COMPARING DISABILITY MANAGEMENT STANDARDS AND GOOD PRACTICE GUIDELINES

SUMMARY REPORT

National Institute of Disability Management and Research™

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NOTE FROM THE RESEARCHERS

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The report presents the findings of a framework analysis of three international good practice guidelines, a national standard and a national law which provide guidance on disability management processes at system, organisational and individual levels.

If, as a reader, you have any contributions to make that you believe could add value in terms of missing or additional content, we would be very pleased to hear from you.
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MAIN ABBREVIATIONS

ACC	New Zealand Accident Compensation Corporation
BGG	Act on the Equalization of Disabled Persons
BTHG	Federal Participation Act
CBDMA	Consensus Based Disability Management Audit tool
CCMC	Commission for Case Manager Certification
CDMP	Certified Disability Management Professional
CDMS	Certified Disability Management Specialist
CPD	Continuing Professional Development
CRTWC	Certified Return to Work Coordinator
CSAS	Canadian Work Disability Management System Standard
CSA Group	Canadian Standards Association
DPOs	Disability Representative Organisations or Disabled Persons Organisations
DSGVO (GDPR)	Datenschutz-Grundverordnung (General Data Protection Regulation)
DM	Disability Management
DMP	Disability Management Professional
EAP	Employee Assistance Plans
EFAP	Employee and Family Assistance Plans
GP	General Practitioner
HCP	Healthcare Practitioner
HR	Human Resources
HRM	Human Resource Management
HRA	Health Risk Assessments or Appraisals
HRSDC	Human Resources and Skills Development Canada
ICF	International Classification of Functioning, Disability and Health
IDMSC	International Disability Management Standards Council
ILO	International Labour Organisation
ILOC	ILO Code of Practice on Managing Disability in the Workplace
ISSA	International Social Security Association
ISSAG	International Social Security Association Guidelines Return to Work and Reintegration
LTD	Long-term Disability

JR-SAW	Job Retention/Stay-at-Work
JTA	Job Task Analysis
KPIs	Key Performance Indicators
OH&S	Occupational Health and Safety
OHSMS	Occupational Health and Safety Management System
NIDMAR	National Institute of Disability Management and Research
NDMRC	Code of Practice for Disability Management – National Institute for Disability Management and Research 2004
OECD	Organisation for Economic Co-operation and Development
PCP	Person centred planning
PDCA	Plan-Do-Check-Act
RTWC	Return to Work Coordinator
RTW	Return-to-Work
STD	Short-term Disability
SGBIX	German Social Code Book IX
SAW	Stay-at-Work
TQM	Total Quality Management
UDL	Universal Design for Learning
UNCRPD	UN Convention on the Right of Persons with Disabilities
VR	Vocational Rehabilitation
WDA	Workforce Development Agreement
WDM	Work Disability Management
WHP	Workplace Health Promotion
WHO	World Health Organisation

EXECUTIVE SUMMARY

AIMS OF THE REVIEW

The importance of disability management (DM) is increasing due to numerous social developments. These include longer life expectancies and longer working lives, an emphasis on labor market inclusion as a whole, and efforts towards participation by almost every citizen in the open labour market. This review provides the first comparison of five existing documents that are intended to guide the development and implementation of DM. The aim is to provide insight into their themes and content. It is intended that the analysis can facilitate discussions about an international and uniform standard for DM that has a global relevance and to promote the progress of transnational discourse on DM by providing clarity on the terms and key words being used and documenting their potential impact on best practice.

FOCUS OF THE REVIEW

The documents that were selected for this review were produced between 2001 and 2020 and are the primary sources for good practice in work disability management internationally, in Canada and in Germany. Each has within it either an explicit or implicit definition and description of the meaning of DM. They specify good practice across a range of system and workplace policies, processes and procedures. The selected documents are following:

- The International Labour Organization's Code of Practice on Managing Disability in the Workplace (ILOC), published in 2001. The ILOC adopts a policy perspective based on a social partnership approach. The intention of the ILOC is to guide employers, worker representatives and competent authorities in a jurisdiction to establish a system for managing disability issues in the workplace.
- The National Institute for Disability Management and Research Code of Practice for Disability Management (NDMRC), published in 2004. The NDMRC is addressed to a person who is tasked with establishing DM processes within an employing organization. This was the first published guide to workplace disability management (WDM) program development and implementation. The primary focus of the Code is on the workplace and employing organizations.
- The ISSA Guidelines on Return to Work and Reintegration (ISSAG), published in 2013. The ISSAG is addressed to leaders in social security agencies and specifically the board and senior management. These are intended to reflect good practice in relation a proactive approach for social security systems to reduce the incidence or severity of disabling conditions, maintain the employment relationships for disabled employees and reduce inflow into or reliance on the social security system.

- Social Code Book IX (SGBIX) which came into force in July 2001 and has been updated over the years, most recently in 2018. It is a legal document which adopts a system administrator perspective. It addresses participation benefits across the lifespan. It sets out the German social policy and system framework to support the participation of persons with disabilities and those at risk of becoming disabled in all aspects of life.
- Canadian Standards Association Work Disability Management System Standard CSA Z1011:20 (CSAS), published in 2020. The CSAS adopts a quality-standards approach which is intended to address both managers and quality professionals within employing organizations. This specifies the elements of a workplace management system for managing work disability which reflects evidence-informed good practice.

Each document reflects the consensus view of international experts and stakeholders based on the state of the art at the time it was produced. As a result, the content and themes of the selected documents can provide insight into the good practice dimensions of DM which reflect the evidence base over a 20-year time frame. Each of the selected documents deals with different perspectives on DM and addresses it at macro, meso and micro levels.

There is little doubt that the frontline implementation of a DM process is experienced by workers within an employing organisation. Nevertheless, it is widely acknowledged that organizational culture and practices can be influenced by external factors such as the legal and policy context, the requirements of regulatory and administrative agencies and incentives and supports available to sustain good practice. A comparison of the approaches adopted in each of the documents can provide an appropriate frame of reference for an international standard on DM which integrates the perspectives and approaches adopt

METHODOLOGY

The starting point for the review comprised four overarching questions about the dimensions of the domain of DM.

1. **Scope** – What aspects of workplace policies and processes are considered to be within the remit of DM?
2. **Principles** – What underpinning values and principles are considered essential to good practice in DM?
3. **Elements** – What processes and components are addressed as being within the remit of a DM approach?
4. **Stakeholders/Actors** – What stakeholders and actors are addressed as being central to an effective DM strategy or process?

The approach adopted for the review involved an interpretive process. An analytic framework was generated based on current research and practice which specified a set of 60 items covering the Scope (9), Principles (13), Elements (20) and Stakeholders/Actors (18).

Every reference to an item was extracted from each of the documents and a comparative table was prepared. An iterative interpretative data-reduction process was applied to each table to distil the key concepts proposed in each of the documents. It transpired that the diversity of purpose, scope and responsible actors across documents created a challenge in identifying a consistent characterization of many central and supporting concepts. The fact that one of the documents was only available in German provided insight into some of the terminological and translation challenges that need to be addressed in generating an truly international standard.

MAIN FINDINGS OF THE REVIEW

A key function of a standard is to act as a knowledge transfer mechanism. The documents reviewed span a period of 20 years and there is little doubt that some concepts have remained stable over that period, while others have evolved.

The level of detail presented varied significantly across the documents under review. The themes that were addressed in the greatest amount of detail were:

- DM program
- Job Retention/ Stay-at-Work
- Return-to-Work
- Disability
- Accommodations
- The Role of Worker Representatives.

The themes for which relatively little detail was presented in any of the document were:

- Attitudes Towards Disability
- Claims Management
- Graduated Return to Work
- Management Champion
- Human Resources
- Co-Workers
- Worker's Family
- Private Insurance
- Health and Psychosocial Service Providers.

ISSUES IDENTIFIED BY THE REVIEW

A number of issues arose during the interpretive process which would need to be resolved as part of the development of an international standard on DM.

Variation in Terminology: One challenge that arose in the early stages of the data extraction process was the variance in terminology between documents. This was particularly challenging in translating terms into German.

Level of Detail: While recruitment/onboarding, career advancement and promotion were clearly viewed as being within the remit of DM. There were differences between the documents on the extent to which DM was considered to refer to mechanisms of support and intervention that are implemented at a workplace to reduce the likelihood that a worker will become disabled by workplace factors. Whether OHS and workplace health promotion are integral to DM or are areas of workplace health intervention that intersect with DM practice, they are focused on reducing risk of disabling injury/illness. Consequently, they support early and sustainable job retention/stay-at-work and return-to-work outcomes by ensuring safe and timely interventions. Those documents that focused on DM specifically addressed prevention in greater detail than workplace health promotion.

The Person Responsible for Implementation: A number of questions arose in relation to the formatting of the reports that could usefully inform the production of an international standard on DM. One of these was the perspective that is reflected in the text of the document. Each document reviewed adopted the perspective of a different responsible person.

- The ILOC adopts addresses employers, competent authorities and worker representatives. The responsible person is an policy informer in one of the three sectors.
- The NDMRC is addressed to a person who is tasked with establishing DM processes within an employing organization.
- The ISSAG is addressed to leaders in social security agencies and specifically the board and senior management.
- The SGBIX is a legal document which adopts a system administrator perspective. It addresses participation benefits and systems of delivery across the lifespan.
- The CSAS adopts a quality management approach that specifies the QM system required to support an effective stay-at-work and return-to-work program. Essentially, it addresses both managers and quality professionals within employing organizations.

The Method and Scope of Dissemination: While implementation and dissemination could be considered to be outside the remit of this review, the approach that will be taken to support the deployment of an international standard could influence its development process in terms of consistency of terminology across languages of publication, the production of plain language and video versions, establishing an online platform to support its implementation, and providing access to training and mentoring.

RECOMMENDATIONS

Twenty-three recommendations intended to provide guidance for those tasked with the development of an international standard on DM are proposed. They focus on terminological clarity, intended impact, scope and focus, and structure. They are summarised below.

Terminological Clarity

A number of issues arose during the interpretive process which would need to be resolved as part of the development of an international standard on DM.

1. **Definitions and Distinctions:** Ensure that it is clearly signalled that a person does not require to be deemed to be disabled to benefit from a DM approach.
2. **Synonyms:** Explore the commonalities and distinctions between synonyms and near-synonyms and take account of these in the glossary.
3. **Linguistic Equivalence:** Agree on the languages in which it is intended to publish and clarify equivalent key terms in each of the selected languages from the outset.
4. **Intended Audience:** Clarify in advance which stakeholders are the intended audience, what their information needs are and the extent to which they can use a common set of standards or require additional specific standards related to their roles.

Intended Impact

5. **Knowledge Transfer:** Establish the intended audience and the relevant domains of research and good practice to be addressed. This needs to inform the knowledge to be incorporated, the perspective from which it is presented and the language in which it is phrased.
6. **Responsible Agent:** Agree the responsible agent(s) being addressed by the standard. This will influence the level at which the standards are pitched i.e., macro, meso or micro levels. This may require the production of different versions of the standard customized to the needs of different stakeholders.
7. **Intended Beneficiaries:** Maintain a focus on the person as the direct beneficiary of DM and the effective delivery of DM to an individual job seeker or worker throughout. Additional extended beneficiaries, such as the employer or the person's family, need to be addressed as appropriate.
8. **Informing Policy, Principles or Practice:** Clarify the extent to which the standard is intended to impact on policy, legislation, system measures and mechanisms or delivery processes. A decision on the level or levels of action that it is intended to address is a prerequisite.
9. **Stimulating Change:** How the standard is intended to impact on system, organisational, professional and cultural change needs to inform the phrasing of the text and the subsequent dissemination initiatives taken after its publication such as, a plain language version, a supporting video, an online platform/network and access to training.

10. **Harmonising or influencing:** In advance of the drafting process, clarify the extent to which the standard is intended to harmonise policy, processes and practice across jurisdictions and the degree of flexibility in interpretation that can be assigned to national contexts.

Scope and Focus

11. **Areas of Implementation:** Give consideration, in the development of the standard, to the scope of DM in terms of the employment cycle of an individual.
12. **Inclusions and Exclusions:** Clearly specify the components that are addressed and those that are excluded from the outset.
13. **Intersecting Domains of Action:** Provide a clear map of the domains of interest that need to align to achieve an effective DM response for workers. At the very least, the domains of HR and Occupational Health and Safety need to be addressed.
14. **Levels of Implementation:** Consider the most appropriate and user-friendly approach to encapsulating the multi-level nature of an effective system of DM and consider producing versions for specific audiences.
15. **Core and Context:** Clearly specify the core and contextual components at all levels of the system. The domains of action, with which DM intersects, with which it needs to align and to which it can provide added value, should be clearly described.
16. **Actors or Stakeholders:** Describe the direct and indirect beneficiaries of DM, who the actors are and who holds a stake in each component of DM as appropriate.

Structure

17. **Perspective Taking/Point of View:** Decide in advance the perspectives or points of view to be addressed. This will influence the type of terminology to be used, how the content will be presented and the level of detail required. Emphasize pragmatic and practice components to ensure that the audience can work with it in their daily work.
18. **Principles and Values:** From the outset, achieve a consensus on the principles and values that underpin the DM approach being espoused in the standard. These will form the basis for selecting content to be addressed, the level of detail provided and the language used.
19. **Superordinate Organisers:** An early decision needs to be made about the underpinning conceptual framework and how this will be reflected in the chapter, section and sub-section headers in the text, taking into account that the standard will need to maintain relevance across jurisdictions with diverse cultures, contexts and laws.
20. **Categories and Sub-categories:** Prior to setting out to draft the text, agree on the main categories and sub-categories to be included and the sequence in which these will be presented.
21. **Level of Detail:** A balance between usability and usefulness needs to inform the decision on the level of detail to be included in the standard. A broad overview of a DM approach

is unlikely to have a significant impact on practice. A very detailed description of each component could result in a dense and unwieldly document.

22. **Mandatory and Informative Annexes:** Consideration could be given to extending the detail in the standard by attaching a number of mandatory annexes which are clearly part of the standard. Informative annexes could provide brief summaries of other documents that are required to complement the standard.
23. **Review, Monitoring and Update:** Build into the standard a date for review and update. A mechanism for monitoring the progress in disseminating the standard could be put in place and a monitoring committee of interested experts could be established to oversee this.

1. Background and Context

The importance of DM is increasing as a result of numerous social developments including longer life expectancies and longer working lives, the rise in disability benefits expenditure, and an increasing emphasis on inclusion and participation by every citizen in the open labour market. This review provides the first overview of five existing documents that set out to establish standards, regulations and guidelines to inform best practice in DM. It is intended that the analysis can facilitate discussions about an international and uniform standard for DM that has a global relevance. Another goal is to promote the progress in the discourse on DM, in particular, by providing more clarity about the terms and key words being used.

