and evaluation of return-to-work (RTW) rehabilitation programs for workers with mental health problems. Indeed, several
authors describe organizational approaches to primary and secondary prevention (information on mental illness, detection of depression in companies, improvement of employee assistance programs, support measures in companies, etc.), but few of them describe re-integration measures (tertiary prevention) which consider at the same time the worker, his work environment and the various stakeholders involved (Michie, Wren, & Williams, 2004; Putnam & McKibbin, 2004). The tertiary prevention approaches that have been documented are mainly oriented towards cognitive behavioural interventions involving problem-solving and stress management strategies centred on the individual and do not focus on the work environment and concerted action among the various stakeholders (Nystuen & Hagen, 2003; van der Klink, Blonk, Schene, & van Dijk, 2003). In the field of psychiatry, other studies report on the difficulties of employment integration programs for people suffering from severe mental disorders (for example, schizophrenia and other psychotic disorders) but few studies examine the difficulties related to the RTW process for those who have been absent from work due to a common mental health problem (Goldner et al., 2004; Kirsh, Cockburn, & Gewurtz, 2005). In the field of occupational health, studies focus more on people with physical disabilities. Moreover, the best documented work rehabilitation programs are designed for this clientele (Corbiere & Shen, 2006; Franche et al., 2005; MacEachen, Clarke, Franche, & Irvin, 2006).

In particular, work rehabilitation programs for workers with musculoskeletal disorders (MSKD) have been extensively evaluated in recent years. Socio-economic incentives linked to long-term absences as well as evolving views on work disability undoubtedly account for the proliferation of studies in this area. Clinical practice has evolved from a medical and fragmented perspective (in which the focus was on reducing the impairment or, more positively, on improving the individual’s capacities) towards a global perspective centred on the disability paradigm, in which psychosocial and socio-economic factors and, more recently, workplace-based interventions and early intervention are taken into account (Loisel et al., 2001). Long-term work disability is thus no longer seen simply as the consequence of an illness (or impairment), but rather as the result of interactions between the worker and three main systems: the health care, work environment and financial compensation systems (Loisel et al., 2001).

Furthermore, several authors confirm the importance of taking into account the dimensions related to the work environment and the roles of stakeholders involved in the RTW process, regardless of the type of disorder (Baril, Clarke, Friesen, Stock, & Cole, 2003; Durand, Loisel, Hong, & Charpentier, 2002; Loisel et al., 2001; St-Arnaud, St-Jean, & Rhéaume, 2003). The work environment is said to be involved in almost 90% of accounts of people who are absent from work for mental health reasons (St-Arnaud et al., 2004a). Thus, for both workers with MSKD and those with mental health problems, RTW interventions must consider the influence of a complex set of interrelated factors (clinical, psychological, work environmental and related to the involvement of the various stakeholders) (Corbiere & Shen, 2006; St-Arnaud, St-Jean, & Damasse, 2006; Waddell, Burton, & Main, 2003).

A review of programs which are designed for workers with MSKD and which may be widely applied to workers with mental health problems (Briand, Durand, St-Arnaud, & Corbiere, submitted for publication) has shown that only two programs (2/50), the Multi-disciplinary Work ReEntry Rehabilitation Program (Feuerstein et al., 1993) and the Sherbrooke Model (Loisel et al., 1997), contain all the components identified as relevant, that is, those advocating an optimal return to work (Corbiere & Shen, 2006; Franche et al., 2005; MacEachen et al., 2006). This article will examine one of these programs, the Sherbrooke Model implemented in a natural environment, as a first step towards assessing whether it is possible to transfer RTW interventions designed for workers with MSKD to workers with mental health problems.

2. Goals of study

Based on the body of knowledge and expertise developed in the area of work rehabilitation for workers with MSKD, the main goal of this article is to present the first results of an exploratory study aimed at determining the possible links between the RTW process for workers with MSKD and that for workers with mental health problems.

The specific goals of the study are:

– to describe the clinical activities conducted by the rehabilitation professionals in a work rehabilitation program which address the psychological factors, work environmental factors and those related to the involvement of the various stakeholders during the rehabilitation process (the Sherbrooke Model implemented in a natural environment) and which can be widely applied to workers with mental health problems, through a multiple-case analysis and mapping of interventions; and
to identify the links between RTW interventions carried out with workers with MSKD and those with mental health problems.

This project is the first stage in a process to design a program theory which seeks to identify and understand the essential parameters (the steps, clinical activities and their mechanisms of action) to be taken into account in the RTW process for people who are absent from work due to mental health reasons (Chen, 2004; Weiss, 1997). The next stage involves consulting experts on mental health in the workplace in order to validate the results obtained and identify the first parameters for the design of work rehabilitation programs for workers who are absent from work due to mental health problems. These first two stages correspond to Phase I of Campbell et al.’s framework for the design and evaluation of complex interventions (Campbell et al., 2000) i.e. the defining components of the intervention. The subsequent phases are: defining trial and intervention design for testing both the feasibility of delivering the intervention and acceptability to providers and patients (Phase II), methodological issues involved in the main trial (Phase III) and promoting effective implementation (Phase IV).

