

Employee Awareness and Empowerment Research Report

The Collaborative Partnership
to improve work participation

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Executive summary

Each year, too many Australians are unable to work due to a temporary or permanent injury, illness or disability. Amongst OECD countries, Australia ranks 21 out of 29 for employment rates among people with disabilities relative to the population and evidence shows that for people with a workers' compensation claim, return to work rates have stagnated since 2006.

The objectives of the Employee Awareness and Empowerment research is to better understand the experiences, beliefs, and needs of people with a health or disability related reason for work incapacity and identify evidence-based interventions to empower '**employees**' with a health condition or disability to use work as part of their recovery.

The World Health Organization defines **empowerment** as:

the process by which people gain control over the factors and decision that shape their lives

This definition includes the process by which people build their personal attributes in order to achieve their capacity. Personal attributes can include confidence or self-worth, building knowledge, developing coping mechanisms, or enhancing personal skills to make health and wellbeing related choices. Many examples of successful empowerment interventions and programs already exist in the public health field.

The study addresses an important gap in evidence on empowerment strategies for people with a health condition or disability to use work as part of their recovery. The findings presented in this report are based on a rapid review of evidence on empowerment interventions; qualitative research to gain a first-hand account of lived experience that sets the context for what needs to be considered when addressing empowerment; and insights from stakeholder from the relevant systems and sectors. This report provides important insights for policy makers, service providers and system owners responsible for supporting people with ill health or disability and work participation.

The key findings from this study shows that:

- employees are motivated to work and their motivation is not a barrier to participation – it is not for lack of trying that people have not secured suitable work. People are aware that work provides purpose, self-sufficiency, stability and socialization. Being off work makes it harder to get work, leads to loneliness, loss of self-confidence, loss of perceived control and loss of social networks.
- employees find the benefit and income support systems complex and overwhelming, personified by a 'one size fits all' approach that leaves little room for flexibility or empathy. They report a lack of transparency regarding their rights, benefits and processes, significant uncertainty, ineffective communication between stakeholders that is particularly problematic as people transition between systems, and a continuous requirement to retell their story. These experiences can contribute to worsening health and delayed recovery for the individual.
- there is a strong belief amongst employees that employers lack understanding of the work ability of people with a health condition or disability and how to effectively accommodate them.

In this report the term '**employees**' refers to individuals staying at, or returning to work, or commencing new work (including their first job); with injuries (psychological or physical), disabilities (cognitive or physical), or disease

"An estimated 786,000 Australians are unable to work due to an injury, ill health or disability and access income support from a commonwealth, state, territory or private source."
(Cross-Sector Systems Report, 2017)

"A further 6.5 million people access employer provided leave entitlements for periods of work incapacity due to their health).
(Cross-Sector Systems Report, 2017)

A number of interventions can be used to empower employees to use work as part of their recovery including mentorship, education and goal-setting approaches; however, these interventions require enabling mechanisms to be in place by relevant systems and providers.

This study highlights that for empowerment interventions to be effective, will require a multi-dimensional approach that addresses broader cultural attitudes, system improvements and work accommodation principles.

- *Cultural change* – shifting beliefs and attitudes towards the value of good work and inclusion. Culture and social norms provide the over-arching context and motivation that makes individual interventions effective. It is a high order ‘empowerment’ tool that goes in-hand with the need for better across-community **health literacy**.
- *System change* – the perceptions and experiences of employees of the benefit and income support systems may be considered harsh, but presents a very real impediment to personal empowerment. Reports show that parts of the system by causing secondary conditions such as depression. Reports show that parts of the system are out of step with best practice approaches to customer-centric servicing and streamlined operating processes.
- *Work accommodation* – there is a need for employers to have a better understanding and improve management of the capabilities of employee’s with a physical or psychological condition. This is supported by the literature and the findings from employees and stakeholders. This is the practical aspect of the work experience and enabling individuals to obtain, stay at or return to work is reliant on employer engagement.

Health literacy refers to the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy is critical to empowerment.

Empowering people to use work as part of their recovery and wellbeing can lead to better health and economical outcomes for individuals, their families, the community, and Australian workplaces. The key message from this research is that empowerment is a complex strategy that sits within complex environments and settings. Effective empowerment strategies depends not only on the individual and their ability to control the factors that shape their lives, but also the overall context in which they take place.