The first references to DM occurred in the 1980s in the United States of America in vocational rehabilitation journals (Murphy & O'Hare, 2011; pp. 43-44). The articles espoused the importance of early intervention for workers who acquired or developed occupational injuries or illnesses. The rationale for early intervention by employers was primarily the control of workers' compensation costs and meeting the needs of injured workers (Galvin, 1986; Akabas, Gates and Galvin 1992).

Essentially, DM referred to a workplace prevention and corrective strategy aimed at preventing occupational injury and illness and intervening early when a worker developed an occupational health condition in a coordinated and cost-efficient manner which included rehabilitation in the workplace. It reflected an organisational commitment to maintaining workers with reduced functional capacity in employment by joining up occupational health and safety programs (OH&S) with allied health and return-to-work interventions.

While early conceptions of DM emphasised the role of the employer in the process, for example, 'employer-driven DM' (Murphy & Foreman, 1993), 'employer-based DM' (Galvin, 1986) and 'employer-led DM' (Shrey & Lacerte, 1995), the National Institute of Disability Management and Research (NIDMAR) published Occupational Standards for Disability Management (NIDMAR, 1999) and a Code of Practice for Disability Management (2000) which reflected a consensus-based approach. This proposed that a joint worker-management collaboration needed to be at the heart of DM workplace programs.

The principles of the consensus-based approach were incorporated into the Code of Practice on managing disability in the workplace approved by the International Labour Organization (ILO) (International Labour Organisation, 2002) and the International Social Security Association (ISSA) in its return-to-work guidelines (International Social Security Association, 2012). There is evidence that lack of worker involvement and a consensus-based approach to DM can result in the reduced impact of DM programs such as prolonged work disability episodes, permanent disability and poorer health outcomes (Randall and Buys, 2011).

The original approaches to DM were developed within a workers' compensation context. A principle aim of DM was to reduce disability compensation costs on the part of employers. As a result, the approach was initially adopted only for those workers who had acquired an occupational health condition. In contrast, the most common cause of absence for both manual and non-manual workers is non-work illness and injury (Business NZ, 2013; Confederation of British Industry, 2011; Jørgensen, & Laursen, 2012). This wider remit for workplace DM p rograms to address both occupational and non-occupational health conditions is clearly stated in the ISSA Guidelines on Return to Work and Reintegration (International Social Security Association, 2013; p. 9).

2. The Objectives of the WDA DM Review

The Workforce Development Agreement (WDA) comparative review on DM standards and guidelines sets out to create a synthesis of the essential components of selected landmark publications that were intended to specify and describe good practice in the field. The publication of an externally reviewed synthesis report that highlights the commonalities and distinctions of existing standards and guidelines is intended to provide an evidence base that can inform the development of a comprehensive and unified set of international standards for DM.

An additional aim of the review is to serve as an important basis for progressing the discourse about DM by creating terminological clarity on key terms and provide a reference point for mapping the diverse approaches to DM to a common framework.

The decision to focus on standards and guides rather than research in the field was based on an assumption that the publication of such standards or guides was intended as a knowledge transfer process from current research to professional and organisational practice. As such, each document reflects the consensus view of international experts and stakeholders based on the state of the art at the time. A detailed review of the selected documents can provide insights into the good practice dimensions of DM which reflect the evidence base over a 20-year time frame.

Another important aspect of the documents selected is the perspectives and intended audiences that were adopted by each. There is little doubt that the frontline implementation of a disability management process is experienced by workers within an employing organisation. Nevertheless, it is widely acknowledged that organisational culture and practices can be influenced by external factors such as the legal and policy context, the requirements of regulatory and administrative agencies and incentives and supports available to encourage and sustain good practice. Each of the selected documents addresses each of these levels of action in a different manner. This can provide insight in the most appropriate frame of reference for an international standard on DM.

The starting point for the review comprised four overarching questions about the dimensions of the domain of DM.

1. **Scope** – What aspects of workplace policies and processes are considered to be within the remit of disability management?

   This question relates to whether DM refers to specifically to job retention and return-to-work processes for ill and injured workers or to an organization's approach to creating an inclusive response to persons with disabilities throughout the employment life cycle. Subsidiary questions are whether DM is an approach that is primarily focused on workers with occupational health conditions or whether it is a workplace strategy for all workers with health conditions that impact on their work capacity regardless of cause and what is understood to be a 'disability' within the code or standard reviewed?

2. **Principles** – What underpinning values and principles are considered essential to good practice in DM?

   Regardless of the focus of a guide or standard and its intended audience, the fundamental principles and values that are espoused by, and integrated into, the recommendations for good practices can form the basis for an accepted international standard on DM.

3. **Elements** – What processes and components are addressed as being within the remit of a DM approach?

   The third question relates to the core components of a DM strategy specified by a code or standard and the extent to which DM encapsulates other workplace health and human resources strategies such as occupational health and safety and workplace health promotion, or whether it is considered to be a separate program that needs to be fully aligned with other workplace programs. This has implications for the elements to be addressed in an international standard on DM.

4. **Stakeholders/Actors** – What stakeholders and actors are addressed as being central to an effective DM strategy or process?

   Effective workplace DM requires collaboration and cooperation between a variety of internal and external actors and stakeholders. Each of the selected documents describes the roles and potential contribution of those with a stake in effective DM. This is an important consideration to be taken into account in generating an international standard on DM.

3. The Focus of the WDA DM Review

The documents that were selected for this review were produced between 2001 and 2020 and are the important sources for good practice in WDM internationally and in Canada and Germany. Each of the documents has within it either an explicit or implicit definition of the meaning of DM and specifies good practice across a range of workplace and system policies, processes and procedures. The aim of this review is to attempt to map the commonalities and differences across the selected documents in order to gain an insight into the themes and topics that could be relevant to an international standard on DM.

The International Labour Organization Code of Practice on Managing Disability in the Workplace (ILOC) - 2001

The International Labour Organisation (ILO) operates on the principle of a tripartite consensus between employer and worker representative organisations and government. It has 186 member states. It is a UN affiliated organisation whose mission is to promote decent work through policies, labour standards and programmes for all women and men. The ILOC was agreed at a tripartite meeting of experts on the management of disability at the workplace in October 2001. Given the remit of the ILO, the Code primarily addresses policy informers and policy makers from a social partnership perspective. It describes a set of positive approaches and mechanisms that can be used to manage disability-related issues in the workplace. While the intention of the ILOC is to guide employers of all sizes, in both developed and developing economies operating in the public and private sectors, it acknowledges the essential role that governments can play in creating the context for more inclusive workplace practices through policy, legislation and incentives. The contribution of representative organisations of persons with disabilities and workers are also acknowledged in the Code. The code reflects a wide range of previous codes and agreements established by the ILO to promote safe and healthy employment of all persons with disabilities, including International Labour Organization Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159), the supporting Recommendation (No. 168), 1983, and Vocational Rehabilitation (Disabled) Recommendation, 1955 (No. 99). While it precedes the UN Convention on the Right of Persons with Disabilities (UNCRPD), it reflects the UN Standard Rules for the Equalization of Opportunities for People with Disabilities. It is not a WDA Review Comparison of DM Standards and Guidelines Summary Report February 2023 legally binding document but is intended to be applied in accordance with national laws and practice.

The ILOC was selected for analysis on the basis that it was the first international code on DM to be agreed by the social partners.

NIDMAR Disability Management in The Workplace: A Guide to Establishing a Joint Workplace Program 2nd Ed. (NDMRC) 2004

The Code of Practice for Disability Management was published with the support of Human Resources Canada and involved a working group of stakeholders representing employers, unions and government. The NDMRC is based on extensive research and development carried out by NIDMAR in relation to workplace practice and occupational standards and reflect a consensus opinion that an implementation guide for workplace programs to facilitate the (re)integration and accommodation of person with disabilities was required. The NDMRC reflects the content of the ILOC and developments in other countries including Germany, Australia and New Zealand. The NDMRC addresses a person who is tasked with establishing DM processes within an employing organization as its primary audience. Its main focus is on the workplace, while acknowledging the impact of the external legal context and the influence of employers, insurance and worker and disability representative organisations. The goals of the NDMRC include increasing the recruitment and retention of persons with disabilities, sustaining the employment of workers with disabilities, enhancing management practice and work environments and improving support and coordination for work accommodations and other interventions based on agreement between the worker, labour and management supported by internal and external actors.

The NDMRC was selected for analysis as one of the first published guides to workplace DM program development and implementation.

The NDMRC needs to be interpreted in conjunction with its 2003 publication Disability Management in the Workplace: A Guide to Establishing a Joint Workplace Program, the Occupational Standards in Disability Management (NIDMAR, 1999) and the Consensus Based Disability Management Audit™.

International Social Security Association Guidelines on Return to Work and Reintegration (ISSAG) 2013

The International Social Security Association was established under the auspices of the ILO in 1927 and has over 320 member organisations in 160 countries. ISSA member organizations include social security institutions operating in both the occupational and non-occupational sectors. A primary purpose of the organisation is to promote excellence in social security administration. It achieves its mission through the publication of professional guidelines, the sharing of expert knowledge and services and providing support to its member in developing dynamic social security systems and policies.

The return to work and reintegration guidelines (ISSAG) are intended to respond to the requirement to provide support for return-to-work programmes, under Article 27, section1(k) of UNCRPD. It differs from the other documents selected in two important respects. Firstly,

it focuses narrowly on return-to-work of existing employees and does not address recruitment. Secondly, the perspective adopted represents that of the 'competent authority' in the domain of social security and social protection, specifically the board and senior management. It was produced under the auspices of the ISSA Technical Commission on Insurance against Employment Accidents and Occupational Diseases and is based on a broad ranging international consultation. It is intended to reflect good practice in relation a proactive approach for social security systems to reduce the incidence or severity of disabling conditions, maintain the employment relationships for disabled employees and reduce inflow into or reliance on the social security system.

The ISSAG were selected for analysis because they provide a detailed description of the role that social insurance carriers can play in encouraging a DM approach to return-to-work at system and workplace levels and they reflect the values and principles of DM at the time they were published.

The ISSAG needs to be interpreted and applied in conjunction with its Guidelines on Workplace Health Promotion and Guidelines on Prevention of Occupational Risks.

Social CODE - Book IX - Rehabilitation and Participation of Disabled Persons (SGBIX) 2001/2018

Social Code Book IX (SGBIX) sets out the German social policy framework for supporting the participation of persons with disabilities and those at risk of becoming disabled in all aspects of life. It came into force in July 2001. is a legal document which adopts a system administrator perspective. It is intended to address disability-related discrimination, promote self-determination and enhance equal participation. It sets out the range of targeted measures that are aimed at integration assistance. It provides for the involvement and participation of persons with disabilities and disability representative organisations. The SGBIX has a significantly broader scope than that which is within the remit of DM. It addresses the needs of children with disabilities and their families and all life circumstances including independent and community living. The services it covers include medical rehabilitation, occupational and social integration assistance and support to cover living expenses and other supplementary assistance. Important mechanisms for the delivery of the assistance specified in the SGBIX are the networks of rehabilitation providers.

The SGBIX was selected for analysis because it was the first national law to create enabling conditions for the development of workplace DM initiatives. Specifically, an important element of the SGBIX was the support it provided for company integration agreements, which addressed the needs of workers who became impaired in the course of their working career. Integration agreements adopt a preventive approach which involve the employer, worker representatives and the representative body of disabled employees in retaining workers in employment (Niehaus, & Bernhard, 2006). This in combination with the inclusion of measures to address the needs of people at risk of developing a disability resulted in the development of proactive workplace DM programs in Germany.

The SGBIX was last updated in 2018 and needs to be interpreted in the context of the provisions of the Federal Participation Act (BTHG) (2017) which implements the UNCRPD into German law. One important impact of the BTHG was the removal of integration assistance from the welfare system which increases self-determination on the part of person with disabilities. The BTGH is scheduled for full implementation by 2023.

Canadian Standards Association (CSA Group) Work Disability Management System Standard CSA Z1011:20 (CSAS) 2020

The Canadian National Work Disability Management System Standard (CSAS) was prepared by the Technical Committee on Work Disability Prevention Management System under the jurisdiction of the Strategic Steering Committee on Occupational Health and Safety. The technical committee included representatives of employers, unions, professionals, researchers, experts, insurers, government and regulatory agencies. It is focused at a workplace systems level rather than at program level and reflects evidence-informed good practice. It adopts a quality-standards approach which is intended to address both managers and quality professionals within employing organizations.

It is intended to provide employing organisations with a set of requirements and guidance to allow them to respond to workers' health needs as they arise and, consequently, to reduce the impact of a work disability on a current worker. It also addresses how best to onboard job applicants with existing disabilities. It provides guidance on adopting a management systems approach to minimize work disability by targeting the cultural, social, healthcare, insurance, workplace, and individual barriers to recruitment, hiring, and onboarding, staying-at-work, absence management, RTW, and quality of life. It includes a framework for the management of work disability at the organizational level which is relevant to all sizes of organizations (with at least ten workers) across the private, not-for-profit, and public sectors.

The CSAS was selected for analysis as representing the first national DM standard to be published and because it is likely to reflect current thinking in the field.

The CSAS is designed to be used in conjunction with other CSA standards relevant to worker health, including occupational health and safety management (CSA Z45001); psychological health and safety in the workplace (CSA Z1003), and workplace ergonomics (CSA Z1004).

4. The WDA DM Review Methodology

The approach adopted to the review was an interpretative (hermeneutic) process in which a framework generated by the researchers on the basis of current thinking, professional practice and research in the field, including an overview of the selected documentation, was applied to the text of each document. The entire text of each document was analyzed including prefaces and annexes.

It was decided at the outset that a definition of DM ought not be selected as part of the analysis in order to avoid biasing the results in one particular direction. Nevertheless, there was an aspiration that an acceptable global interpretation of the content and characteristics of the domain of DM would emerge from the interpretive process.

In the absence of a definition, the analytic framework guided the data collection procedure. Each instance of a framework item in a document was identified and recorded in a data capture table with the page and paragraph number as a reference. This approach identified concepts that were addressed as ancillary in one document but which had a more central role to play in another.

4.1 THE ANALYTIC FRAMEWORK

The items of the framework were generated with reference to workplace and system processes, the DM literature and a preliminary review of the content of each of the selected guides. Each of the items included in the template was specified in detail to ensure that its application was consistent across each of the texts.

The analytic framework is intended to fulfil two functions. In the first place, it specifies the key terms to be identified under each of the research questions. In the second place, each term is described in detail and can serve as a glossary of terms for the reader. Another important application of the detailed descriptions, which emerged during the analysis, was that they provided a basis for generating synonyms and near synonyms which could be applied to validate the presence or absence of a concept in a text under review. This was particularly relevant in the translation of the terms into German. In this case, there were a range of options for each English term and the detailed description in the text was consulted in determining which search terms to use in the German text. This has implications for the generation of terminology for an international standard on DM which are discussed in the concluding section of this report. Where an alternative term was identified in a text, this was noted in the data capture tables.

The analytic framework was developed through an iterative process between the two principal researchers. An initial set of items were agreed and detailed descriptions were generated.

Additional items were added to a section when they emerged from the production process. The process involved a review and revision procedure in which each researcher critiqued the work of the other until a mutually agreed description was achieved.

Prior to the application of the analytic framework to the selected documents, it was submitted for review to an independent content expert. The role of the external reviewer was to:

- Identify whether there were any omissions in terms of the key concepts included in the framework
- Judge the relevance of the draft list of concepts to the domain of DM and indicate concepts that could be removed
- Critique the descriptors of each of the concepts and suggest addition or revisions
- Suggest any additional sources that could be incorporated into the framework.

Based on the feedback from the external reviewer, the analytic framework was revised prior to its application. They represent a guide to the content that was used to inform the deductive coding process of the content of the selected documents.

The items included in the analytic framework which were applied in the review are listed in Table 1. A detailed description of each is provided below.

Table 1: Items included in the Analytic Framework

1	Scope
1.1	Recruitment
1.2	Career Advancement and Promotion
1.3	Prevention
1.4	Health Promotion
1.5	Job Retention/Stay-at-Work
1.6	Return-to-Work
1.7	Occupational Health Conditions
1.8	Work-Relevant Nonoccupational Health Conditions
1.9	Disability

Table 1: Items included in the Analytic Framework – *Cont.*

2	**Principles**
2.1	Equal Opportunities
2.2	Non-discrimination
2.3	Holistic Process
2.4	Biopsychosocial Perspective
2.5	Consensus-based Approach/Co-Leadership
2.6	Evidence-informed Practice
2.7	Legal Compliance
2.8	Integral to HR strategy
2.9	Organisational Strategy
2.10	Integrated Approach
2.11	Early Intervention
2.12	Person-centred
2.13	Return-to-Work Hierarchy of Outcomes

3	**Elements**
3.1	Accessibility
3.2	Disability Management Program
3.3	Disability Awareness Training
3.4	Attitudes towards Disability
3.5	Joint DM Committee
3.6	Disability Knowledge and Skills
3.7	Ergonomics
3.8	Accommodations
3.9	Information Management
3.10	Confidentiality of Personal Information
3.11	Communication
3.12	Employee Benefits
3.13	Case Management
3.14	Claims Management

Table 1: Items included in the Analytic Framework – *Cont.*

3	Elements
3.15	Accessibility
3.16	Disability Management Program
3.17	Disability Awareness Training
3.18	Attitudes towards Disability
3.19	Joint DM Committee
3.20	Disability Knowledge and Skills

4	Stakeholders/Actors
4.1	Leadership
4.2	Management Champion
4.3	Manager/Supervisor
4.4	Human Resources
4.5	Occupational Health & Safety
4.6	Worker Representatives
4.7	Disabled Workers
4.8	Co-workers
4.9	Workforce
4.10	Individual Worker
4.11	Workers Family
4.12	Responsible Agency
4.13	Social Insurance
4.14	Private Insurance
4.15	Occupational Health Services
4.16	Health and Psychosocial Service Providers
4.17	Suppliers and Subcontractors
4.18	Disability Representative Organisations

Scope of Disability Management

Scope 1.1.-Recruitment: Recruitment can also be referred to as onboarding. It covers all the processes and procedures that employers implement to hire new people. There is a continuum of processes that need to be made accessible or be universally designed to ensure that job seekers with disabilities have an equal opportunity of becoming aware of a position, making an application, participating the interview process, completing any pre-employment assessments, partaking in induction training and accessing any reasonable accommodations to the work setting and working conditions required. An important characteristic of inclusive recruitment is ensuring that all processes are non-discriminatory.

Successful recruitment of people with disabilities needs to transition into retention management processes in the early stages of employment in order to enhance the likelihood of a successful hire. Retention management monitors the extent to which the new employee is fitting into their role, identifies any workplace barriers and addresses these through adaptions or technical aids. In this regard, the recruitment process overlaps with the DM process.

Scope 1.2-Career Advancement and Promotion: Career Advancement and Promotion also cover continuing profession development (CPD). Employers need to ensure that disabled workers are made aware of opportunities for CPD and promotion as they arise. CPD courses need to be designed based on the principles of Universal Design for Learning (UDL) or delivered in an accessible way to accommodate the individual learning needs of disabled workers. A strengths-based approach to selecting participants and the principle of non-discrimination need to be applied to all policies, processes and procedures covering promotion and CPD.

Scope 1.3-Prevention: Occupational Health and Safety (OH&S) is regulated in the majority of developing and developed economies. The main aim of OH&S is to ensure that workplace risks to the physical and psychological health or safety of workers are identified, removed, reduced or mitigated through an overall organizational strategy. This can be referred to as primary prevention as it applies to all workers. Secondary prevention refers to processes that are put in place by employers to identify occupations, groups or individuals who are at greater risk of acquiring or developing a health condition and putting in place interventions and supports to reduce the likelihood that work will aggravate the condition or that a worker will require to resort to health-related absence. Tertiary prevention refers to interventions and supports offered to workers already absent on health grounds to reduce the risk that they will progress into long-term disability benefits, unemployment or economic inactivity.

Scope 1.4-Health Promotion: Workplace Health Promotion (WHP) refers to proactive programs and measures that employers implement to encourage workers to adopt healthier work and life behaviours in order to enhance the physical and psychological well-being of the workforce. It is essential that WHP are either universally designed or that accommodations are put in place to ensure that disabled workers can participate on an equal basis with their non-disabled peers in

workplace health promotion activities. These activities include health risk assessments or appraisals (HRA), behaviour change programming targeted a chronic disease risk reduction etc. Disease management may be included as well.

Scope 1.5-Job Retention/Stay-at-Work: There is a strong economic and social case for employers to identify, at an early stage, workers who are experiencing challenges in fulfilling their job duties as a result of an emerging health condition and to put in place the interventions, supports and accommodations required to ensure that the worker's health is not exacerbated by work, that they access appropriate treatment in a timely manner and that their productivity and wellbeing are protected. Effective job retention or stay-at-work (SAW) can significantly reduce the frequency, severity and duration of health-related absence among the workforce. This can also be referred to as secondary prevention.

Scope 1.6- Return-to-Work: Return-to-Work for workers on short- or long-term health-related absence is at the core of a disability management strategy. The rationale for effective return-to-work interventions is based on the benefits that can accrue for the employer, for the individual worker and for society. For the employer there are gains in terms of reduced disability-related costs, enhanced productivity and staff morale and the retention of valued experience and skills. For the individual worker, it means that they remain actively employed, retain their earning capacity so that they can support their lifestyle and do not need to resort to long-term disability benefits. For society, the main gain is a reduction in the number of citizens entering disability pensions dependency, economic inactivity and requiring additional vocational rehabilitation, retraining and job search support. This is also referred to a tertiary prevention because it prevents the worker from becoming disabled and unemployed.

Scope 1.7 Occupational Health Conditions: In many jurisdictions, employers and workers contribute to compensation insurance policies to cover the costs of accidents and illness arising from work. Workers' compensation insurance can be provided on a statutory or private basis depending on the system in place in a jurisdiction. Each workers' compensation agency operates its own procedures and applies eligibility criteria to ensure that only bona fide claims for occupational health conditions are approved. Workers' compensation agencies also differ in terms of the benefits that they offer with some only offering financial compensation for lost wages, while others cover the costs of medical treatment, post-acute rehabilitation, return-to-work interventions and support and workplace accommodations.

Scope 1.8-Work-Relevant Nonoccupational Health Conditions: Any injury or illnesses that arises outside of the workplace is considered to be a non-occupational health condition. The distinction is of primary importance in jurisdictions that operate a workers' compensation insurance system. Workers who develop or acquire a health condition which cannot be attributed to working conditions or the workplace are not eligible for the benefits and supports provided under workers' compensation. It is estimated that about 75% of all health conditions experienced

by workers are due to non-occupational causes. Many of these can be considered work-relevant health conditions because they impact on work capacity. The onus on employers to cater for workers with work-relevant non-occupational health conditions differs between jurisdictions with some systems requiring employers to pay private insurance to cover short- and long-term disability benefits for workers with non-occupational health conditions, other jurisdictions placing this responsibility on statutory health, pension or unemployment insurance funds and, in a small number of cases, placing no requirements on employers to address the needs of workers with such conditions.

Scope 1.9-Disability: The term 'disability' has a wide range of meanings and applications that have evolved over many years. The application of the concept of disability in this framework reflects its meaning and use in the UN Convention on the Rights of Persons with Disabilities and the World Health Organisation's International Classification of Functioning, Disability and Health (ICF)

The UN Convention use of the term has two main components. The first of these is having a long-term physical, mental, intellectual or sensory impairment. The second is that full and effective participation in society on an equal basis with others is hindered by interaction with various barriers in the environment. This reflects the social model of disability.

The WHO uses the term as an umbrella term to describe the negative consequences of the dynamic interaction between health conditions (diseases, disorders, injuries, traumas etc) and contextual factors. It is a process rather than a state which is common to all humans across the life span. The WHO model has been referred to as a biopsychosocial model of disability because it covers impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. In both uses of the term, it is possible to develop or acquire an impairment and not experience disability, if the environment facilitates full participation in society. DM is intended to reduce the disabling impact of an impairment within an employment context by building a worker's capacity, introducing environmental facilitators and reducing or removing barriers.

One implication of these conceptions of disability at the individual level is that that it is essential to emphasise the capacities and strengths of a person in assessment, planning and intervention, rather than focusing on diagnosis or symptoms. Strengths can exist within a worker's environment as well as in the person themselves. On this basis, the case has been made that DM could be referred to as Ability Management to reflect this positive view. One drawback of this that the term 'ability' can be taken to refer solely to intrapersonal factors, whereas disability clearly includes the physical and psychosocial environment within its scope.

Principles of Disability Management

Principle 2.1-Equal Opportunities: Equal opportunities refer the right for people to be treated without discrimination on the grounds of a range of individual characteristics including age, gender, ethnicity, religion, marital status, sexual orientation or disability. An equal opportunity employer is an employer who adopts an equal opportunities policy and strategy which commits the organisation to comply with relevant legal requirements and to strive to achieve diversity in the workplace based in the principle that everyone is entitled to an equal chance for a rewarding job or career. The policy needs to be underpinned by training managers, supervisors and staff on what it means to be an equal opportunity employer and how they can play an important role in achieving an inclusive workplace.

Principle 2.2- Non-discrimination: The majority of jurisdictions have legislation in place to prohibit discrimination in employment on the grounds of disability and place a requirement on employers to make reasonable accommodations for workers with disabilities. The relevance of non-discrimination legislation to disability management arises from the argument that intervening in a safe and timely manner to protect the employment of a worker with reduced work capacity will reduce the likelihood that a complaint of discrimination will occur and ensure that appropriate reasonable accommodations are put in place in a timely manner.

Principle 2.3-Holistic Process: A holistic process is one which addresses the whole person and the system and not just selected parts using a biopsychosocial framework and prioritising the perceptions of the person with a disability. Disability management involves many stakeholders and is made up of a range of possible actions which need to be coordinated in across actors and over time if it is to achieve its objective of promoting and protecting the productivity, health and wellbeing of workers. A holistic DM process will address workers with occupational and non-occupational health conditions on an equal basis in an integrated and inclusive manner and address both work and non-work factors that impact on job retention or return-to-work. It focuses on both abilities and needs and applies capacity building measures and environmental mechanisms to reduce the likelihood that a person with a heath condition will be disabled by their circumstances.

Principle 2.4-Biopsychosocial Perspective: A biopsychosocial perspective on disability views it to be a process through which a person with a health condition, that reduces their capacity, can be disabled by physical or psychosocial factors in the environment. It encapsulates the social model of disability in which disability is effectively the result of a dynamic interaction between individual differences in physical or mental function and system, workplace or non-work factors. In a disability management approach, this means that the aim of a workplace program or individual job retention or return-to-work plan is to reduce or remove environmental barriers, put in place environmental facilitators or build the capacity of the person to meet the challenges faced in staying at work or returning to their employer. Organisation leadership needs to understand and have the

competence to apply the principles of a biopsychosocial perspective in developing and deploying disability policies. The International Classification of Functioning, Disability and Health (ICF) provides a useful framework to assist in identifying biological, psychological and environmental factors that can impact on effective job retention or return-to-work (Angeloni, 2013).

Principle 2.5-Consensus-based Approach/Co-Leadership: To ensure that DM processes are appropriate to meet the needs of the individual and the organization, the cooperation of all workplace stakeholders is required. A consensus-based approach requires a robust joint-labour management approach. According to the National Institute of Disability Management and Research, disability management policies, program and individual plans need to be agreed upon by management and labour representatives, unions and the individual worker; supported by the coordination of work accommodations, health care and rehabilitation interventions; underpinned by the promotion of continued safe employment for persons with disabilities; and supported by external voluntary and statutory service providers. Co-leadership is an approach that fits well with a consensus-based approach particularly as it relates to sharing responsibilities and having shared ownership over the outcome of a disability management program. Co-leaders bring complementary experiences and skills to bear on problem-solving, decision making and planning, enhance the quality of solutions and responses, broaden the scope of influence and contribute to a collaborative culture.

Principle 2.6-Evidence-informed Practice: The rigorous standards applied in an evidence-based practice approach results in important sources of evidence being discounted when reaching decisions on interventions and strategies in non-medical settings. The is a growing consensus that evidence-informed practice which uses of relevant available peer-reviewed research in combination with the opinions of recognized experts, the conclusions of qualified professionals and the documented experiences of individual participants in the process is a more appropriate approach. It is a more suitable for use in contexts such as workplaces where it is challenging to comply with the steps required for evidence-based practice. Evidence-informed practice requires that effective program evaluation procedures are in place in an organization (Schultz, Chlebak, & Law, 2016).

Principle 2.7-Legal Compliance: Policies and approaches to workplace health and disability management can be fundamentally influenced by the legal requirements placed upon employing organizations within a jurisdiction. The most relevant domains in which legislation can impact on disability management include non-discrimination and equality, duty to accommodate, undue hardship, occupational health and safety, employment, data protection, workers' compensation and social protection.

Principle 2.8-integral to HR strategy: Where there is no occupational health function in an organization, the Human Resource Management (HRM) function is frequently where many of the processes and personnel which need to be involved in disability management are located.

Critical components of HRM policy that contribute to positive disability management, job retention, SAW and RTW processes include recruitment and onboarding, employment contracts; remuneration; job design; work organisation; health and safety; job placement; incentives and employee benefits; employee and family assistance programs; training and development; promotion; and joint labour-management agreements. In a disability management program, the HRM function can also oversee workplace health promotion; job retention and return-to-work case management, absence management, early contact with absent workers, safe and early intervention, accommodations, transitional work and redeployment. The HRM function can play a central role in communicating the disability management policy throughout an organisation. This can address a major barrier to reintegration or SAW i.e., a lack of knowledge and awareness of the process on the part of co-workers and supervisors which can lead to bias and implicit discrimination against a working with an impairment.