3. Methods

3.1. Context: the Therapeutic Return to Work (TRW) program

The described program, namely the Therapeutic Return to Work (TRW) program of the Centre for Action in Work Disability Prevention and Rehabilitation (CAPRIT) (Durand, Loisel, Charpentier, Labelle, & Hong, 2004; Durand, Vachon, Loisel, & Berthelette, 2003), is the application of the Sherbrooke Model in a natural environment (Loisel et al., 1997). Loisel et al.’s study involved a randomized clinical trial with the prior agreement of all stakeholders and the case management of workers with MSKD in an acute or subacute phase. In its application without control for cases, the program was offered more to workers in a chronic phase. It was then adapted based on the referrals received from the financial compensation system.

The TRW program is based on a well-documented theoretical model and is supported by evidence-based data on the return-to-work process (Durand et al., 2004, 2003). The theoretical principles underlying the model are the client-centred approach (Falardeau & Durand, 2002), evidence-based practice (Bury & Mead, 1998) and the disability paradigm (Loisel et al., 2001). The TRW program thus favours a global perspective which explains the multicausality of work disability (Loisel et al., 2001). It addresses the psychological factors, work environmental factors and factors related to the involvement of the various stakeholders during the RTW process.

- The psychological factors include the individual psychological and occupational factors described by Waddell, Burton, and Main (2003): poor perceptions of general health, psychological distress, depression, anxiety, fear avoidance, maladaptive coping, pain behaviour, psychological history, stressful life events, personality, alcohol and substance abuse, job (dis)satisfaction and worker disaffection, expectations about return to work.
- The work environmental factors include the structural and human dimensions of work: specific content of the task and work organization (physical, psychological and organizational demands), social relationships at work (relationship between employer and supervisor or co-workers) and the work organization culture (Durand et al., 2002; St-Arnaud et al., 2006).
- The factors related to the involvement of the various stakeholders in the rehabilitation process include all the interactions or concerted action between stakeholders and all systems (compensation system, health care system, work environment) etc. (Corbiere & Shen, 2006; Loisel et al., 2001; MacEachen et al., 2006).

The TRW program is designed for workers with MSKD whose condition has caused them to be absent from work for more than one month (on average: 9 months). The intervention lasts from eight to twelve weeks (individualized according to the needs of each worker) and is delivered on a daily basis. Interdisciplinary team work is the coordination model favoured. The clinical team is made up mainly of occupational therapists but also includes a kinesiologist, an ergonomist, a psychologist, a work rehabilitation physician and a clinical coordinator. Their interventions are mainly oriented towards a sustainable return, for the person with MSKD, to his role as a worker, by increasing competent work behaviours resulting from the successful interaction between the worker and the work environment (Durand et al., 2003). To this end, they seek to increase the worker’s work capacities, to reduce work environmental demands and to
promote concerted action by stakeholders involved in the work disability situation. The increase in work capacities is contingent on an increase in perceived health status, a reduction in fear of pain and movement, an increase in physical performance and an increase in the feeling of self-efficacy through the use of several therapeutic means, including gradual conditioning directly in the workplace. The rehabilitation professionals simultaneously consider the individual clinical and psychological variables, the variables linked to the work environment (workplace and organizational interventions) and those related to relations between stakeholders. In addition, they favour workplace-based interventions in order to validate the work demands, make work accommodations and gradually condition and expose the worker to work (Durand & Loisel, 2001).

3.2. Methodological approach used

The clinical activities conducted by the TRW program team, as well as their objectives and mechanisms of action, were described based on the pathway through the program of eight workers (6 men and 2 women), documented retrospectively through the word-for-word accounts of weekly team meetings. These data came from a larger study on decision making in a multidisciplinary team (Loisel, Durand, Baril, Langley, & Falardeau, 2004). This previous study involved 22 workers (15 men and 7 women) aged between 22 and 58, who had been absent from work for more than two months (2–24 months) due to an MSKD and who had received services under the TRW program for 7 to 37 weeks. Eight of these 22 workers were selected for the present analysis. They were selected on the basis of being representative of the diverse pathways taken through the program (with or without obstacles and according to different rhythms of progression) in order to ensure that all the clinical activities conducted by the TRW program team were considered.