1.0 The project approach

1.1 Project objective

This project aims to use an evidence informed approach to identifying effective or successful interventions to empower employees to stay at, obtain or return to work.

1.2 Project approach

This study is an initiative of the *Collaborative Partnership to improve work participation* (the Collaborative Partnership) and has been led by EML. The Collaborative Partnership is a national alliance between the public, private and not-for-profit sectors and is focused on improving work participation of Australians with a temporary or permanent, psychological or physical health condition or disability.

There is limited current understanding of the beliefs, perceptions and attitudes of people with a temporary or permanent injury, illness or disability and their experience of people with a temporary or permanent injury, illness or disability and their experience of navigating the various benefit and income support systems in Australia, and interactions with employers, and relevant service providers. This project used qualitative research methodology to inquire deeply into specific experiences, with the intention of describing and exploring meaning through narrative data, by developing themes exclusive to the study participants. While the qualitative approach provides us with a rich understanding of people's experience, it does not allow us to infer or generalise about the experience of those who did not participate in the research.

The project is informed by a rapid literature review, citizen panel discussion and individual interviews, and expert stakeholder interviews.

Rapid Literature Review

The Rapid Literature Review was focused on interventions that have been proven to encourage employees to stay at, obtain, or return to work.

It was based on the PICO framework:

- **P**opulation: Individuals staying at, or returning to work, or commencing work (including first job); with injuries (psychological or physical), disabilities (cognitive or physical), or disease (e.g. cancer).
- **I**nterventions: Empowerment (unlikely to exist), active participation, navigation, self-management (insurance), health literacy, scheme navigation, work planning, problem solving, support mechanisms, self-management support, self-sufficiency, social support (e.g. community involvement, family stability), and active interventions.
- **C**omparison: No specific comparison group was set
- **O**utcomes: Work status (return to work, stay at work, commence new work), feeling of empowerment, attitudes, needs, and motivations.

The review included international data covering the last five years and yielded 71 relevant articles.

Citizen Panel and Interviews

The purpose of the Citizen Panel and interviews was to understand the attitudes, motivations, beliefs, experiences, drivers, barriers and needs of employees navigating the work disability system.

A total of 23 citizens participated – 10 for the Citizen Panel and 13 in individual interviews.

Recruitment ensured participant representation across:

- work status: obtaining, staying at or returning to work.
- claim type: physical and psychological.
- health conditions: Injuries (psychological or physical), disabilities (cognitive or physical), or disease.
- cross sector experience: workers’ compensation and motor accident, disability support and social welfare; superannuation or life insurance.

The line of enquiry was informed by the results of the Rapid Literature Review.

Participant Profile

10 respondents were involved in the Citizen Panel and 13 participated in one-on-one interviews. The distribution of participants across the above categories is summarised below in Table 1

Table 1: Participants in Citizen Panel and Interviews

Job status	Injury type	Workers’ Compensation	Motor Accident Compulsory Third Party	Disability Support Pensions	Superannuation	DE Services
Time in the ‘system’		A majority representation across three, four and sixth months with a few long tail (e.g. +52 weeks).				
Obtaining work	<i>Physical</i>		1	1	2	1
	<i>Psychological</i>	1	2	2	3	
Returning to work	<i>Physical</i>		3	1	1	
	<i>Psychological</i>			1		
Staying at work	<i>Physical</i>	1	1	1		
	<i>Psychological</i>		1			
		2	5	7	5	4

A more detailed breakdown of participants can be seen in Appendix 2.

The sample was recruited in collaboration with a panel recruiter that specialises in social issues research. We also distributed material advertising via partner stakeholders from specific systems where possible.

This study recruited across the different sectors of: Motor accident: (22%); Disability Support Pensions (DSP) (30%); Superannuation:(22%); Disability Employment Services (DES): (17%). The recruitment of individuals from the workers’ compensation (9%) sector was more challenging. Nearly half of our participants (43%) were those with psychological claims or conditions. One area of recruitment difficulty was for individuals trying to stay at work, which only comprised 17% of the final sample, compared to ‘Obtaining work’ (57%) and ‘Returning to work’ (26%). Additionally, we found that individuals from the psychological profile were much more likely to be looking for new work (80%) than returning to work (10%) or staying at work (10%).

Workers' compensation was the least well represented in the study sample (9%), whereas it is one of the larger systems according to the the Cross-Sector Project Report (n=156,000; 2%). The under representation of participants from the workers' compensation category may be partially explained by employees in this category preferring not to discuss their claim experiences publicly.

There was an almost even split between interviews conducted by phone compared to attendees at the Citizen Dialogue Panel: eight scheduled interviews and five rescheduled from individuals who did not participate in the citizen panel. Six (46%) of these interviews were with individuals from the 'psychological' profile, six (46%) were from the 'physical injuries or conditions' profile, and one (8%) was from the 'disease or illness' profile.

There are two speculations that arise from the data: people with psychological conditions or learning disabilities seem more likely to be out of work and looking, rather than in work and trying to get back or staying; and interviews may have been favoured for accessibility or privacy reasons. We are unable to determine if these speculations are true, or whether there are other participant motivations that are driving these numbers and participation rates.

Expert Stakeholder Interviews

Ten one-on-one interviews were conducted with stakeholders from across the sectors and systems to understand their perspective of the biggest challenges in empowering employees to obtain, stay at or return to work and capture their insights into what interventions would be effective and when.

Interview participants represented organisations responsible for disability services, workers' compensation, motor accident compensation, employee rights, insurance schemes and government welfare and employment services.

1.3 How to interpret the research findings

Whilst the intended outcome of this study is to identify what information and support employees need to use good work to facilitate their recovery through 'empowerment' and 'self-management', the symbiotic nature of employees, employers, health care providers and 'system' managers inevitably leads to commentary on how these component parts need to change to facilitate recovery. Important points to be aware of in reading this report include:

- there are clear synergies between the outcomes of the Rapid Literature Review, Citizen Panel, Citizen and Expert Stakeholder Interviews but the 'solutions' may be differently expressed
- with the Rapid Literature Review focusing on interventions that have proven to be effective, the key recommendations in this report are led by its evidence and confirmed by the qualitative findings from the employee and stakeholder research
- purpose of this study is to explore how it might be possible to best support the endeavours of people with a health condition or disability to facilitate their own recovery and does not in any way imply that the study participants were not already trying their best
- the structure of the research activities was to: conduct a rapid review of the literature that shows demonstrable successful or unsuccessful interventions; and use the outputs from the review to structure the subsequent qualitative components. This report will follow this structure, using the rapid review results as a framework for discussing ways to support individuals' recoveries.

2.0 Findings

2.1 Rapid review results

A rapid literature review was undertaken to identify, evaluate and synthesise published literature investigating empowerment interventions to help people return to work, stay at work or commence new work after injury, disease and disability.

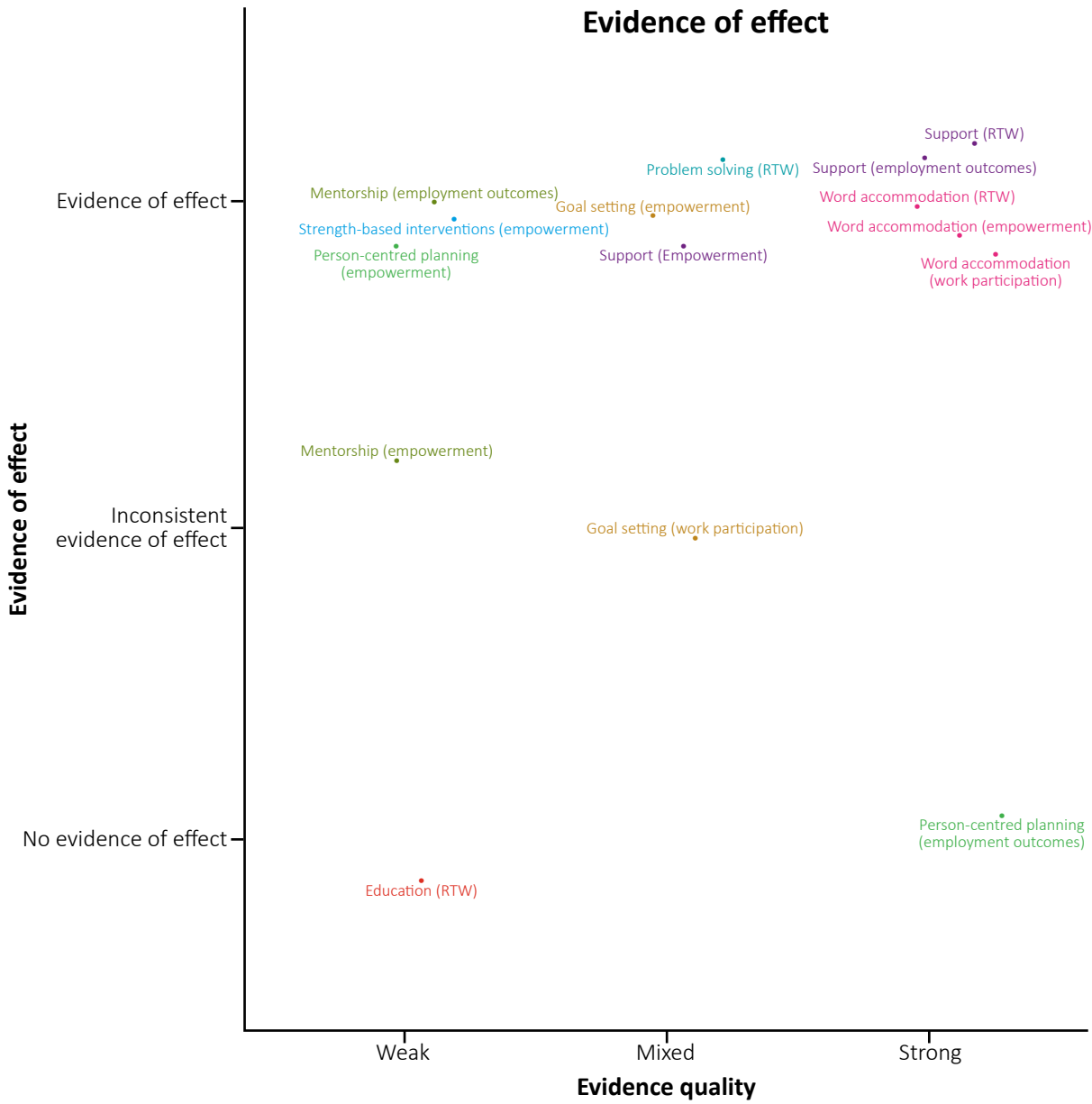
Rapid reviews are an emerging method of efficiently synthesising research evidence in health policy and other settings where a broad overview of research evidence is required in a short timeframe. Unlike traditional systematic literature reviews, rapid reviews focus on synthesised research evidence. Caution needs to be applied when interpreting rapid review findings, as more comprehensive review approaches may elucidate further information and insights, which would influence review interpretation and conclusions (Khangura, Polisena, Clifford, Farrah, & Kamel, 2014). Therefore, systematic reviews remain the definitive method of literature review, and we recommend that systematic reviews are undertaken whenever possible.

The literature review yielded a total of 3549 citations, after the removal of duplicates. Following screening, 23 systematic reviews were identified. Areas covered by the reviews are presented in Appendix 3 and detailed information regarding the quality appraisal are presented in Appendix 4.

The Rapid Review identified eight interventions types	Education
	Goal setting
	Mentorship
	Person-centred planning
	Problem solving
	Strength-based interventions
	Support
	Word accommodation

Interventions are charted according to whether they improve outcomes and the quality of that evidence. Outcome variables are presented in parentheses. It is possible that an intervention type is evaluated against several outcomes such as 'Support (empowerment)' vs. 'Support (RTW)'. The data points can only vary along three possible evidence quality values ('weak', 'mixed', or 'strong') and three possible evidence of effect values ('no evidence of effect', 'inconsistent evidence of effect', or 'evidence of effect'), for a total of nine possible positions on the graph. Because datapoints with the same evidence quality and evidence of effect values would sit atop one another, we have floated the datapoints around each possible position.

Evidence of effect



2.2 Intervention ranking

The qualitative interviews captured the perspective of employees and expert stakeholders relative to the eight interventions identified in the Rapid Literature Review, as well as leading to an additional two intervention territories to bring the total potential suite to 10.

This chart summarises what was found through evidence and compares it to employee and stakeholder input.

Table 2: summary of evidence on interventions

Intervention	Evidence	Employees	Stakeholders
1. Work accommodation	✓	✓	✓
2. Support	✓	✗	✓
3. Mentorship	?	≡	✓
4. Goal setting	?	✓	✓
5. Person-centred planning	?	✓	✓
6. Problem-solving	?	?	?
7. Strength-based interventions	?	?	?
8. Education	✗	✓	✓
9. