Overview of Session # 1 of the Newfoundland and Labrador Dialogue on Return to Work, November 10, 2022.

This document provides an overview of some of the presentations and discussion at Session 1 of the Dialogue. We will add summaries of the other sessions to this document as they come available and integrate them into the final report.

A reminder that session recordings (of just the presentations) are being posted to the SafetyNet website for those who missed the session or wish to revisit the presentations in full and for others interested in RTW in the future.

The link for the Session 1 recording is: https://www.youtube.com/watch?v=L_S-ZiUKiyM

A quick reminder of the overall goals and objectives of the NL Dialogue on Return to Work. These include:

a) transferring to Newfoundland and Labrador key findings from recent and ongoing research on return to work being carried out in other parts of Canada;
b) reflecting on the potential relevance of these findings for our understanding and approach to RTW in Newfoundland and Labrador;
c) presenting and providing an opportunity for multi-stakeholder commentary on findings from an environmental scan of policy and practices related to return to work across Canadian provinces compared to NL; and,
d) an opportunity to discuss overall insights from the dialogue and future research priorities on return to work in NL.

The Dialogue is co-sponsored by the *Policy and Practice in Return to Work Partnership* (PPRTW) based at the University of Ottawa and by Memorial University's SafetyNet Centre for Health and Safety Research. The PPRTW Partnership is jointly funded by the Social Sciences and Humanities Research Council and by the Canadian Institutes for Health Research. Originally established and led by the late Professor Katherine Lippel, Distinguished Research Chair in Occupational Health and Safety Law, PPRTW focuses on particular challenges around return to work for growing segments of the Canadian (and Newfoundland and Labrador) labour force. These segments include the precariously employed, immigrant workers, and internally and internationally mobile workers including temporary foreign workers.

Session # 1

Stephanie Premji

Session # 1 opened with a presentation by Professor Stephanie Premji of McMaster University and co-lead of PPRTW. Stephanie introduced the Partnership and presented on her research on return to work among recent immigrants in Toronto. Racialized immigrant workers, including international students, comprise a growing share of the Canadian and NL labour force. Existing research indicates they tend to be at high risk of injury and illness and experience particular challenges with accessing compensation and return to work supports. These workers are often precariously employed and this, combined with lack of knowledge about their rights, constraints on their access to appropriate health services, linguistic and other challenges, need to be taken into account when identifying ways to protect their health *and*

improve their access to compensation and to return to work after injury. Stephanie reported that their research has identified ways delayed and non-reporting of work-related injuries can impact multiple things including access to workers' compensation and ability to recover and rejoin the workforce due to lack of access to return to work supports. RTW challenges for these workers relate to limited access to suitable modified work; shortcomings in retraining programs related to labour market re-entry; and the exclusion of immigrant injured workers from decision-making processes.

Claim suppression was one of the issues raised by Stephanie. This led to a discussion, later in the session, around definitions of claim suppression that need more dialogue.

Stephanie also discussed a guide on language barriers they had developed as part of their research. That Guide is open access and can be found here: https://macsphere.mcmaster.ca/handle/11375/25331. Professor Premji can be contacted via email at spremji@mcmaster.ca if you have further questions about the particular challenges of immigrant workers and available resources for addressing those challenges.

Kim Cullen

Kim Cullen is the co-director of the SafetyNet Centre for Health and Safety Research at Memorial and former research scientist at the Institute for Work and Health in Toronto. She has more than 20 years of experience working in the field of return to work.

Kim presented a high-level synthesis of the findings from systematic reviews of return to work scientific research that sought to answer the question: what do we know about what works in return to work? These systematic reviews focused on what workplaces and system partners (compensation agencies, safety sector councils) can do to help workers with mental health and musculoskeletal injuries return to work by reducing the time away from work, costs associated with time away, and ways to improve work functioning when back. The research indicates there are three types of intervention approaches that tend to be helpful: 1) health-focused interventions; 2) service coordination interventions involving improved communication, planning and coordination and helping workers to navigate the system; and 3) work modifications such as changes in duties and other types of interventions. **A key finding from this research is, however, that these approaches do not work well in isolation. This suggests you need an individualized approach that draws from each of these areas to customize the experience of each injured worker.**

Kim noted that while this sounds simple, it can be really complex and challenging to achieve because of numerous barriers in each of these areas including, for example, barriers to access to health care services and the quality of those services that vary across types of work and workers. There are also service coordination barriers such as problematic internal workplace dynamics and challenges around access to training and other services that can delay return to work. Similarly, there are potential barriers to achieving appropriate work modifications that tend to be greater for older workers, within small workplaces and in certain types of industries such as remote work and work offshore where workplace demands may be dynamic and changes related to, for example, weather that can affect the work that needs to be done.