Each of these eight cases was analyzed using a specific content-analysis methodology drawn from intervention mapping (Bartholomew, Parcel, Kok, & Gottlieb, 2006). Intervention mapping is a process that sheds light on the changes expected by the treatment team (i.e., improvements expected in the worker) and their underlying objectives and determinants, and creates a matrix from which to draw a diagram of the interventions delivered and their practical and theoretical rationale for each worker (i.e., how the interventions can be explained based on accounts and practical knowledge of clinicians and the theoretical models of the literature). Thus it is possible to clearly highlight the specific mechanisms of action behind the rehabilitation and return-to-work interventions.

As a result of the analysis of the individual pathway taken in each case, a global matrix was created to describe all of the TRW program interventions. More specifically, the global matrix was created by moving back and forth between the analysis of each case and of all the cases combined together. Each new case thus fed information to the global matrix until the point of saturation (i.e. up to the point when a new case no longer brought any additional information to the synthesis). Thus, it was possible to bring to light the clinical activities conducted and their rationale, but also to consider in the analysis the workers’ real trajectory in a complex system of interactions between the stakeholders and the continuous adjustments made by the clinical team to ensure a successful process (which was sometimes achieved (success) and sometimes not (failure)). The analysis was conducted by a researcher in the team (first author) working in the field of psychosocial rehabilitation (rather than in the field of physical work rehabilitation) and was thus influenced by this type of theoretical background. The idea was to allow the preconceptions of this psychosocial perspective to operate in order to induce the linkage between these two fields of expertise, based on common rehabilitation principles.

Intervention mapping (Bartholomew et al., 2006) was used in this project to identify the general objectives, the specific objectives and the clinical activities favoured by the TRW program team. However, the personal and external determinants which account for the choice of objectives and clinical activities could not be systematically identified based on the word-for-word accounts of weekly team meetings. Additional meetings with the clinicians are planned in order to more specifically identify these determinants and to ensure that at the meetings with the experts, which will take place in the next stage of the project, all the transfer elements will be included in the discussion.

4. Results

The results (see Table 1) led to the identification of four steps in the TRW process and several rehabilitation models which can serve as a link between these two fields (Anthony, Cohen, Farkas, & Gagne, 2002; de las Heras, Llerena, & Kielhofner, 2003; Farkas, Sullivan-Soydan, & Gagne, 2001; Fougeyrollas, Bergeron, Cloutier, Côté, & St Michel, 1998; Kielhofner, 2002).
### Table 1
General objectives, specific objectives and clinical activities of the TRW Program

#### Step 1: Evaluate the work disability situation

<table>
<thead>
<tr>
<th>General objective</th>
<th>Clinical activities</th>
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| 1.1 Identify levers and obstacles to return to work | **Interdisciplinary work:**  
  - Work Disability Diagnostic Interview  
    - demographic characteristics and work history;  
    - pain syndrome;  
    - general health and previous health history;  
    - family and social history, including financial situation;  
    - medical history and physical examination;  
    - work environment, including working relationship, perception of work demands, litigation;  
    - patient perception of disability status, including perceived barriers and facilitators to return to work, fears and apprehensions;  
    - standardized questionnaires (Psychological Distress Index, Work APGAR, Oswestry Disability Index, Fear-avoidance Belief Questionnaire, etc.)  
  - Evaluation of physical condition and work capacities  
  - Discussion with the various stakeholders, including the worker  
  - Work environment visit |

#### Step 2: Increase the readiness to commit to the return to work

<table>
<thead>
<tr>
<th>General objectives</th>
<th>Specific objectives</th>
<th>Clinical activities</th>
</tr>
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</table>
| 2.1 Infer the need for commitment | 2.1.1 Increase awareness of self and one’s environment (first level)  
  - Strengths and limitations  
  - Interests and values  
  - Constraints and possibilities | Knowledge conditioning:  
  - Information (informal)  
  - Psychological conditioning:  
    - Belief/attitude adjustments  
  - Occupational conditioning:  
    - Work simulation (first contact with reality)  
    - Work environmental interventions:  
      - Worksite visit+contact with employer and supervisor to gradually expose the worker (therapeutic means) |
| 2.2 Increase feeling of self-efficacy | 2.2.1 Reduce apprehensions and worries/fears about the return to work | Knowledge conditioning:  
  - Information (informal)  
  - Psychological conditioning:  
    - Psychological support/reassurance  
    - Belief/attitude adjustments  
    - Pain and stress management (relaxation+coping strategies)  
  - Occupational conditioning:  
    - Work simulation (first contact with reality)  
    - Work environmental interventions:  
      - Worksite visit+contact with employer and supervisor (therapeutic means)  
      - *If excessive anxiety, sleep disorders, depression => external consultation*  
  - 2.2.2 Increase confidence in one’s capacities | Psychological conditioning:  
  - Psychological support/reassurance+support between peers  
  - Belief/attitude adjustments  
  - Occupational conditioning:  
    - Work simulation (positive reinforcement+experiences of success) |
| | 2.2.3 Re-activate work habits | Physical conditioning:  
  - Re-activation program+physical reconditioning  
  - Work simulation (re-appropriating a regular work schedule+ learning to cope with pain during work) |
**Table 1 (continued)**