Principle 2.9-Organisational Strategy: To optimize its effectiveness, disability management needs to be adopted as an organization-wide strategy rather than viewed as a mechanism to address the needs of an individual worker experiencing reduced work capacity due to a health condition. In the absence of a properly deployed organizational strategy, an individual worker is likely to feel victimised or singled out. There could be a perception that the organization is coercing the employee back to work before he or she is ready. Transitional work options could run into difficulty with the trade unions or worker representatives. There is a strong possibility that effectiveness of supports and interventions will be reduced by a lack of commitment from senior management or supervisors, insufficient resources, a lack of knowledge and skills on the part of the actors or access to appropriate services. Key areas where organisational capacity needs to be developed and maintained include: needs-based health interventions (physical fitness, mental well-being, rehabilitation); work environment interventions (health and safety improvements, ergonomic improvements, accommodations); work organisation interventions (team building, leadership training, human factors balance score card); and organisational structures (supporting policies, implementation plan, joint DM committee, RTW coordination process, information management, internal and external communications).

Principle 2.10-Integrated Approach: An integrated approach to workplace health operates on a continuum which starts with occupational health and safety and workplace health promotion, aimed at the whole workforce, and creates a continuum of interventions targeted at workers with reduce work capacity through medical intervention, disease management, post-acute rehabilitation, return-to-work profiling and planning, return-to-work case management, follow up, evaluation and continuous improvement.

Principle 2.11-Early Intervention: In so far as it is possible, intervening before a worker withdraws from work is considered to be the most effective approach. Once a worker has withdrawn from work on health grounds, it is generally accepted in the disability management community that the longer a worker remains absent, the lower the likelihood of successful return-to-work.

This was first noted in 1994 in relation to work related back pain (Crook, & Moldofsky, 1994). The authors found that "Three quarters of workers who experienced an incident of work-related back pain, had returned to work within I month after the injury. Workers who remained absent from work after 3 months had a strong tendency to remain absent for more extended periods. Approximately 50% returned to work after an absence of 6 months, 25% after 12 months, 10% after 18 months and 2% after 24 months" (p. S98). This has resulted in the principle of 'early intervention' being incorporated into disability management best practice. Perhaps a more appropriate term for such interventions is 'safe and timely' reflecting the fact that the appropriate point in recovery to address return to work differs depending on the severity and complexity of a health condition. It is also important to distinguish between interventions targeted at workers with reduced work capacity who are still at work from those who have withdrawn from work. Once a worker has resorted to health-related absence, early contact refers to a procedure in which contact is made within three days to provide information about the return-to-work process, offer support and signpost appropriate treatment options. s Early (safe and timely) intervention for the majority of health conditions is initiated after 6 weeks and involves any activities that are designed to prepare the employee for returning to work even if they cannot return immediately to their current job or to a different job. Medical clearance of fitness to participate in a return-to-work plan is required.

Principle 2.12-Person-centred: A founding principle of good practice in disability management is that it ensures the proactive participation of the worker as an essential member of the job retention or return-to-work team. Person centred planning (PCP) values reflect this social model principle most fully. In disability management, a PCP approach focuses on the needs of the individual worker and balances these with the requirements of the work context. The principles of person-centred planning from a DM perspective include a focus on the worker at the centre of the planning process; the worker can exercise choice and self-determination about services and supports as well as decisions regarding their own health, well-being and life goals; the worker must have full access to the community and be treated with dignity and respect, worker should have access to an array of individualized services that meet their particular needs; information should be provided in a clear and meaningful way in order for the worker to understand options and make informed decisions, service should work together to deliver services; the process needs to adopt positive expectations as a starting point for planning (National Center on Advancing Person-Centered Practices and Systems, 2019).

These imply the proactive engagement of the workers in the assessment of return-to-work needs and strengths, involvement in the return-to-work planning process, being an active member and engaged in activities of the return-to-work team, active self-monitoring during the return-to-work process and the evaluation of the success of the return-to-work plan.

Principle 2.13- Return-to-Work Hierarchy of Outcomes: The National Institute of Disability Management and Research (2003, pp. 70-71) first proposed that return to outcomes could be classified in terms of a hierarchy of return-to-work outcomes. The most desirable outcome is return to the worker's original job without accommodations or restrictions. At the next level of the hierarchy is return to the original job with accommodations or restrictions. If this is not feasible, then return to the same employer in a different job with or without training, accommodations or restrictions needs to be considered. Occupational rehabilitation is an important component of the return to own workplace process. If it transpires that none of these options are possible, then the focus should shift to vocational rehabilitation which can support the workers to find similar job with a different employer within the same industry or failing this a different job in a different industry or self -employment. he least desirable outcome in the hierarchy is transition to long-term disability benefits.

Elements of Disability Management

Element 3.1 Accessibility: Accessibility refers to the design of the environment so that it can also be used and perceived by people with disabilities without additional assistance. This means easy, simple accessibility (English Accessibility, Spanish Accesibilidad, French Accessibilité). The broader perspective no longer primarily differentiates between individual groups of people, rather the needs of all people should be taken into account. This understanding of accessibility is therefore also called "design for all" or "universal design". The addition of the cultural aspect describes the measures of the concept of interculture, with which cultural accessibility is created and thus institutions are enabled to deal with individuals in a society of diversity and multiplicity.

Element 3.2-Disability Management Program: A disability management program (DMP) is a component of an integrated workplace health strategy alongside Occupational Health and Safety (OH&S) and Workplace Health Promotion (WHP) programs. Its purpose is to protect the productivity, health and wellbeing of workers by supporting stay-at-work (job retention) and return-to-work for workers with reduced work capacity as a result of illness or injury. An important outcome of effective DM is the retention of experienced, trained employees. A DMP consists of several components, however not all DMPs have all possible components. Smaller programs may only include the basic components while larger programs generally have more components. DMPs are applied in different ways. Their implementation depends on a jurisdiction's social security system and disability policies. An effective DMP will ensure that both "impairment" and "disability" are addressed in a balanced manner by ensuring timely access to medical treatment, rehabilitation and the removal of disabling factors in the workplace.

Element 3.3-Disability Awareness Training: The purpose of Disability Awareness Training is to raise the awareness of the workforce of the meaning of disability and promote positive attitudes to colleagues with impairments, giving them the knowledge, they need to distinguish between good inclusive practice and inappropriate behaviour or attitudes over and above compliance with

disability discrimination legislation. It aims to enhance the knowledge of managers, supervisors and workers about the advantages and opportunities that people with disabilities can bring to an organisation and how the workplace environment can disable a worker with reduced work capacity as a result of a health condition. While disability is addressed in workplace diversity and inclusion initiatives, these tend to focus on cultural and social diversity. Within a diversity framework, disability is viewed as a trait of the person rather than a dynamic process in which the environment can create disability. Effective disability awareness training can break down prejudices and highlight a strengths-based approach and positive attitudes to colleagues who have developed or acquired a health condition which has reduced their psychological or physical functioning. An important function of disability awareness training is to foster appreciative, supportive and impartial communication with co-workers with reduced function. In addition to validation and technical aids, it is important to that each person perceives that they are being treated with the respect and consideration that any person would expect.

Element 3.4-Attitudes towards Disability: Attitudes are often complex and multi-faceted. They can occur at a conscious or unconscious level. Factors that influence attitudes include personal experiences, the internalisation of social preconceptions and organisational ethos. Workforce attitudes to disability can create a stigma around the concept of disability. This can discourage individual workers experiencing reduced capacity or work challenges as a result of a health condition from disclosing this to their supervisor of HR department. Negative attitudes to disability can represent a major barrier to the success of job retention or return-to-work plans. Positive attitudes underpin a strengths-based rather than a deficit-based approach. It is essential that measures to change attitudes to disability are reference to the whole workforce rather than to particular individual workers who have developed or acquired a health condition. There is little doubt that the attitudes of co-workers can be a factor in successful SAW and RTW processes. The challenge for the DM professional is that addressing these attitudes in relation to an individual worker has the potential to target the worker as the source of the problem and can create ethical dilemmas relating to the personal information of the worker. This a particular challenge when the worker does not consent to disclosure of the nature of their health condition. Good practice would indicate that attitudes to disability needs to be addressed at an organizational and workforce level rather than focusing in on an individual worker.

Element 3.5-Joint DM Committee: An essential element of an effective workplace disability management strategy is a Joint DM Committee. Joint committees to oversee the administration of a disability management program on a company-wide or worksite-wide basis. Members provide overall policy direction and advise on dispute resolution. In a consensus-based approach to disability management, the committee will involve representatives of all the key workplace stakeholders in workplace health including representatives of:

- Senior Management
- Injured/ill workers

- Human Resources
- Unions (worker representative)
- Occupational Health & Safety
- Occupational Health
- Disability Management

Element 3.6-Disability Knowledge and Skills: Disability knowledge includes an understanding of the dynamic nature of the disability process and the ways in which the workplace environment can impact on workers with reduced work capacity as a result of a health condition to place them at risk of work withdrawal either on a temporary or permanent basis. Disability skills relate to the capability to intervene to adapt the work environment, to mediate between a worker with an impairment and other workplace actors and to identify areas where it is appropriate to build the capacity of a worker with an impairment to enhance the likelihood of job retention or return-to-work. Disability knowledge and skills are a basic requirement for every DM professional and their application needs to be underpinned by supervised practice under a suitable certified professional.

Element 3.7 Ergonomics: Ergonomics is the science of the regularity of human or automated work. The aim of ergonomics is to arrange the working conditions, the workflow, the arrangement of the objects to be gripped (workpiece, tool, semi-finished product) in a spatially and temporally optimized manner and to optimize the tools for a task in such a way that the work result is optimal (qualitatively and economically) and the working people tire or even be harmed as little as possible, even if they do the work for years. Particular attention is paid to user-friendliness, i.e., improving the workplace, work organization and, today, mostly the human-machine interface.

Element 3.8-Accommodations: A key strategy in the stay-at-work and return-to-work processes is to modify the work context, processes, conditions or environment and/or to provide assistive devices in order to accommodate the abilities and needs of a worker with reduce capacity as a result of a health condition. They can assist a person with reduced function to live and work independently. The term is most often encountered in relation to "reasonable accommodation". This is an essential component of most non-discrimination or equality legislation and refers to the requirement of employers to provide modifications to support the employment of a disabled person in employment as long as it does not create a disproportionate burden for the employer (undue hardship). Determining an appropriate accommodation requires that the views of the person concerned are central to the process from start to finish, so that the person's needs are properly taken into account.

Element 3.9-Information Management: Information management refers to the systems in place to management disability data and the personal information of workers who have developed and acquired a health condition. Effective information management requires that macro data is available to the DM joint committee to allow it to monitor the outcomes the disability

management program, its impact on absence frequency and duration and the effectiveness of job retention and return-to-work interventions while ensuring that the personal data of individual workers is properly protected. An effective HR information management system can manage supports to workers with reduced function by providing access to the information required to match needs to demands in a work situation.

Element 3.10-Confidentiality of Personal Information: At an organisational level, it is essential that companies are familiar with the data protection regulations in their jurisdiction, for example, in Europe, the principle of integrity and confidentiality is specified in Article 5 / 1f DSGVO (Datenschutz-Grundverordnung), which integrates the General Data Protection Regulation (GDPR) (European Commission, 2016) into German law, and, in Canada, in the Personal Information Protection and Electronic Documents Act (PIPEDA) Government of Canada, 2019). In most jurisdictions, the principle of integrity and confidentiality in specified in data protection legislation and includes the prohibitions of the unlawful processing of information by unauthorized persons, protection against accidental damage and loss and a requirement for appropriate technical and organizational measures. Transparency, integrity, confidentiality and accountability are general principles that underpin data protection regulations.

While there is no globally applicable standard for how personal data should be collected, processed and stored, DM professionals, like other health and human services professions, have a primary ethical obligation to protect the confidentiality of personal information of those they are assisting. and participants in their research. The only exceptions to this are where this conflicts with legal requirements for disclosure, where withholding information could result in substantial harm to others or where the person concerned is deemed to lack competence (safety and security of the client). If there is a requirement to release personal information to others, the person concerned must be informed. It is essential that a worker is informed of the limits to confidentially at the outset of the DM process and that informed consent is obtained prior to the release of sensitive personal information (Canadian Society of Professionals in Disability Management, 2007).

Element 3.11-Communication: At both organisational and individual levels, the clear communication of goals, intentions, concerns and actions is essential. Many of the actors or stakeholders involved in the job retention and return-to-work process may not normally come into contact with each other or have any reason to communicate except in relation a RTW plan. Misunderstandings can jeopardise a successful outcome, lead to unnecessary frustrations or conflicts or reduce the commitment of actors and stakeholders to the process. Consequently, communications need to be prioritised in the project plan and in the program processes and the DM team must be provided with adequate training in interpersonal, small group communications and marketing techniques.

Element 3.12-Employee Benefits: Employee benefits will differ depending on the jurisdiction and policy approach to work disability. They offer a way to attract and keep employees,

contribute towards improving employee well-being and motivate desirable behaviours, achievements, values and skills. Employee benefits can act as an incentive or a barrier to return-to-work. The benefits that are most relevant to disability management are disability-related employment benefits, income maintenance plans and other insurance plans (short- and long-term disability or group sickness plans) and retirement schemes.

Element 3.13-Case Management: While case management was originally a management strategy used in the United States with the aim of managing the care of insured persons in an acute episode of illness in such a way that the individually necessary health services are made available promptly in a coordinated process, case management in disability management refers to the coordination of job retention or return-to-work interventions and supports. Its components include strengths and needs profiling and planning, organizing required health and medical interventions and support, negotiating workplace accommodations and assistive devices, advocating the views and aspirations of the ill or injured worker, monitoring the progress of the plan, changing the plan in response to altered circumstances and evaluating the impact of the case management plan. Often, they are very individual and different from person to person.

Element 3.14-Claims Management: Claims management is primarily an administrative responsibility within insurance providers. The main responsibilities relate to settling insurance claims, where relevant, paying out to interested parties, ensuring that payments are correct and comply with company operating procedures. Claims managers have a responsibility to ensure the efficient settlement of claims, detecting fraudulent claims, reducing costs to the insurers and avoiding the risk of litigation. Not all claims managers are involved in the return-to-work process for workers who have submitted claims and are more concerned with the speedy resolution of the claim. It is essential that the disability management professional keeps the claims manager up to date on return-to-work progress and to substantiate that return-to-work or stay-at-work are more desirable options than placing a worker on a pension, where this is the case.

Element 3.15-Transitional Work: A Transitional Work Assignment is a temporary work assignment which complies with all medical restrictions indicated by the employee's treating physician or healthcare practitioner (HCP). It may involve modification of the injured employee's job duties, i.e., tailoring work duties to the injured employee's medical limitations and vocational abilities to maximize recovery, or alternate work that is compatible with the employee's job skills and experience. Most transitional work assignments will be of short duration, allow for minimal to moderate work restrictions, and are provided with the expectation that full recovery will occur within thirty days. Generally, if work restrictions last over thirty days, then the work assignment will be re-evaluated and adapted.