So, what works in return to work? You need multidisciplinary, well-coordinated and individualized approaches tailored for different groups of workers, types of work and work contexts.

Chris McLeod

Chris McLeod from the Partnership for Work, Health and Safety at the University of British Columbia was the third speaker. At the Partnership, they have been studying policy and practice around return to work using linked administrative data from WorkSafeBC and other types of data for two decades.

Chris reported on some of the findings from their program of research on the effectiveness of gradual return to work, including work led by Ester Maas. Chris's presentation focused on gradual return to work including:

a) trends over time in the proportion of workers on compensation for musculoskeletal injuries who are offered gradual return to work in BC;

b) variability in the likelihood workers will be offered gradual return to work across sectors, types of workplaces, nature of injury and worker demographics; and,

c) the question of whether gradual return to work improves the likelihood of sustained return to work?

The team uses linked data from compensation claims, demographic, health care and other data without which these kinds of analyses would not be possible. These linked data allow them to study the effectiveness of policies at a population level.

The research showed an overall increase in the proportion of workers compensated for musculoskeletal injuries offered gradual return to work over time, so that by 2015 roughly half of the workers received offers of gradual return to work.

In terms of sectors, there was an upward trend across all sectors but some sectors were much more likely to offer gradual return to work than others. The lowest rates of gradual return to work were found in primary resources, construction and transportation and warehousing.

Large employers were more likely to offer gradual return to work than smaller employers and workers with fractures, middle aged workers and female workers in BC were more likely to be offered gradual return to work that those with other types of injuries, in other age groups and male workers.

What do we know about what is happening in NL around trends in offers of gradual return to work and access to gradual return to work for these different populations?

Chris noted that it is challenging to answer the question about how well gradual return to work works as a strategy to improve time off or the sustainability of return to work. While more research is needed, their study of a large sample of people with musculoskeletal injuries that compared similar types of workers/injuries who were offered and not offered gradual return to work **found that graduated return to work "can be a good strategy for some workers who continue to have ongoing impairments." It is not effective for everyone in every circumstance; it is effective for claims of longer duration, representing moderate or severe injuries; and could have significant impact on overall work disability duration for those off work for 30 days or more.**

Following the three presentations of academic research findings on return to work, two leading experts in return to work reflected on the main messages in the presentations and on their own extensive experience in the field.

Alec Farquhar

Alec Farquhar, formerly with the Office of the Worker Advisor in Ontario, gave a presentation entitled *Key pillars for successful return to work*. He noted that he has been part of some big RTW collaborations, from which much can be learned.

Alec's pillars for successful RTW include:

Pillar 1: developing a strategic framework for effective return to work:

a) that integrates return to work with primary and secondary prevention (as opposed to concentrating it in HR);
b) is based on collaboration around prevention. The latter can contribute to a workplace culture more supportive of disability disclosure and accommodation;
c) where all workplace parties and external parties including health care providers are included in the strategy; and,
d) where the case for change around RTW should be based on measures that are meaningful in the workplace that are broader than claims data and encompass surveys of workers.

Pillar 2 relates to engagement of employers *and* unions in return to work structures ideally using a well-supported collaborative approach encompassing education and awareness-raising and going beyond simple internet presentations and tests to processes that help workers and employers 'place themselves in workers' shoes.'

Pillar 3 includes the need to address individual cases in a broader context to encourage transferring learning from one case to another while maintaining attention to individual needs and requirements. This includes actively addressing such barriers as language, gender, disability, and supporting these workers "in expressing their concerns and asserting their needs and rights." Linking RTW to broader inclusion and diversity initiatives can help ensure these issues are addressed. In addition, taking steps to ensure injured worker accommodations do not place additional burdens on other workers is important. Ideally the accommodations made for injured workers will benefit other workers as well through, for example, making workplaces safer and less stressful.

Pillar 4 highlights that in the case of complex, long-term cases, it is important to ensure access to support from WCBs; long-term disability support and access to training programs for alternative work that recognize the full range of skills and abilities of the injured workers involved. It is also important to learn from research findings such as those outlined here around who is likely to be offered graduated RTW (and why) and in which kinds of disabilities and contexts it is likely to contribute to sustained RTW.

Please note: After the session, Alec Farquhar shared with Barb a copy of a powerpoint presentation about a Niagara Health/ONA joint return to work program. The presentation, by Krystle Etherington, Pauline Lefebvre-Hinto and Loretta Tirabassi. The presentation provides an overview of a pilot project involving Niagara Health, a large health care area, three unions and the joint health and safety committee. Those interested in a copy of the presentation can access it from Alec. His email address is afarquhar7@gmail.com. It might be of particular interest to representatives (labour and management) from the health care sector and from other large, unionized organizations. Alec offered to organize a presentation by this group to those who might be interested.

John Beckett

John Beckett is VP Operations for the BC Maritime Employers Association. He runs a training activity focusing on movement of goods on and off vessels in the port of Vancouver and is responsible for strategic safety and rehab for his 50 members. John opened by indicating he has always tried to pride himself on moving forward on difficult issues and rehab and RTW is one of those areas.

John has always prided himself on trying to find a way to move forward on difficult issues like return to work. His background on rehab and return to work was implementing a system in a very large organization in a municipal environment based on putting in place a rehab and return to work system. They had done a good job on prevention but had not done a good job helping those who were hurt. His perspective as an employer is that you need to focus on both prevention and RTW because they are the flipside of the same coin. As an employer, you are assessed on how well you prevent injuries, but also on what you do to help people who get hurt. John also learned quickly that you have to focus not only on regulations and the law, but also on the injured worker.

Like Alec, John believes rehab and RTW systems only work if you are intentional in your intentions to try to get your employees whole and back to work. The focus is often on saving money but if you don't come at it with the right intent and focus you won't save money *and* you will create a negative culture. How do your employees know you are serious: by what you say, what you do and what resources you throw at the problem. You need to throw money at rehab and RTW but that is not enough. Rehab and RTW programs can be a key employee engagement system and could improve productivity and workplace culture.

John is an advocate for the BC workers compensation system and based on extensive experience both inside and outside that compensation system, he believes that it only really works when it is a balanced system. Furthermore, employers should not leave management of rehab and RTW to workers' compensation. It is a way to engage because it is in your best interest to make sure employees get back to work. He also feels it does not matter where people get hurt and so you need to develop a rehab and RTW system that works regardless of where people and the system that that is paying for it (insurance or comp) rather than having two different systems depending on the source of funding involved. The rules are different but you are looking for similar outcomes.

In terms of the roles of the workplace parties. If he starts with injured workers, there are three types: those who are willing to participate and want to get back to work (they are the majority); those who are afraid to participate and those who do not want to participate. His approach is to use the same process of engagement for all of these groups. Supervisors have a critical role in RTW but often injury changes that relationship.

Who should do rehab and RTW? We heard from almost every presentation – it is complicated. You need to have medical knowledge, compensation system knowledge, knowledge of the organizational culture, etc. so it cannot be done off the side of someone's desk, at least for large employers (the basis for his experience). You need to hire someone. The components of the approach need to include: having a rehab system that includes service coordination, work modification, a rehab plan versus program; that is coordinated, based on early intervention, stay at work if possible, and education of supervisors and

peers. A consensus-based approach is best but you have to do something. Also, advocate for your employees in the system when appropriate.

John concluded by reminding participants to keep in mind that they are not alone. There are some great tools in the system, including great documents from the Institute for Work and Health that encompass research to action.

(Check out, for example, the tools and guides page of the webpage of the Institute for Work and Health: Tools and guides | Institute for Work & Health (iwh.on.ca)).

Polling questions and responses:

During the first session, participants were given the opportunity to provide anonymous responses to a set of polling questions. The polling questions and response summary from Zoom is attached to this email for those who are interested. A couple of things to note from the polling report:

1. *There was a query about how the polling questions would be used in the Dialogue research. The only research that is happening through the Dialogue is the interprovincial, comparative environmental scan of policies and practices around return to work. The Dialogue itself is not a research initiative but a knowledge transfer and exchange opportunity and the polling questions were intended to address the constraints on dialogue in this first session created by the large number of presentations and large number of participants.*
2. *Among the things people felt they needed to know more about was the goals and objectives of the Dialogue. These were initially laid out in the Dialogue description document that went out with the invitation to participate but I have reiterated them at the top of this document. It is worth noting that since this is a dialogue, our objectives/focus may shift over the course of the sessions.*

The Q and A and Discussion

In this session, there was limited opportunity for Q and A and discussion due to the large number of presentations. Questions touched on the challenge of accessing appropriate healthcare for injured workers in NL and on whether panelists were aware of any RTW programs centred human rights in the process. There were also some questions about claim suppression including what constitutes claim suppression and penalties for claim suppression in NL. This is a complex topic that it would be good to explore in more depth in the future. In the meantime, those interested in this and the broader issue of under-reporting (which is much larger than claim suppression) might find this open access report from Manitoba useful:

Claim Suppression in the Manitoba Workers Compensation System: Research Report (wcb.mb.ca)