### Step 2: Increase the readiness to commit to the return to work

| 2.3 Create a favourable context | 2.3.1 Ensure a coherent discourse between various stakeholders | Interactions between stakeholders:
  - Telephone contact and joint meetings with stakeholders (information sharing, clarifying medical–legal issues, reassuring some stakeholders)
  - Work environmental interventions:
    - Clarify employment relationships + identify the main employer where the worker will return to work
    - Telephone contact and meetings with the employer + workplace visit

| 2.3.2 Re-activate the employment relationship | | |

### Step 3: Support active commitment (mobilization) to return to work

| 3.1 Maintain readiness to commit to the process | 3.1.1 Avoid experiences of failure, disappointments over objectives not achieved | Interdisciplinary work:
  - Continuous analysis of worker’s progress, daily monitoring
  - Discuss his process with him
  - Look out for sign of overconditioning
  - Gradual increase in demands
  - Do not start workplace-based intervention too early

| 3.1.2 Encourage expression and management of emotions | Psychological conditioning:
  - Psychological support/reassurance (individual + group sessions)
  - Stress management (coping skills, relaxation, psychocorporal self-regulation technique)

| 3.1.3 Ensure meaningful process | Occupational conditioning:
  - Provide meaningful simulated work tasks
  - Conditioning in real work environment

| 3.2 Foster a realistic perception of the situation, adjustment of expectations | 3.2.1 Increase perception of health status (self-awareness – second level) | Knowledge conditioning:
  - Information (group sessions about physiology, pain mechanism, etc.)
  - Psychological conditioning:
    - Psychological support/reassurance/reflection, reframing (individual + group sessions)
    - Belief/attitude adjustments
  - Occupational conditioning:
    - Work simulation (contact with reality)
  - Interactions between stakeholders:
    - Contact with GP
    - Limit discourses promoting the diagnostic label and increasing somatization

| 3.2.2 Increase worker’s self-regulation skills (self-awareness – third level) | Knowledge conditioning:
  - Teaching techniques of safe movements, energy saving, etc.
  - Psychological conditioning:
    - Psychological support/reassurance (individual + group sessions)
    - Reflection, reframing
    - Stress management (coping skills, relaxation, psychocorporal self-regulation technique)
  - Occupational conditioning:
    - Work simulation (application of techniques taught)

| 3.2.3 Provide the worker with a common coherent and clear message | Interdisciplinary work:
  - Regular contact with various stakeholders (information on impact of incoherent discourse)
  - Team meeting with worker and insurance company representative

| 3.3 Create a context conducive to return to work | 3.3.1 Ensure all available levers for a successful return (reduce obstacles to the return to work) | Interdisciplinary work:
  - Continuous analysis of levers and obstacles
  - Weekly team meeting
  - Interaction with stakeholders:
    - Negotiation with stakeholders-obstacles
    - Alliance with stakeholders-levers

(continued on next page)
Table 1 (continued)

| 3.3.2 Ensure concerted action among stakeholders | Interaction with stakeholders:  
| | • Regular contact (in writing, by telephone, etc.)  
| | • Discussion between stakeholders + proposal of a precise and concrete plan of action  
| | • Negotiation as needed  
| 3.3.3 Ensure employer’s collaboration for a progressive return | Work environmental interventions:  
| | • Meeting with employer for information sharing, reassurance, negotiation  
| | • Frequent meetings to establish a plan of action for progressive conditioning in the work environment  
| 3.3.4 Ensure collaboration of co-workers and supervisor | Work environmental interventions:  
| | • Meetings in the work environment  
| | • Document the situation prior to absence from work + their perception of the situation  

| 3.4 Support the worker as he returns to his role as worker | 3.4.1 Empower the worker in the process | Psychological conditioning:  
| | | • Precise plan (or even written contract) with worker  
| | | • Incentive to the worker to make contact and take steps required (reframing as needed)  
| | | Interaction between stakeholders:  
| | | • Team meeting with the insurance company representative and worker  
| | 3.4.2 Maintain work habits and develop safe work habits | Physical conditioning:  
| | | • Pursue physical reconditioning program  
| | | Occupational conditioning:  
| | | • Work simulation + workplace-based interventions (regular work schedule + application of techniques taught)  
| | | • Work environmental interventions:  
| | | • Therapeutic means + work accommodation  
| 3.4.2 Re-integrate progressively into the work | Psychological conditioning:  
| | | • Psychological support/reassurance  
| | | Occupational conditioning:  
| | | • Workplace-based interventions  
| | | Work environmental interventions:  
| | | • Meeting with employer for re-integration plan  
| | | • Ensure collaboration of co-workers and immediate supervisor  