Element 3.16 Graduated Return to Work: A When it is judged that a worker is medically fit to engage in the return-to-work process but not yet ready to return to full duties in their original job and needs to be prepared for full duties either psychologically or physically, a graduated

return-to-work can be arranged. This allows a worker to gradually get into the rhythm of work and to improve his or her physical or mental condition. It can act as a way of work hardening. A graduated return to work can occur in a transitional position or the original job. It is a temporary arrangement that is suited to the worker's current health and functional capacities which can involve restricted duties, reduced work hours, additional rest breaks and time off to continue treatment. It is carefully scheduled to increase in line with the recovery of the worker, the achievement of pre-specified targets in terms of health and productivity and improved strength and stamina.

Element 3.17-Monitoring and Evaluation: Ongoing monitoring and evaluation are essential components of an effective workplace disability management strategy. They must be based on quantitative and qualitative data in order to identify strong points, areas for improvement and where efficiencies can be achieved. They require the collection of good quality information on the current performance of a program or intervention through a systematic process on a consistent basis that can be compared to standard or expected level of performance. It involves defining key performance indicators (KPIs), developing appropriate information systems and analysing and evaluating results. Monitoring and evaluation can promote a change positive ethos by identifying learning opportunities, successes and areas for improvement and ensure the sustainability and relevance of the DM system. An important element of monitoring and evaluation is an internal audit process which is carried out at regular intervals as well as benchmarking against other organizations.

Element 3.18-Continuous Improvement: Continuous improvement is part of a Total Quality Management (TQM) system which tracks organisational performance against a set of targets through a set of key performance indicators (KPIs) that represent how an organisation is progressing in all core areas of operation. It is a fundamental component of a sustainable and effective workplace disability management strategy. It involves an iterative Plan-Do-Check-Act cycle through which areas for improvement are identified, DM processes are updated and enhanced and positive trends are documented against baselines. It assists an organisation to adjust its procedures and approach to changing circumstances, work environments, work processes and evolving good practice. It can address workplace health interventions such as accident prevention and health promotion, disability prevention measures including occupational health and safety and return-to-work processes in terms of early intervention, case management and transitional work programmes.

Element 3.19 Employer Supports and Subsidies: In some jurisdictions, the competent authorities operate schemes to provide employers with grants or subsidies to defray the additional costs of employing a worker with a disability. These can include wage subsidies to compensate an employer for the reduced productivity of a worker, financial support to assist in adapting the physical environment in the workplace or at a workstation or grants to support the assessment of the work needs of a worker who has acquired an impairment.

Element 3.20-Disability Management Professional: DM evolved from the field of vocational rehabilitation (VR) and some of its early proponents were rehabilitation professionals. However, over the years it has evolved into a separate field of research and practice that spans a range of workplace focused health interventions and supports. In 1999, Occupational Standards in Disability Management were published in Canada (National Institute of Disability Management and Research, 1999). The process that developed these standards was supported by organisations and professionals nationally and internationally. The occupational standards formed the basis for professional certification at two levels: Certified Return to Work Coordinator (CRTWC) and Certified Disability Management Professional (CDMP). The certification process is overseen by the International Disability Management Standards Council (IDMSC) which operates in over 60 jurisdictions. In the United States a Certified Disability Management Specialist (CDMS) designation is offered by the Commission for Case Manager Certification (CCMC). A number of studies have reviewed the domains of knowledge and functions in the fields of disability management and concluded that it needs to be viewed as a standalone profession (Matthews, et al, 2015; Niehaus & Marfels, 2010; Rosenthal, et al, 2007; Westmoreland & Buys, 2004).

Stakeholders and Actors in Disability Management

Stakeholder/Actor 4.1 Leadership: Leadership is responsible for changing a system or organization and pulling others along with it. Successful DM-leadership can make a significant contribution to minimizing absenteeism. DM requires a disability sensitive leadership with compassion. To do this, managers must be specially trained.

Further, the development and deployment of effective DM policies, processes and procedures at system or organizational levels require a clear and consistent commitment at leadership level. A new and special leadership perspective and awareness are required. There are several important aspects to be considered to lead a Disability Management successfully and to implement it sustainably.

- At system level, leaders include elected political representatives and senior administrators in permanent government.
- Leadership in an organization includes the Board of Directors, Chief Executive or General Secretary and members of the senior management team.

The successful roll out of DM policies, measures and mechanisms requires a change in system or organizational culture from one in which disability is viewed as a characteristic of a person (medical model) to one that recognizes that disability is the result of an interaction between a person and their physical and psychosocial context (social model).

System and organizational change require a sustained effort by leadership over an extended period of time. Effective leaders can inspire and motivate change; insist that DM is addressed in strategic planning processes; ensure that DM measures and mechanisms are adequately

resourced; communicate a strong commitment to DM to others; require that training in DM approaches is included in continuous professional development and staff training opportunities; integrate DM-relevant key performance indicators into progress appraisal and monitoring processes; and drive the pursuit of continuous improvement throughout a system or organization.

Stakeholder/Actor-4.2 Management Champion: A champion is a senior manager or organizational leader who generates support for the consistent application of disability management policies, the dissemination of the concept of a disability management approach and in overcoming challenges to implementation. Senior management support is particularly important at the early stages of development of a disability management approach and in sustaining and continuously improving a disability program. A champion can bring the concept to the table at director level, leverage personnel and resources in the proof-of-concept phase and insist that job retention and return-to-work outcomes are included as key performance indicators. The support of a senior manager is required in order to gain access most senior leaders of an organisation and to ensure that disability management is integrated into governance and reporting processes. A champion can play a crucial role in building partnerships and collaboration with external actors and stakeholders and particularly with workers' compensation agencies and other insurance providers.

Stakeholder/Actor 4.3 Manager-Supervisor: Managers and supervisors are a key actor in a workplace disability management strategy. Senior management has a leadership role in developing DM policy and disseminating it throughout the organisation. Middle management act as mediators ensuring that appropriate procedures implemented, make sure that the accommodations required are approved and that staff are provided with appropriate awareness training when required. They are also involved in annual budgeting and supporting the case for an adequate budget for the workplace disability management program. Supervisors are team leaders and have important roles to play in facilitating job retention and return-to-work interventions identifying potential at risk workers, supporting workers during their plans and monitoring the success of plans. Supervisors can be viewed as the delivery point for many of the processes that are important for the effective functioning of a DM program such as monitoring the success of the RTW plan, providing additional breaks or providing encouragement and support to a worker.

Stakeholder/Actor 4.4 Human Resources: The Human Resource (HR) function is inextricably linked to the goals and processes of workplace disability management. In many organizations, the majority of workplace health functions will fall under the responsibility of the head of HR. HR is the process of employing people, training them, compensating them, developing policies relating to them, and developing strategies to retain them. It plays a crucial role in an integrated workplace health strategy in terms of developing disability and diversity policies procedure, implementing occupational health and safety and workplace health promotion processes and in many cases managing the workplace disability management program. Human resource management practice provides an important focus through which to explain and describe workplace health policies and processes and a fulcrum around which an integrated workplace health strategy can be built.

Stakeholder/Actor 4.5 Occupational Health & Safety: Occupational Health and Safety (OH&S) function in most companies is responsible for creating a safe and health work environment in which the risks to workplace health are identified, removed, reduced or mitigated. OH&S in most jurisdictions is regulated by laws, monitored against standards and monitored by statutory agencies. OH&S has an important role in job retention strategies aimed at identifying and ameliorating health problems before they become serious and return-to-work following a disability-related absence by confirming that proposed adaptations, adjustments and devices can be accommodated within current standard OH&S operating procedures and potential risks or hazards in their return to work are identified.

Stakeholder/Actor 4.6-Worker Representatives: Committed and informed worker representatives are key to success in the roll-out of effective workplace health initiatives. The support of worker representatives for the development and piloting of a workplace disability management program sends a powerful message when recruiting workers for the program and the representatives themselves can influence their members favourably towards the program. Well-informed worker representatives can be an important source of advice and guidance for workers who are experiencing reduced work capacity as a result of illness or injury and they may be able to assist in the identification of alternate work where that is necessary. Their views and perspectives make an essential contribution to program design that can ensure that the resulting policies and processes are viewed as being worker-friendly. Worker representatives are also an important voice in the monitoring, evaluation and continuing improvement of a workplace disability programme.

Stakeholder/Actor 4.7-Disabled Workers: The most appropriate term to refer to workers who have developed or acquired an impairment is a contested issue. UN Convention refers to Persons with Disabilities. In contrast, there is a view that Disabled Person is a more appropriate term because it implies that the person is disabled by external factors. It is important to note that these terminological issues are more contested in the English language than in other languages. In Germany, for example, section 178, Paragraph 1 of Book IX of the Social Code, mandates work-place representation for severely 'handicapped' persons (SBV). This is referred to as the Disabled Persons' Representative in English. From a disability management perspective, any worker who develops or acquires a health condition that negatively impacts on their work capacity is at risk of being disabled by the environment. In the case where a worker has one or more impairments (or comorbidities) and is being challenged in remaining at work, disability management involves providing interventions and supports to enhance work efficiency and productivity. This approach aims to avoid the many stereotypes that can inhibit the inclusion of persons with disabilities in the labour market. It emphasises the characteristics that make a good employee in the eyes of the employer and assists managers, supervisors and co-workers to resolve any uncertainties they may have about the level of productivity that a worker can achieve with appropriate accommodations. Nonetheless, disabled workers do indeed have special characteristics, particularly in terms of gradations of discrimination arising from the type of impairment a worker has. It is essential

that the differences between assumptions about the work-restricting nature of an impairment are clearly distinguished from the impact of workplace explicit or implicit discrimination against disabled people. This requires a high degree of empathy and compassion on the part of the DM professional, the HR manager, the supervisor and co-workers.

Stakeholder/Actor 4.8-Co-worker: Co-workers of employees, who are experiencing reduced work capacity, have a significant role to play at the frontline of workplace disability management program delivery. The role of co-workers can be central to the sustainability of return-to-work. When the return-to-work plan is completed, co-workers can provide informal supports to the returning worker. It is important to consider whether co-workers require some additional training to provide appropriate support or, in the case where the extra work demands on co-workers are substantial, whether additional support is required.

Stakeholder/Actor4.9-Workforce: The workforce needs to be addressed as an important stakeholder of the DM program not least because company culture and attitudes to disability can have a major impact on early disclosure of emerging health conditions. If the workers in a company regard JR/RTW services as part of the employee benefits package, their level of engagement and participation will be high. In the early stages of program implementation, it is important to address the myths and misconceptions that often exist in relation to disability and to build worker support for the concept of work ability. Creating a diverse workforce is good for business. When employees feel less awkward around co-workers with different capacities, they can be more comfortable and more productive. If necessary, employees can be prepared to respond more effectively by collaborating with disability agency that offers workplace orientation and training, ideally as an overall disability awareness initiative for business.

Stakeholder/Actor 4.10-Individual Worker: Because the worker must be regarded as an active partner in the return-to-work plan rather as the object or passive beneficiary of the process, promoting the proactive participation of individual workers in the RTW process is essential. How an individual worker perceives the contacts and interventions offered by a disability management professional will strongly influence the outcome of the process. The worker's own perceptions of obstacles to return-to-work and his or her self-belief can be important factors in determining the effectiveness of a return-to-work process. Consequently, the proactive engagement of the worker in a person-centred SAW or RTW assess and planning process is crucial. The individual worker's understanding of the problem, their desires and needs and the actions they can take to resolve their challenges are central to the return-to-work plan. They can be enabled to make a more proactive contribution to the return-to-work process if equipped with the skills and tools to self-monitor and self-manage the challenges arising from their health condition. They can also provide important feedback on the effectiveness of allied health and workplace interventions.

Stakeholder/Actor 4.11-Worker's Family: Factors external to the workplace can have a profound impact on the likelihood of a successful SAW or RTW outcome. One such factor is the extent to which a worker's partner or other family members support the RTW process. It is likely that a worker will seek advice and support when having to make a decision about the RTW plan. While it is important to respect the worker's right to confidentiality, it is often useful to suggest a meeting with the worker and a family member when finalising the RTW plan or where a particular significant decision or intervention is being considered. It is important that family members understand that early intervention and RTW can have therapeutic benefits and that it is not about forcing the worker back to the job.

Stakeholder/Actor 4.13-Social Insurance: Social insurance is a concept where the government intervenes in the insurance market to ensure that a group of individuals are insured or protected against the risk of any emergencies that lead to financial problems. This is done through a process where individuals' claims are partly dependent on their contributions, which can be considered as insurance premium to create a common fund out of which the individuals are then paid benefits in the future. Thus, social insurance is also a concept based inherently on the work done by the Individual over his life and how they will ultimately benefit from this. Example of social insurance can include workers' compensation insurance, health insurance, pension insurance and unemployment insurance. Jurisdictions differ in terms of the extent to which these types of insurance are operated on a statutory or private basis. Some statutory insurance providers also offer return-to-work case management. In such cases, it is essential that the internal disability manager professional establishes good working relationship with claims or case managers who are responsible for an individual worker's return-to-work process and benefits.

Stakeholder/Actor 4.14 Private Insurance: Depending on the jurisdiction, private insurance providers can play a central role in the operation of a workplace disability program. For example, in the United States only four States rely entirely on statutory workers' compensation insurance. In a number other jurisdictions, private insurance providers are responsible for offering short- and long-term disability insurance for workers with work-relevant non-occupational health conditions. Some of these offer return-to-work case management services. Where there is an internal disability management professional, excellent working relationships and effective communication with claims and case managers employed by the insurance provider are essential.

Stakeholder/Actor 4.15-Occupational Health Services: In most jurisdictions, occupational health services can be provided by occupational health physicians or nurses, hygienists, psychologists, ergonomists or physical or occupational therapists to name a few. The primary purpose of an occupational health professional is to diagnose, manage and prevent health condition that are caused or exacerbated by workplace factors. They provide advice about workplace health, support workers to stay healthy, assess individual workers' capacity and monitor workers with occupational health conditions in a company. An important service provided in some occupations is carrying out per-employment medical assessment.

The extent to which occupational health professionals are involved in the disability management varies across jurisdictions. In some jurisdictions, the main contribution of an occupational health physician is to certify a worker as being medically fit to embark on a return-to-work plan or resume work, while in other jurisdictions they can have responsibility for coordinating the entire return-to-work process in consultation with the worker and the employer. If an organization is outsourcing occupational health services, it is essential that is ensures that the professionals providing the support are fully committed to an ethical disability management approach and adopt a biopsychosocial perspective on disability and impairment.