Step 4: Maintaining work

| 4.1 Reduce risks of relapse | 4.1.1 Ensure safe work site | Work environmental interventions:  
| | | • Work environment visit + meeting with immediate supervisor and co-workers  
| | | • Ergonomic analysis of worksite (type of work, demands, production targets, etc.)  
| | | • Discussion with employer  
| | | • Procedure for purchase of more appropriate equipment (call for suppliers, find documentation, etc.)  
| | | Interaction between stakeholders:  
| | | • Meeting of employer with the insurance company representative to put forward recommendations for equipment + concrete proposal for change put to employer  
| | | • Negotiation with employer and insurance company representative  
| 4.1.2 Increase worker’s self-regulation skills and self-assertion | Knowledge conditioning:  
| | | • Teaching techniques of safe movements, energy saving, new equipment maintenance, etc.  
| | | • Information on rights  
| | | Psychological conditioning:  
| | | • Psychological support  

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4.1. Step 1: evaluate the work disability situation

The first step involves the process of evaluating the work disability situation. The concept of disability situation refers to the result of the interaction between the worker’s individual characteristics (impairment and disabilities) and the obstacles deriving from environmental factors (Disability Production Model) (Fougeyrollas et al., 1998). This situational interaction can thus produce disability situations in terms of lifestyle habits. Lifestyle habits ensure the survival and development of an individual in society. The fact of working (or not working) is part of this. Thus, in order to clearly define the worker’s situation (and intervene), the clinical team of the TRW program ensures that all the levers and obstacles to the worker’s return to work are identified throughout the rehabilitation process. To this end, several tools are used, including the Work Disability Diagnostic Interview (WoDDI) (Durand et al., 2002). The WoDDI reports on the multicausality of the worker’s situation by systematically documenting all of the parameters likely to limit or facilitate the worker’s return to work (see Table 1—Step 1). The WoDDI brings together information on the worker (medical, historical, psychological and related to lifestyle habits), his work environment and his family and social situation, thus allowing for the combination and interaction of effects to be identified in the analysis of the obstacles to the worker’s return to work. The clinical team of the TRW program can then identify the interventions which should be given priority and the levers on which to rely. The standard methods of evaluating the worker’s physical condition and capacities for work, discussions with all of the stakeholders (attending physician, insurance company representative, employer and immediate supervisor, worker) and workplace visits also inform the team’s weekly discussions. This evaluation process is conducted before the return-to-work interventions but also throughout the RTW process to allow for re-adjustments and progression in the understanding of the worker’s specific situation.

4.2. Step 2: increase the readiness to commit to the return to work

The second step involves interventions to prepare for the worker’s return to work by increasing his readiness to commit to the rehabilitation process (Concept of Rehabilitation Readiness) (Farkas et al., 2001). As a result of prolonged absence from work (or a disability situation constructed over several months or years), the worker is often caught in a vicious circle of demotivation and deconditioning. Gatchel, Adams, Polatin, and Kishino (2002) refer to the impact of secondary losses that occur in situations involving physical disabilities and absence from work. These include physical losses (for example loss of a capacity) but also, and especially, symbolic losses (for example, loss of a social role or an identity, or decline in self-esteem) which lead to a series of events and impacts on all of the worker’s lifestyle habits and can cause demotivation (or even depression). The work of the clinical team is thus essential in order to stop this downward spiral, which is devastating for the worker’s volition, that is, his motivation which pushes him to take action in view of a return to work (Model of Human Occupation of Kielhofner and the Remotivation Process of de las Heras et al.) (de las Heras et al., 2003; Kielhofner, 2002; Kielhofner et al., 1999).

The clinical team of the TRW program thus attempts to intervene through several means:

- at the level of perceptions (or cognitions) by promoting awareness of self and one’s environment (Objective 2.1.1), reducing fears and apprehensions (Objective 2.2.1) and increasing confidence in one’s capacities (Objective 2.2.2);
- at the level of actions (or behaviours) by promoting the re-activation of lifestyle and work habits (Objective 2.2.3);
- at the level of environmental context by ensuring a coherent discourse (that does not provoke anxiety) among stakeholders (Objective 2.3.1) and the employer’s collaboration by maintaining the employment relationship (Objective 2.3.2).
The therapeutic activities which allow the team to achieve these objectives include interventions focused on increasing knowledge (knowledge conditioning), as well as cognitive behavioural approaches centred on adjusting perceptions and developing coping strategies (psychological conditioning), but also interventions related to putting the worker in contact with the reality of work and into action through a visit to the workplace and simulation of work tasks (occupational conditioning). The change in behaviours is thus based on a realistic perception of the situation and the effective means to deal with this situation but, especially, on experimenting with real work tasks. Work simulation is thus used as a means to regain confidence in one’s capacities by trying out certain tasks perceived to be more difficult, learning to cope with residual symptoms in the work situation (for example pain), gradually increasing work demands in order to establish a regular work schedule and experimenting with successful situations. The assurance of an employment relationship can, in such circumstances, be an important lever, based on which the workplace visit can be envisaged. This allows the worker to come to the realization that he is expected to return and that the workplace is ready to welcome him back.

The establishment of a coherent discourse among the various stakeholders is also a major issue. The negative impact of lack of cohesion between medical-administrative practices and support measures as well as the detrimental effects of requests for medical expertise no longer need to be demonstrated (Baril et al., 2003; St-Arnaud et al., 2003). An incoherent and divergent discourse among the stakeholders will break the relationship of trust, create anxiety in the worker and worsen the downward spiral (loss of control and of meaning in this case) provoking a feeling of abandonment and anguish. The establishment of a favourable context and the hope of a better future (which leads to mobilization) are thus essential before engaging in the third step of the process.

4.3. Step 3: support active commitment to return to work

The third step involves interventions to support the worker’s active commitment to return to work (maintaining his mobilization and fostering action). This step builds on the preceding step by pursuing the adjustment of perceptions and expectations about the return to work (Objectives 3.2), by actively supporting the worker as he returns to his role as a worker (Objectives 3.4) and by creating a context which is conducive to concerted action among stakeholders and, more particularly, to the collaboration of the employer, immediate supervisor and co-workers in the return-to-work process (Objectives 3.3).

The adjustment of perceptions and expectations aims more specifically at the worker’s perceived health status (Objective 3.2.1) and self-regulation skills (Objective 3.2.2) which allow him to develop healthy and safe work habits related to his strengths and limitations (Objective 3.4.2). Support for the worker as he returns to his role as a worker is based on principles of empowerment where effort is made to help the worker regain full control over his life (particularly over his work situation) through a rehabilitation process centred on his needs and on his participation and autonomy in the process (Objective 3.4.1) (Anthony et al., 2002). Progressive conditioning in the work environment is one of the key elements in this process (work environmental interventions). Indeed, the work environment is rapidly integrated into the process in order to stop the mounting spiral of apprehensions and fears that the worker may be caught in regarding his return to work. This practice acts as a therapeutic means of gradually exposing the worker to the anxiety-provoking situation and putting him into action (as long as the work environment acts as a lever to his return to work rather than as an obstacle) (Durand & Loisel, 2001). The worker can thus regain confidence in his capacities as a worker, take up his place again at work and reconstruct his socio-professional identity as a worker. Work thus once again becomes a source of self-worth, social status and control over his environment (rather than a source of pain and apprehension). However, the essential condition leading to this positive and therapeutic effect is the establishment of a favourable and flexible context. Moreover, St-Arnaud et al. (2003) emphasize that it is important to know the environment to which the worker is returning and how he left it. Thus, the clinical team of the TRW program spends a substantial amount of time meeting with the employer, immediate supervisor and co-workers in order to organize a return to work that is as smooth and as positive as possible, without misunderstandings or prejudices, while respecting the tacit rules established by the work environment. Obviously, all of the stakeholders must agree with the plan of action and, in particular, must be sensitive to the precarious context to which the worker is returning, and to the sometimes highly strategic actions of the clinical team. The internal and often informal principles surrounding a worker in his work environment can foster healing and integration but can also be destructive by marginalizing and isolating him. They might also have contributed to the absence from work and the disability situation experienced by the worker. The clinical team of the TRW program thus acts tactfully in order to ensure the development of a favourable context and the collaboration of all stakeholders, and to seek to remove the worker from the medical-administrative and
economic principles which often govern this type of rehabilitation process. The success (or failure) of the return-to-work process seems moreover to be based on the establishment of this partnership, which is a result of sometimes extensive negotiation (or mediation).

4.4. Step 4: maintaining work

Lastly, the fourth step involves interventions to help the worker maintain his employment. They are rather brief and centred on the consolidation of past gains (Objectives 4.1.1–4.1.2) as well as on the ergonomic analysis of the worksite to ensure that the work is safe and that the risk of relapse is low (Objective 4.1.3). Thus, the focus is on continuing the conditioning directly in the work environment and on meetings with the employer (and the insurance company, if necessary) to put forward recommendations for work accommodations (adding equipment, modifying the work routine, increasing work space, etc.).

It should be mentioned that in a real situation, all steps (and substeps) are interlinked without any particular chronological order having been determined beforehand. For example, the ergonomic analysis of the worksite is often conducted earlier so that there is enough time to make adjustments and try them out in the presence of the occupational therapist or the ergonomist.

This very detailed description of the clinical activities of the TRW program team allows for a better understanding of the objectives and mechanisms of action underlying the work rehabilitation process and from it we can ascertain that these activities do not lead to the identification of the nature of the worker’s impairment. The therapeutic activities conducted are guided by rehabilitation principles and models and lead to interventions which are informed by a comprehensive understanding of the work disability situation and to concerted action to serve the worker’s needs, regardless of the type of disorder. Despite a different context and different principles underlying the offer of services, workers who are absent from work due to mental health problems should benefit from the experience and practices related to workers with MSKD.

5. Discussion

This study sought to establish a link between workers who are absent from work due to MSKD and those who are absent from work due to mental health problems, in order to lay the basis for the design of return-to-work programs in the area of mental health, based on a person-environment dynamic.

The multiple-case analysis based on intervention mapping showed that, regardless of the nature of the impairment, the psychological variables, work environmental variables and variables related to concerted action among stakeholders mainly guide the interventions aimed at work rehabilitation. The work disability situation experienced by workers who are absent from work for a long period of time due to an MSKD is mostly caused by variables not related to their initial injury. Clinical activities oriented towards a global analysis of the work disability situation, readiness to commit to a rehabilitation process, the perception of the situation and the adjustment of expectations, the feeling of self-efficacy, a return to one’s role as a worker and the establishment of a favourable context should also be favoured, in relation to workers with mental health problems.

5.1. Designing a Work Disability Diagnostic Interview (WoDDI) — relevant to mental health problems

First of all, a tool such as the WoDDi (Durand et al., 2002) could be highly useful for this clientele. According to St-Arnaud, St-Jean, and Damasse (2004b), St-Arnaud et al. (2003), the following variables should be considered when using this tool:

- the previous history and the events which preceded the absence from work (psychological vulnerability, stressful events outside of work, work organization);
- the process of restoring capacities (treatment and acceptance of illness, meaning of withdrawal from work, self-esteem and feeling of self-efficacy, fears and apprehensions about the return to work, effects of other people’s views, type of disorders, support from actors involved in the medical-administrative management of the absence, incoherent discourse and requests for expertise, work environment and possibilities for change);
– the return to work (progressive return, working conditions to which the worker is returning, receptiveness and support from co-workers and supervisors, stigmas and prejudices, social network).

The implementation of work accommodations adapted to the needs of workers who are absent from work for mental health reasons should also be considered. Corbière and Ptasiński (2004) propose a measuring tool to identify the accommodations which are available and which would be helpful for the worker in his work environment.

5.2. Promoting the establishment of a favourable return-to-work context

In addition, the clinical activities suggested by the TRW program team in order to promote the establishment of a favourable context are worth considering in the case of workers who are absent from work due to mental health reasons. Through different means, the TRW program’s rehabilitation professionals ensure that the employment relationship remains activated and that there will be collaboration on the part of the employer, immediate supervisor and co-workers. Moreover, St-Arnaud et al. (2004a) assert that it is important to take greater account of the work environment and the conditions surrounding the absence from work and the return to work in the work rehabilitation process of workers with mental health problems. In their view, the worker who comes back to work under the same working conditions as those which contributed to his withdrawal from work (overload, non-recognition, harassment and/or work conflict), will see his return and the possibility of maintaining employment as being jeopardized. Moreover, the role of the immediate supervisors should not be overlooked in this process. Nieuwenhuijzen, Verbeek, de Boer, Blonk, and van Dijk (2004) demonstrate a significant association between the role of supervisors and the success or failure of the return-to-work process. Nevertheless, the immediate supervisors very often lack training and the latitude needed to properly guide the workers to an effective return to work (James, Cunningham, & Dibben, 2002). Co-workers’ attitudes and views about the absence from work are also important. The opinion and judgment of other people, in particular regarding diseases or disorders which are more subtle than work-related physical injury, are important to the process by which the worker regains self-confidence and re-appropriates his place and his status as a worker and member of a community which gives meaning to his life (St-Arnaud et al., 2004a, 2003). The type of actions taken by the TRW program team can serve as a guide for achieving this.

5.3. Integrating work and working conditions into the intervention

Individual clinical activities proposed by the TRW program team, which are psychological and occupational in nature, are, in part, similar to the programs found to be effective for workers who are absent from work due to mental health problems. The three studies, which document interventions which helped to reduce these workers’ duration of absence from work (McCulloch et al., 2001; Nieuwenhuijzen, Verbeek, Siemerink, & Tummers-Nijsten, 2003; van der Klink et al., 2003), suggest similar support centred on the development of individual coping skills and on increasing the capacity to manage work demands. However, few, if any, clinical activities are used to encourage workers to resume their work habits and roles ‘in vivo’, for example, through progressive conditioning directly in the work environment (with or without the therapist). St-Arnaud et al. (2003) mention that, for workers with mental health problems, it is important to integrate work as a useful instrument into the reconstruction of health and the capacity to work. All of the variables involved in the absence from work which increase the worker’s anticipation of, and fears and apprehensions about the return to work must be taken into account in the worker’s reconstruction process (St-Arnaud et al., 2003). To enable the worker to regain confidence in his capacities and the feeling of self-efficacy (Bandura, Cioffi, Taylor, & Brouillard, 1988) and to integrate work and the working conditions into the intervention, beyond a standard medical and psychological intervention, the worker must also be accompanied during his real return to the work environment. In this way, the worker will be able to gradually return to his workplace and to his role as a worker, and the rehabilitation professional will be able to create a context which is conducive to the best possible working conditions. Given the more personal nature of mental health disorders and the consequences related to their disclosure, the best way to deal with this issue, however, needs further thought. How can work and the various dimensions (St-Arnaud et al., 2006) of the work environment be integrated into the rehabilitation process without isolating the worker who is highly likely to be subject to prejudices and marginalization?

The limitations of such a process include: how can the role of the various stakeholders and the possible level of intervention in the work environment be situated? Should interventions related to primary (and secondary) prevention
which act more specifically on the pathogenic elements of the organization be integrated into a worker’s return-to-work process? Interventions which are specific to and clearly identified with a worker based on his working conditions should not be overlooked (or even denied). However, they must be delivered in a very tactful way. The programs for workers with MSKD mainly target the organization of work tasks in order to reduce the demands and adapt them to the worker’s situation. By involving the various stakeholders in the return-to-work process (employer, immediate supervisor, co-workers) and giving them information and listening time, these programs also act upon perceptions and prejudices with regard to the situation, while complying with the organization’s rules, whether formal or informal, sound or unsound.

5.4. Specific challenges for workers with mental health problems

The return-to-work context of workers with mental health problems certainly gives rise to several issues and challenges to be dealt with. First, under the compensation system, responsibility and power in the RTW process are shared out differently, thus leading to quite different principles underlying action and the offer of services. In the context of Canada (but which can certainly be generalized to other countries), the principles underlying the offer of services for workers who are absent from work due to MSKD and for those who are absent from work due to mental health problems differ greatly. On the one hand, the services offered to workers with physical disabilities are organized in close collaboration with the medical and rehabilitation teams and in frequent collaboration with the employer, under the governance of workers’ compensation systems. On the other hand, the services offered to workers with mental health problems are restricted to a medical follow-up (sometimes psychological, through employee assistance programs or in private practice) which is completely independent and involves very little collaboration with the employer. The rehabilitation teams are rarely involved with this clientele and employers do not feel responsible for their workers’ mental health. Yet, the risk of these workers not returning to work is quite considerable.

The establishment of structures (laws, rules and procedures), the commitment of appropriate resources and the development of common principles and shared values with regard to work rehabilitation are all essential to the success of a return-to-work process. The use of the disability paradigm (and other rehabilitation models) in understanding work disability could help to address not only the symptoms but also all of the person’s circumstances thus genuinely supporting him in regaining his quality of life. Adding new actors who are more willing to act in this way should be considered (e.g. rehabilitation teams).

The “invisible” and marginalizing nature of mental health problems also suggests that the interventions should be considered in a different light, taking into account the wider reality of the worker and his work environment by providing training to the clinicians and stakeholders involved in the workplace and by questioning the practices and the mechanisms of action that are currently used. For workers with mental health problems, the challenge is to ensure that both the recovery process (defined in a different way for workers with MSKD) and the best time for starting the RTW process are respected by the various actors involved.

Regardless of the type of illness affecting a worker, he is entitled to a healthy environment which is conducive both to his regaining confidence in his capacities and to his return to work, and which is stimulating for his personal and social development (thus to his retaining his employment in good health). To exclude a person from the work environment (deliberately or otherwise) is to deprive him of important benefits in terms of his social integration and his quest for identity (income, social status, time and space management, interpersonal relations, key role, achievements and meaning of life) (Brown et al., 2001; Limoges, 1987).

6. Conclusion

The goal of this study was to initiate an examination of the first parameters for the design of return-to-work programs for workers who are absent from work due to mental health problems. The results confirm the importance of adopting a common understanding of rehabilitation and of how the work disability situation is produced which takes into account the complex and multi-causal nature of work disability, i.e. the interaction between the dimensions of the person and of all the systems involved in the rehabilitation process. The body of knowledge and expertise developed for workers with MSKD, particularly the interventions designed to foster the feeling of self-efficacy, the return to one’s role as a worker, and the establishment of a context which is conducive to a return to work, should be considered in the design of work rehabilitation programs for workers who are absent from work due to mental health problems. The clinical activities proposed and their mechanisms of action are consistent with the recommendations made for these
workers. Work and the work environment can no longer be excluded from the work rehabilitation process for this clientele. However, the role of the various stakeholders needs to be clarified and the involvement of new actors should be considered. The services currently offered do not meet the needs of workers and organizations. Thus, there is scope for innovation and change in paradigms and structures.

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References