Stakeholder/Actor 4.16-Medical and Allied Health Service Providers: Medical and Allied Health service providers can include medical professionals such as a family physician or GP, medical specialists such as osteopaths, dermatologists or neurologists; allied health professionals such as occupational health nurses, occupational therapists or physiotherapists; and psychosocial services providers such as clinical psychologists, psychotherapists or social workers. Health and human services professionals play a key role in the job retention and return-to-work process. Medical professionals are responsible for treating the worker with an illness or injury and certifying them as being fit to engage in a return-to-work plan. Allied health professionals can assess functional capacity, offer capacity building interventions and make recommendations for appropriate workplace accommodations. Psychosocial service providers can assessment cognitive and neurological functioning, offer psychological and social interventions and support the worker and their family to adapt to their changed circumstances. Effective communication between the workplace disability manager and external health and psychosocial service providers is critical in achieving optimal outcomes in a job retention or return-to-work process.

Stakeholder/Actor 4.17-Suppliers and Subcontractors: Disability management or return-to-work case management is frequently outsourced to an external provider and in some jurisdictions, disability management professionals operate as private companies offering both job retention and return-to-work services. Other services that are often externalized include allied health services, occupational health and safety, functional assessment, ergonomics and psychological therapy. It can be the case, particularly for small and medium employers, that the required expertise is not available within the company. Nevertheless, an effective disability management program or process requires a multidisciplinary approach. The required expertise can be accessed by creating a preferred provider list of subcontractors. Disability management or return-to-work case management is frequently outsourced to an external provider and in some jurisdictions, disability management professionals operate as private companies offering both job retention and return-to-work services. Other services that are often externalized include allied health services, occupational health and safety, functional assessment, ergonomics and psychological therapy. There is an onus on a company that is outsourcing services to suppliers and subcontractors to ensure that the professionals delivering the service are certified professionals in their field, the provider operates to a high ethical and quality standard and applies a social or biopsychosocial approach to disability and impairment.

Stakeholder/Actor 4.18-Disability Representative Organisations: Disability Representative Organisations or Disabled Persons Organisations (DPOs) are rights-focused organisations that are led, directed and governed by persons with disabilities. A clear majority of their membership are persons with disabilities themselves. They can be either individual organisations or umbrella/coalition organisations and their focus can be cross disability or on a single impairment. DPOs are an important source of information on the most appropriate processes to implement to accommodate workers with a particular condition, on establishing discrimination-proofed recruitment and job retention procedures and can be a positive sources of peer support for individual workers. Consultation with DPOs is an essential component in the development of a responsive and equitable disability management program. However, Collaboration with DPOs can be impeded in certain jurisdictions because local and national DPOs do not always pull together. Nevertheless, international DPOs continue to play a critical role in ensuring the full implementation of the UN Conventions on the Rights of Persons with Disabilities.

4.2 PROCEDURES

The methodology for analysis reflects a concept-driven approach which relies on template analysis using deductive coding (Crabtree, & Miller, 1999). The content identified in each document that informed the recommendations of this report is available in detail in Annex 1 to the full report which presents separate analysis (comparison) tables for each item of the framework for each document reviewed. These are derived from the original text (raw data) which are recorded in data capture tables. There is a single data capture table for each of the documents analysed. These are available on request.

The content search for a selected document was carried out by one of the researchers who generated the initial draft of the data capture table for that document. This was shared with the other researcher who carried out a validation check and made recommendations for amendments. The final versions of the data capture tables were agreed through a series of meetings between the two researchers.

The text included in each of the data capture tables relating to a particular framework item was transferred to the analytic (comparison) table and rephrased as a coherent set of paragraphs. The references to the location of the text were retained in the analytic table.

In order to come to a decision about the status of each of the framework items, each analysis (comparison) table was critically reviewed by each researcher independently. They assigned a rating representing their view as to the extent to which each of the documents under review addressed that item. A consensus rating for each item was agreed by the researchers in a series of meetings. The ratings presented in the results section are the result of this consensus procedure which reconciled and aligned the individual ratings.

The consensus rating scale adopted included the following descriptors:

This component is:

0 = Not addressed in the document
1 = Implied but not addressed directly in the document 2= Referred to but no detail is provided in the document 3= Addressed in some detail in the document
4 = Addressed in detail in a supporting document
5 = Addressed in substantial detail in the document.

The consensus ratings for each of the items in each of the documents under review are presented along with the item descriptor and identified content in Annex 1 to the full report. They are summarised in the results section of this report.

The analytic (comparison) tables and ratings were submitted for external review prior to the production of this report.

5. Results of the WDA DM Review

5.1 INTRODUCTION

This section of the report presents the findings of the review for each of the selected documents. A summary of the extent to which each element of the framework was addressed in each document is present in Table 2. Only elements that were described in some or substantial detail or which were addressed in a supporting document are included. Items that were not addressed, implied or simply referenced have been omitted.

Columns 1 and 2 specify the reference number and label of each element. Columns 3-7 indicate whether at least some detail was included in each of the documents reviewed. Column 8 specifies the number of documents which included at least some detail.

Table 2: Analytic Framework Items for which at least some detail is available - All Documents

		ILOC	NDMRC	ISSAG	SGBIX	CSAS	N.
1	**Scope**						
1.1	Recruitment	•	•		•	•	4
1.2	Career Advancement and Promotion	•	•			•	3
1.3	Prevention		•	•	•	•	4
1.4	Health Promotion		•	•	•		3
1.5	Job Retention/ Stay-at-Work	•	•	•	•	•	5
1.6	Return-to-Work	•	•	•	•	•	5
1.7	Occupational Health Conditions		•	•		•	3
1.8	Work-Relevant Nonoccupational Health Conditions		•		•	•	3
1.9	Disability	•	•	•	•	•	5

Table 2: Analytic Framework Items for which at least some detail is available – *Cont.*

		ILOC	NDMRC	ISSAG	SGBIX	CSAS	N.
2	**Principles**						
2.1	Equal Opportunities	•	•		•		3
2.2	Non-discrimination					•	1
2.3	Holistic Process			•	•		2
2.4	Biopsychosocial Perspective			•	•	•	3
2.5	Consensus-based Approach/ Co-Leadership		•				1
2.6	Evidence-informed Practice		•			•	2
2.7	Legal Compliance		•	•	•	•	4
2.8	Integral to HR strategy		•	•			2
2.9	Organisational Strategy		•	•		•	3
2.10	Integrated Approach	•		•		•	3
2.11	Early Intervention		•	•	•	•	4
2.12	Person-centred			•			1
2.13	Return-to-Work Hierarchy of Outcomes	•	•	•		•	4

Table 2: Analytic Framework Items for which at least some detail is available – *Cont.*

		ILOC	NDMRC	ISSAG	SGBIX	CSAS	N.
3	**Elements**						
3.1	Accessibility	•				•	2
3.2	Disability Management Program	•	•	•	•	•	5
3.3	Disability Awareness Training	•					1
3.4	Attitudes towards Disability						0
3.5	Joint DM Committee		•				1
3.6	Disability Knowledge and Skills		•	•		•	3
3.7	Ergonomics		•				1
3.8	Accommodations	•	•	•		•	4
3.9	Information Management		•	•	•	•	4
3.10	Confidentiality of Personal Information	•	•	•	•	•	5
3.11	Communication		•	•		•	3
3.12	Employee Benefits		•	•	•		3
3.13	Case Management		•	•	•	•	4
3.14	Claims Management						0
3.15	Transitional Work		•				1
3.16	Graduated Return-to-Work						0
3.17	Monitoring and Evaluation		•	•		•	3
3.18	Continuous Improvement					•	1
3.19	Employer Supports and Subsidies				•		1
3.20	Disability Management Professional		•	•			2

Table 2: Analytic Framework Items for which at least some detail is available - All Documents

		ILOC	NDMRC	ISSAG	SGBIX	CSAS	N.
4	**Stakeholders/Actors**						
4.1	Leadership				•		1
4.2	Management Champion						0
4.3	Manager/Supervisor					•	1
4.4	Human Resources						0
4.5	Occupational Health & Safety	•	•	•		•	4
4.6	Worker Representatives	•	•	•		•	4
4.7	Disabled Workers	•	•		•	•	4
4.8	Co-workers						0
4.9	Workforce			•			1
4.10	Individual Worker		•	•	•	•	4
4.11	Workers Family						0
4.12	Responsible Agency	•		•	•		3
4.13	Social Insurance		•	•	•	•	4
4.14	Private Insurance						0
4.15	Occupational Health Services				•		1
4.16	Medical and Allied Health Service Providers						0
4.17	Suppliers and Subcontractors			•			1
4.18	Disability Representative Organisations	•			•		2

Overall, all the analytic framework items relating to DM Scope and Principles are addressed in detail by at least one of the documents or are described in a supporting document.

Three DM Elements are not addressed in any detail in any of the documents reviewed or in supporting documentation. These are:

- Attitudes towards Disability
- Claims Management
- Graduated Return to Work.

The role of five Stakeholders/Actors in the DM process are not addressed in any detail by any of the documents reviewed or in a supporting document. These are:

- Management Champion
- Human Resources
- Co-workers
- Workers Family
- Private Insurance
- Medical and Allied Health Service Providers.

Two additional areas of note emerged in the application of the framework to the documents under review.

Firstly, the framework included three key elements related to workplace health programming: occupational health and safety (OH&S), workplace health promotion (WHP) and disability management (DM). Each of these makes a contribution to reducing disability within the workplace through complementary processes. As a result, there are areas of overlap between the three domains of action and other areas in which they intersect. This is well represented in the distinctions between three levels of prevention: primary, secondary and tertiary prevention as specified in the CSAS. In essence, OH&S and WHP are focused on reducing risk for disabling injury/illness. DM includes some disability prevention efforts, but is also focused on OH&S and WHP practices that support early and sustainable JR-SAW/RTW outcomes by ensuring they do not further aggravate an existing impairment or cause further work disability.

While the CSAS adopted the three levels of prevention perspective and the ISSAG clearly characterised RTW as a component of tertiary prevention, none of the documents specified the relationship between these three workplace health programs in sufficient detail. This is something that would need to be clarified in an international standard.

Secondly, given that all documents under review acknowledged that DM is integral to a HR strategy and this was addressed in some detail in the ISSAG and in a supporting document to the NDMRC, it is difficult to understand why the role of Human Resources as a stakeholder or actor was not specified in detail in any of the documents. This is interesting, as in many organizations, the DM professional is part of the HR team and HR is a key DM stakeholder in all organizations. It would make sense for an international standard to provide clarity on the responsibilities of HR in the DM process and how the DM professional's role relates to the HR function at the outset. A related issue that needs to be addressed is the leadership function to which the DM program is responsible. Possibilities include having DM as a standalone pillar reporting to senior management, being part of an occupational health function or under the remit of the HR function.

5.2 DM ELEMENTS ADDRESSED IN EACH OF THE DOCUMENTS REVIEWED

This section provides a summary of the findings for each document reviewed in table format followed by an overview.

Table 3-7 present a summary of the extent to which the items in the analytic framework are addressed in the each of the documents under review. Items that were not addressed, implied or simply referenced have been omitted from the tables. Column 1 of each table specifies the item of focus. Column 2 provides the reference number of the item addressed. Column 3 lists the titles of the item addressed and Column 4 presents the rating assigned by the researchers to each item.

- A rating of 3 indicates that the element is addressed in some detail
- A rating of 4 indicates that the element is addressed in detail in a supporting document
- A rating of 5 indicates that the element s addressed in substantial detail.

The detailed ratings of each document for each item are presented in Annex 1 which accompanies the full report.

5.2.1 ILO CODE of Practice on Managing Disability in the Workplace (ILOC)

n the ILOC, 18 of the 60 items, in the analytic framework, are described in at least some detail. These are listed in Table 3 below along with the consensus rating of the level detail. No reference is made in the ILOC to supporting documentation for additional detail. Thus, the ILOC describes in detail less than 30 percent of the items considered in the analysis. Five Scope items were described in substantial detail and are a useful source of information relating to the workplace areas in which a DM approach can make a positive contribution. The ILOC addressed three DM Principles, two of which were described in substantial detail and one in some detail. The ILOC provides some or substantial detail on five DM Elements and on five DM Stakeholders.

Table 3: Analytic framework items for which some detail is available – ILO Code*

1	**Scope (5)**	1.1	Recruitment	5
		1.2	Career Advancement and Promotion	5
		1.3	Prevention	5
		1.4	Health Promotion	5
		1.5	Job Retention/Stay-at-Work	5
		1.6	Return-to-Work	5
		1.9	Disability	5

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

Table 3: Analytic framework items for which some detail is available* – *Cont.*

2	**Principles (3)**	2.1	Equal Opportunities	5
		2.10	Integrated Approach	3
		2.13	Return-to-Work Hierarchy of Outcomes	5
3	**Elements (5)**	3.1	Accessibility	3
		3.2	Disability Management Program	5
		3.3	Disability Awareness Training	3
		3.8	Accommodations	5
		3.10	Confidentiality of Personal Information	5
4	**Stakeholders/Actors (5)**	4.5	Occupational Health & Safety	3
		4.6	Worker Representatives	5
		4.7	Disabled Workers	3
		4.12	Responsible Agency	5
		4.18	Disability Representative Organisations	5

Scope:

In relation to the question, "What aspects of workplace policies and processes fall within the remit of disability management?", the ILOC:

- Describes how a strategy to address disability issues can enhance inclusive workplace practices across the employment lifecycle
- Specifies that such a strategy can be integrated into the practice of employers, workers representative and competent authorities
- Aims to improve the employment prospects of people with disabilities in terms of r ecruitment/onboarding, job retention/stay-at-work and return-to-work
- Provides detailed procedures for recruiting jobseekers with disabilities and places responsibility on competent authorities to assist employers in addressing disability issues in recruitment
- Describes career advancement and promotion in terms of four components
- Addresses the role of competent authorities and worker representative organizations in promoting job retention and return-to-work in detail

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

- Defines RTW as the process by which a worker is supported in resuming work after an absence due to injury or illness
- Notes that disability may or may not have an impact on the capacity to take part in society or require support and assistance

DM Scope items which are not addressed in any detail include information on prevention, health promotion, occupational health conditions, and work-related non-occupational health conditions.

Principles:

In relation to the central question "What underlying values and principles are considered essential to good practice in disability management?", the ILOC:

- Sets out to provide practical advice to ensure that persons with disabilities have equal opportunities by managing disability issues in the workplace
- Proposes an integrated approach which consists of a continuum of mechanisms from recruitment through to RTW
- Describes the steps to retain a worker with an acquired disability in employment
- Notes the role of organizations of persons with disabilities in contributing to facilitating employment, JR-SAW and RTW opportunities for disabled persons.

The DM Principles not addressed in any detail were non-discrimination, holistic process, biopsychosocial perspective, consensus-based approach/co-leadership, evidence-based practice, legal compliance, integral to HR strategy, organizational strategy, early intervention, and person-centredness.

Elements:

In relation to DM Elements and the main question, "What processes and components are addressed as falling within the scope of a Disability Management approach?", The ILOC:

- Specifies a strategy on DM as a key component of a framework for the management of disability issues in the workplace
- Considers awareness raising in relation to disability issues as a main component of the strategy
- Uses the terms 'adjustment' and 'adaptation' more frequently than 'accommodation'. Accommodation is used as a synonym of adjustment
- Goes into detail on accessibility in relation emergency planning and the safe and effective evacuation of persons with disabilities to an area of safety is described in detail
- Describes the importance of privacy and confidentiality particularly in relation to information regarding the DM program being anonymous and confidentiality protected, before reports are distributed.

It does not refer in any detail to attitudes towards disability, DM committee membership, disability knowledge and skills, ergonomics, information management, communications, employee benefits, case and claims management, transitional work, graduated RTW, monitoring and evaluation, continuous improvement, employer support and subsidies, DM professional.

Stakeholders/Actors:

In relation to the main question "Which stakeholders and actors are addressed as central to an effective disability management strategy or process?", the ILOC:

- Provides practical guidance on the management of disability issues in the workplace with a view to promoting a safe, accessible and healthy workplace
- Addresses the duties of workers' representatives in detail
- Refers to the role played by organizations representing person with disabilities at all stages of the DM process
- Refers to competent authorities rather than responsible agencies and sets out in detail the responsibilities of competent authorities.

Stakeholder/Actor roles not addressed in any detail include leadership, management champion, manager/supervisor, human resources, employees, workforce, individual worker, worker's family, social security, private insurance, occupational health services, health and mental health providers, suppliers and subcontractors.

5.2.2 NIDMAR Disability Management in The Workplace: A Guide to Establishing a Joint Workplace Program 2nd Ed. (NDMRC)

The NDMRC addresses more than 50 percent of the analytic framework items in some detail, substantial detail or refers to a supporting document (35/60). These are listed in Table 4 below along with the consensus rating of the level detail. The supporting documents are the Consensus-based Disability Management Audit Tool and the CSPDM Occupational Standards. The NDMRC addresses all 9 DM Scope items, 8t DM Principles, 13 DM elements and 5 DM Stakeholders/Actors. It integrates disability issues with return-to-work and health aspects and describes processes, communication, monitoring an evaluation.

Table 4: Analytic framework items for which some detail is available – NIDMAR Code*

1	**Scope (9)**	1.1	Recruitment	3
		1.2	Career Advancement and Promotion	3
		1.3	Prevention	4
		1.4	Health Promotion	4
		1.5	Job Retention/Stay-at-Work	5
		1.6	Return-to-Work	5
		1.7	Occupational Health Conditions	3
		1.8	Work-Relevant Nonoccupational Health Conditions	3
		1.9	Disability	5
2	**Principles (8)**	2.1	Equal Opportunities	3
		2.5	Consensus-based Approach/Co-Leadership	4
		2.6	Evidence-informed Practice	4
		2.7	Legal Compliance	3
		2.8	Integral to HR Strategy	4
		2.9	Organisational Strategy	4
		2.11	Early Intervention	4
		2.13	Return-to-Work Hierarchy of Outcomes	4
3	**Elements (13)**	3.2	Disability Management Program	5
		3.5	Joint DM Committee	4
		3.6	Disability Knowledge and Skills	4
		3.7	Ergonomics	4
		3.8	Accommodations	5
		3.9	Information Management	5
		3.10	Confidentiality of Personal Information	4
		3.11	Communication	4
		3.12	Employee Benefits	4

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

Table 4: Analytic framework items for which some detail is available* – *Cont.*

3	**Elements (13)**	3.13	Case Management	4
		3.15	Transitional Work	4
		3.17	Monitoring and Evaluation	3
		3.20	Disability Management Professional	4
4	**Stakeholders/Actors (5)**	4.5	Occupational Health & Safety	4
		4.6	Worker Representatives	5
		4.7	Disabled Workers	3
		4.10	Individual Worker	3
		4.13	Social Insurance	3

Scope:
In relation to the question, "What aspects of workplace policies and processes fall within the remit of disability management?", the NDRMC:

- Includes improving recruitment and retention as a goal
- Describes career advancement and promotion as a process by which a person progresses from one job to another within a single employer
- Contends that accommodation and prevention need to be linked through evaluation, trends analysis, and follow up
- Lists Health Promotion and Wellness as an element of the CBDMA
- Sets out to improve the retention of people with disabilities in employment
- Defines RTW as a process by which an employee is supported in resuming work after an absence due to injury or illness
- Describes a DM pilot program which encompassed all individuals who required help in returning to work
- Highlights the principle that disability can affect anyone at almost any time and contends that this universal likelihood has transformed the understanding of the challenges facing people with disabilities trying to find work
- Discusses the distinction between occupational and work-relevant nonoccupational health conditions
- Proposes a biopsychosocial approach to disability.

Prevention and health promotion are addressed in its supporting documents.

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

Principles:
In relation to the central question "What underlying values and principles are considered essential to good practice in disability management?" The NDMRC:

- References the international conventions and instruments that support equal opportunities for persons with disabilities
- Is the result of a consensus among stakeholders that a guide to the successful implementation of workplace-based programs is required
- Integrates evidence-based practices on facilitating the successful employment of people with disabilities
- Promotes a strategy in accordance with the spirit and rules of human rights and other social legislation.
- Describes the requirements for legal compliance.

Consensus-based approach/co-leadership, evidence-informed practice, HR strategy, organisational strategy, early intervention and the return-to-work hierarchy are addressed in detail in its supporting documents. The NDMRC does not discuss non-discrimination, holistic process, biopsychosocial perspective, integrated approach and person-centredness in any detail.

Elements:
In relation to the main question, "What processes and components are addressed as falling within the scope of a DM approach?", the NDMRC:

- Describes a DM program in a workplace as being designed to facilitate the (re)integration of people with disabilities through a co-ordinated effort addressing individual needs, workplace conditions, and legal responsibilities
- Recommends that wherever possible, a joint committee should be established to oversee implementation and evaluation of the DM program
- Contends that a number of universally accepted principles underpin both the design and implementation of policies and programs and a discrete set of characteristics of experience, skills and competencies – occupational standards
- Explains that ergonomics integrates knowledge derived from the human and technical services.
- Has at its core the DM plan and process which support effective accommodation
- Addresses information management from two perspectives disability information and confidentiality
- Specifies that the key principles of confidentiality and informed consent are foundational values and inherent in its goals and definitions
- Contends that effective and supportive communication between the supervisors and the worker with a disability can be a critical factor in successful recruitment, RTW, and accommodation

- Describes RTW planning as the identification and coordination of employment opportunities available in the workplace to facilitate the continued and productive employment of a person with a disability
- Specifies transitional work options as an element of the Consensus-based Disability Management Audit
- Contends that evaluation is a part of any code of practice and need to be applied to every DM plan
- Describes the role of the DM Professional.

Additional details on a number of elements are provided in its supporting documentation including joint DM committee, disability knowledge and skills, ergonomics, confidentiality of personal information, communication, employee benefits and case management. The NDMRC does not refer in any detail to accessibility, disability awareness training, attitudes towards disability, claims management, graduated return to work, continuous improvement and employer supports and subsidies.

Stakeholders/Actors:
In relation to the main question "Which stakeholders and actors are addressed as central to an effective disability management strategy or process?", the NDMRC:

- Focuses primarily on the workplace recognizing the key roles which laws and worker, employer, insurance, and government representatives play
- Recommends that management, government, and practitioners work effectively with unions and organizations representing people with disabilities to achieve necessary DM improvements
- Discusses the roles of disabled workers, the individual worker and social insurance
- Describes the role of worker representatives.

The role of occupational health & safety is addressed in detail in its supporting documents. The NDMRC does not describe the role of a number of Stakeholders/Actors in any detail including leadership, management champions, manager/supervisor, human resources, co-workers, workforce, workers family, responsible agency, private insurance, occupational health service, service provider, suppliers and subcontractors or disability representative organisations.

5.2.3 International Social Security Association Guidelines on Return to Work and Reintegration (ISSAG)

The ISSAG is primarily focused on RTW which is one major domain of action in a DM strategy. It addresses 32 of the 60 analytic framework items. These are listed in Table 5 below along with the consensus rating of the level detail. It addresses 6 DM Scope items, 9 DM Principles,10 DM Elements and 7 DM Stakeholders/Actors.

Table 5: Analytic framework items for which some detail is available – ISSA Guidelines*

1	**Scope (6)**	1.3	Prevention	3
		1.5	Job Retention/Stay-at-Work	5
		1.6	Return-to-Work	5
		1.7	Occupational Health Conditions	3
		1.8	Work-Relevant Nonoccupational Health Conditions	3
		1.9	Disability	5
2	**Principles (9)**	2.3	Holistic Process	5
		2.4	Biopsychosocial Perspective	3
		2.7	Legal Compliance	3
		2.8	Integral to HR strategy	3
		2.9	Organisational Strategy	3
		2.10	Integrated Approach	3
		2.11	Early Intervention	3
		2.12	Person-centred	3
		2.13	Return-to-Work Hierarchy of Outcomes	5
3	**Elements (10)**	3.2	Disability Management Program	5
		3.6	Disability Knowledge and Skills	3
		3.8	Accommodations	5
		3.9	Information Management	5
		3.10	Confidentiality of Personal Information	3
		3.11	Communication	5
		3.12	Employee Benefits	3
		3.13	Case Management	3
		3.17	Monitoring and Evaluation	5
		3.20	Disability Management Professional	5

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

Table 5: Analytic framework items for which some detail is available* – *Cont.*

4	**Stakeholders/Actors (7)**	4.5	Occupational Health & Safety	4
		4.6	Worker Representatives	5
		4.9	Workforce	3
		4.10	Individual Worker	5
		4.12	Responsible Agency	5
		4.13	Social Insurance	5
		4.17	Suppliers and subcontractors	3

Scope:
In relation to the central question, "What aspects of workplace policies and processes fall within the remit of disability management?", the ISSAG:

- Focuses on the social security institutions operating in both the occupational and non-occupational sectors
- Addresses RTW as its primary focus
- Considers RTW to be one important component of a tertiary prevention approach
- Includes improving the retention of people with disabilities in employment as a goal
- Describes RTW processes as including a coordinated effort focused on JR-SAW particularly, in terms of support strategies.
- Refers to disability mainly in terms of those in receipt of disability benefits or at risk of needing to rely on benefits.

The ISSAG does not address recruitment, career advancement and promotion or health promotion in any detail.

Principles:
In relation to the central question "What underlying values and principles are considered essential to good practice in disability management?", the ISSAG:

- Proposes a holistic approach as one of seven areas important to successful RTW
- Recommends that a RTW program be based upon a biopsychosocial approach which combines medical, psychological and social aspects
- Emphasises that RTW processes need to take into account legal responsibilities
- Recommends that the RTW system should be embedded as part of mainstream human resources practice at the workplace
- Proposes an approach to RTW which is supported through an integrated and coordinated mandate

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

- Specifies a set of intersecting strategies that cover the entire RTW process, rather than single organizational strategy
- Emphasises early identification and intervention, proactive reporting and beginning RTW during acute medical treatment.
- Considers that an individualised person-centred approach should include case management, an individual plan, workplace accommodations and quality control
- Specifies that a workplace accommodation framework should include a range of RTW options in terms of a hierarchy of RTW options
- Provides substantial detail on the holistic process and return-to- work hierarchy of outcomes.

Occupational health & safety is addressed in a supporting document. The ISSAG does not specify a single organizational strategy but rather a set of intersecting strategies that cover the entire RTW process. It does not address in any detail equal opportunities, non-discrimination, consensus-based approach, or evidence-informed practice.

Elements:
In relation to the main question, "What processes and components are addressed as falling within the scope of a Disability Management approach?", the ISSAG:

- Aims to stimulate discussion around good practice RTW programs for social security institutions
- Contends that those responsible for developing and administering a RTW program require specific competencies encompassing a wide range of knowledge and skills
- Specifies that a workplace accommodation framework needs to be in place
- Recommends that social security agencies should ensure there is an information management system to brings together all relevant information to support evidence-based intervention
- Notes that privileged information is accumulated during the RTW process and draws attention to the legal obligations to protect such information
- Emphasizes that a system of effective communication among all stakeholders and partners facilitates seamless and timely RTW
- Addresses case management as part of an individualised approach
- Defines monitoring as the process of observing results and evaluation as the assessment of progress towards reaching specific objectives.

It does not refer in any detail to accessibility, disability awareness training, attitudes towards disability, joint DM committee, ergonomics, claims management, transitional work, graduated RTW, continuous improvement or employer supports and subsidies.

Stakeholders/Actors:
In relation to the main question "Which stakeholders and actors are addressed as central to an effective disability management strategy or process?", the ISSAG:

- Is addressed to its members which are a broad group of social security institutions who are expected to implement it
- Contends that the RTW of workers who are on sick leave is part of a continuum of processes aimed at protecting and promoting the health, well-being and work ability of the workforce
- Recommends that preventive efforts focus particularly on occupational health and safety and promotion of health and well-being
- Specifies employee representatives as among the key stakeholders in the RTW process.
- Refers to the individual worker as the 'person-concerned' and addresses their active participation
- Address suppliers and subcontractors as those who are delivering services on behalf of the social security agency.

The role of occupational health & safety is addressed in more detail in a supporting document. The ISSAG does not address in any detail leadership, management champion, manager/supervisor, human resources, disabled workers, co-workers, workers family, private insurance, occupational health services, health and psychosocial service providers or disability representative organisations.

5.2.4 Social Code Book IX-Rehabilitation and Participation of Disabled Persons (SGBIX)

The SGBIX is essentially a legal document designed to enable effective interventions and supports, to regulate the system of participation benefits delivery and specify eligibility criteria. Occupation health & safety and prevention are addressed in another Social Code (Book VII). It is primarily focused on systems of delivery to support the full participation of persons with disabilities or at risk of disabilities of all ages. It addresses labour market participation and employment in substantial detail. The analytic framework items addressed are listed in Table 6 below along with the consensus rating of the level detail. The SGBIX addresses six DM Scope items, six DM Principles; six DM elements and seven Stakeholders/Actors.

Table 6: Analytic framework items for which some detail is available – Social Code Book IX*

1	**Scope (7)**	1.1	Recruitment	5
		1.3	Prevention	4
		1.4	Health Promotion	4
		1.5	Job Retention/Stay-at-Work	3
		1.6	Return-to-Work	3
		1.8	Work-Relevant Nonoccupational Health Conditions	4
		1.9	Disability	4

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

Table 6: Analytic framework items for which some detail is available* – *Cont.*

2	**Principles (6)**	2.1	Equal Opportunities	4
		2.2	Non-discrimination	4
		2.3	Holistic Process	4
		2.4	Biopsychosocial Perspective	4
		2.7	Legal Compliance	5
		2.11	Early Intervention	3
3	**Elements (6)**	3.2	Disability Management Program	3
		3.9	Information Management	3
		3.10	Confidentiality of Personal Information	3
		3.12	Employee Benefits	5
		3.13	Case Management	3
		3.19	Employer Supports and Subsidies	3
3	**Stakeholders/Actors (7)**	4.1	Leadership	3
		4.7	Disabled Workers	5
		4.10	Individual Worker	3
		4.12	Responsible Agency	5
		4.13	Social Insurance	5
		4.15	Occupational Health Services	3
		4.18	Disability Representative Organisations	5

Scope:

In relation to the central question, "What aspects of workplace policies and processes fall within the remit of disability management?", the SGBIX:

- Seeks to improve the employment prospects of persons with disabilities by facilitating recruitment
- Emphasise preventive interventions and services for those at risk of disability
- Describes the company integration agreement which includes activities to promote health and RTW

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

- Specifies a range of services and supports that need to be available to ensure JR-SAW
- Includes RTW for workers who acquire an impairment during their working lives
- Addresses the delivery of services in the workplace as well as the external context
- Adopts a dual approach to defining disability in terms of a biopsychosocial approach and in terms of the severity or complexity of a health condition.

The SGBIX does not address in any detail health promotion or occupational health conditions.

Principles:
In relation to the central question "What underlying values and principles are considered essential to good practice in disability management?", the SGBIX:

- Is itself a legal instrument with which compliance is required
- Integrates laws relating to different sectors to create a consistent set of benefits and procedures
- Refers to the avoidance of discrimination
- Specifies the necessary social benefits in order to promote holistic personal development and participation in life in society
- Emphasises facilitating participation in an independent and self-determined manner, regardless of the cause of a disability.
- Recommends an exchange of information with disabled employees.

The SGBIX is complemented by other legal instruments that address in substantial detail equal opportunities, non-discrimination, holistic process and biopsychosocial perspective. It does not address in any detail consensus-based approach/co-leadership. evidence-informed practice, integral to HR strategy, organisational strategy, integrated approach, early intervention, person-centred, return to work hierarchy of outcomes.

Elements:
In relation to the main question, "What processes and components are addressed as falling within the scope of a Disability Management approach?", the SGBIX:

- Addresses elements mainly at a system level
- Uses the term 'program' to refer to labour market programs to reduce unemployment among severely disabled people
- Addresses the duty of confidentiality of personal information
- Specifies mechanisms for the coordination of services to support the participation of disabled people
- Describes supports and subsidies for workers as well as for employers
- Specifies the components of company integration agreements
- Sets out the roles of responsible agencies, social insurance providers and disability representative organisations.

The SGBIX does not refer in any detail to attitudes towards disability, accessibility, disability awareness training, attitudes towards disability, joint DM committee, disability knowledge and skills, ergonomics, accommodations, communication, claims management, transitional work, graduated return to work, monitoring and evaluation, continuous improvement, DM professional.

Stakeholders/Actors:
In relation to the main question "Which stakeholders and actors are addressed as central to an effective disability management strategy or process?", the SGBIX:

- Assigns ultimate responsibility for overseeing the implementation of SGBIX to the Federal Ministry of Labour and Social Affairs
- Requires that, at system level, an Advisory Board for the Participation of Disabled People be established to advise on issues
- Refers to associations at the Federal level representing disabled people
- Specifies the supports available to a severely disabled person who is facing challenges at work
- Specifies the role of the statutory social and health insurance providers who are responsible for funding services to persons with disabilities and those at risk of disability
- Refers to the legal regulation of the occupational health institutions.
- Describes the role of representative associations in cooperating with rehabilitation providers.

The SGBIX does not address in any detail the roles of management champions, manager supervisor, human resources, occupational health and safety, worker representatives, co-workers, workforce, private insurance, health and psychosocial service providers or suppliers and subcontractors.

5.2.5 CSA Canadian Work Disability Management System Standard (CSAS)

The CSAS is primarily focused on a workplace-based management system to address work disability prevention and management. The analytic framework items addressed by the CSAS are listed in Table 7 below along with the consensus rating of the level detail. It addresses eight DM Scope items, seven DM Principles, ten DM elements and six DM Stakeholders/Actors.

Table 7: Analytic framework items for which some detail is available – CSA WDM System Standard*

1 Scope (8)	1.1	Recruitment	5
	1.2	Career advancement and Promotion	3
	1.3	Prevention	5
	1.5	Job Retention/Stay-at-Work	5
	1.6	Return-to-Work	5
	1.7	Occupational Health Conditions	3
	1.8	Work-Relevant Nonoccupational Health Conditions	3
	1.9	Disability	5
2 Principles (7)	2.4	Biopsychosocial Perspective	3
	2.6	Evidence-informed Practice	5
	2.7	Legal Compliance	3
	2.9	Organisational Strategy	5
	2.10	Integrated Approach	3
	2.11	Early Intervention	3
	2.13	Return-to-Work Hierarchy of Outcomes	3
3 Elements (10)	3.1	Accessibility	3
	3.2	Disability Management Program	5
	3.6	Disability Knowledge and Skills	3
	3.8	Accommodations	5
	3.9	Information Management	5
	3.10	Confidentiality of Personal Information	5
	3.11	Communication	5
	3.13	Case Management	3
	3.17	Monitoring and Evaluation	3
	3.18	Continuous Improvement	5

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

Table 7: Analytic framework items for which some detail is available* *– Cont. .*

4	**Stakeholders/Actors (6)**	4.3	Manager/Supervisor	3
		4.5	Occupational Health & Safety	4
		4.6	Worker Representatives	5
		4.7	Disabled Workers	5
		4.10	Individual Worker	5
		4.13	Social Insurance	3

Scope:
In relation to the central question, "What aspects of workplace policies and processes fall within the remit of disability management?", the CSAS:

- Addresses the needs of current workers and the recruitment of workers with disabilities from the broader labour force
- Suggests that WDM can be framed as a continuum in terms of managing worker health over their time with the organization including job continuity and advancement
- Characterises work disability prevention as a proactive effort.
- Describes a well-functioning WDM system as targeting safe and timely JR-SAW and RTW
- Refers to chronic and episodic disabilities among workers
- Defines disability in biopsychosocial terms.

The CSAS does not address health promotion in any detail.

Principles:
In relation to the central question "What underlying values and principles are considered essential to good practice in disability management?", the CSAS:

- Defines a biopsychosocial approach as one that takes into consideration the association between biological, behavioural, physical, psychological, and social factors that create a disabling condition/situation
- Contends that there is a clear case for an evidence-informed best-practice standard for a WDM System
- Lists legal compliance as a grounding principle
- Defines workplace accommodation as an evidence-informed strategy to support the (re)integration of individuals with disabilities at work
- Proposes that, there are a number of potential business advantages to adopting a WDM system that is integrated with other aspects of an organization's management system
- Defines early and safe RTW as returning to work before full recovery in a manner that is compatible with the worker's functional abilities and aids in his/her recovery process

* 3=Provides Some Detail; 4=Provides Detail in a Supporting Document; 5=Provides Substantial Detail

- Contends that in cases of health absences, an effective WDM system targets safe and timely RTW with consideration of the RTW hierarchy.

The CSAS does address in any detail equal opportunities, non-discrimination, holistic approach, consensus-based approach, integral to HR strategy or person-centredness.

Elements:
In relation to the main question, "What processes and components are addressed as falling within the scope of a disability management approach?", the CSAS:

- Adopts a focus on inclusion and accessibility to promote engagement and belonging as a guiding principle
- Presents the business case for a WDM system
- Requires organizations to ensure that the key stakeholders involved in the planning and implementation of the WDM system have the requisite knowledge, skills, and abilities
- Promotes accommodation and timely and safe RTW which considers the essential duties of the worker's role within the organization in the case of health-related absences
- Emphasises that the documentation of policies, processes, procedures, and defined practices is critical to ensuring clarity and consistency in management practices, as well easy access to information
- Requires organizations to develop and promote confidentiality policies that balance a worker's right to privacy
- Emphasises the importance of timely communications between the organization and the worker following an incident or illness resulting in disability
- Defines disability case management as a comprehensive, proactive, collaborative process between all parties
- Specifies that monitoring and evaluation need to be appropriate to the size and the nature of an organization and use both qualitative and quantitative methods
- Defines continual improvement as the process of enhancing a system to achieve ongoing improvement in overall performance.

The CSAS does not address in any detail disability awareness training, attitudes towards disability, joint DM committee, ergonomics, employee benefits, claims management, transitional work, graduated return to work, employer supports and subsidies or the DM professional.

Stakeholders/Actors:
In relation to the main question "Which stakeholders and actors are addressed as central to an effective disability management strategy or process?", the CSAS:

- Defines worker as including supervisors, managers and leaders
- Worker representative is defined as a non-managerial worker who is a member of a workplace health and safety committee

- Aims to provide organizations with requirements and guidance on how to effectively manage workers' health needs
- Characterises WDM as a complex process with multiple stakeholders within and outside of the organization, including a range of insurance programs and support service providers.

The Occupational Health and Safety Management Systems (OHSMS) Standard CSA Z45001 is a supporting document. The CSAS does not address in any detail leadership, management champion, human resources, co-workers, workforce, workers family, responsible agency, private insurance, occupational health services, health and psychosocial service providers, suppliers and subcontractors or disability representative organisations.

6. Recommendations

The approach adopted for this review involved an interpretive process. An analytic framework was generated based on current research and practice which specified a set of 60 items covering the Scope (9), Principles (13), Elements (20) and Stakeholders/Actors (18). No attempt was made to determine the extent to which each of the documents reviewed had impacted on actual practice. It could be important to carry out a consultation with those responsible for overseeing the implementation of each of the documents to determine what strategies have worked best. In those jurisdictions in which DM or RTW professionals operate, it would be possible to survey the extent to which the documents form a part of the knowledge base for practice.

While implementation and dissemination could be considered to be outside the remit of this review, the approach that will be taken to support the deployment of the standard could influence the development process for an international standard on DM.

The framework was applied to five publications which are intended to provide guidance, standards or regulations on DM. Every reference to an item was extracted from each of the documents and a comparative table was prepared. An iterative interpretative data-reduction process was applied to each table to distil the key concepts proposed in each of the documents. It transpired that the diversity of purpose, scope and responsible actors across documents created a challenge in identifying a consistent characterization of many central and supporting concepts.

A number of the issues arose during the interpretive process which could well be important to resolve as part of the development of an international standard on DM. These have informed the recommendations of this report. Table 8 presents a summary of the recommendations. A more detailed explanation and rationale is provided below.

Table 8: Summary of Recommendations

7.1 Terminological Clarity	
Recommendations	
1	**Definitions and Distinctions:** Ensure that it is clearly signalled that a person does not require to be deemed to be disabled to benefit from a DM approach.
2	**Synonyms:** Explore the commonalities and distinctions between synonyms and near-synonyms and take account of these in the glossary.
3	**Linguistic Equivalence:** Agree on the languages in which it is intended to publish and clarify equivalent key terms in each of the selected languages from the outset.
4	**Intended Audience:** Clarify in advance which stakeholders are the intended audience, what their information needs are and the extent to which they can use a common set of standards or require additional specific standards related to their roles.

Table 8: Summary of Recommendations *cont.*

7.2 Intended Impact	
Recommendations	
5	**Knowledge Transfer:** Establish the intended audience and the relevant domains of research and good practice to be addressed. This needs to inform the knowledge to be incorporated, the perspective from which it is presented and the language in which it is phrased.
6	**Responsible Agent:** Agree the responsible agent(s) being addressed by the standard This will influence the level at which the standards are pitched i.e., macro, meso or micro levels. This may require the production of different versions of the standard customized to the needs of different stakeholders.
7	**Intended Beneficiaries:** Maintain a focus on the person as the direct beneficiary of DM and the effective delivery of DM to an individual job seeker or worker throughout. Additional extended beneficiaries, such as the employer or the person's family, need to be addressed as appropriate.
8	**Informing Policy, Principles or Practice:** Clarify the extent to which the standard is intended to impact on policy, legislation, system measures and mechanisms or delivery systems. A decision on the level or levels of action that it is intended to address is a prerequisite.
9	**Stimulating Change:** How the standard is intended to impact on system, organisational, professional and cultural change needs to inform the phrasing of the text and the subsequent dissemination initiatives taken after its publication such as, a plain language version, a supporting video, an online platform/network and access to training.
10	**Harmonising or Influencing:** In advance of the drafting process, clarify the extent to which the standard is intended to harmonise policy, processes and practice across jurisdictions and the degree of flexibility in interpretation that can be assigned to national contexts.

7.3 Scope and Focus	
Recommendations	
11	**Areas of Implementation:** Give consideration, in the development of the standard, to the scope of DM in terms of the employment cycle of an individual.
12	**Inclusions and Exclusions:** Clearly specify the components that are addressed and those that are excluded from the outset.
13	**Intersecting Domains of Action:** Provide a clear map of the domains of interest that need to align to achieve an effective DM response for workers. At the very least, the domains of HR and Occupational Health and Safety need to be addressed.
14	**Levels of Implementation:** Consider the most appropriate and user-friendly approach to encapsulating the multi-level nature of an effective system of DM and consider producing versions for specific audiences.

Table 8: Summary of Recommendations *cont.*

7.3 Scope and Focus *cont.*	
Recommendations	
15	**Core and Context:** Clearly specify the core and contextual components at all levels of the system. The domains of action, with which DM intersects, with which it needs to align and to which it can provide added value, should be clearly described.
16	**Actors or Stakeholders:** Describe the direct and indirect beneficiaries of DM, who the actors are and who holds a stake in each component of DM as appropriate.
7.4 Structure	
Recommendations	
17	**Perspective Taking/Point of View:** Decide in advance the perspectives or points of view to be addressed. This will influence the type of terminology to be used, how the content will be presented and the level of detail required. Emphasize pragmatic and practice components to ensure that the audience can work with it in their daily work.
18	**Principles and Values:** From the outset, achieve a consensus on the principles and values that underpin the DM approach being espoused in the standard. These will form the basis for selecting content to be addressed, the level of detail provided and the language used.
19	**Superordinate Organisers:** An early decision needs to be made about the underpinning conceptual framework and how this will be reflected in the chapter, section and sub-section headers in the text, taking into account that the standard will need to maintain relevance across jurisdictions with diverse cultures, contexts and laws.
20	**Categories and Sub-categories:** Prior to setting out to draft the text agree on the main categories and sub-categories to be included and the sequence in which these will be presented.
21	**Level of Detail:** A balance between usability and usefulness needs to inform the decision on the level of detail to be included in the standard A broad overview of a DM approach is unlikely to have a significant impact on practice. A very detailed description of each component could result in a dense and unwieldly document.
22	**Mandatory and Informative Annexes:** Consideration could be given to extending the detail in the standard by attaching a number of mandatory annexes which are clearly part of the standard. Informative annexes could provide brief summaries of other documents that are required to complement the standard.
23	**Review, Monitoring and Update:** Build into the standard a date for review and update. A mechanism for monitoring the progress in disseminating the standard could be put in place and a monitoring committee of interested experts could be established to oversee this.

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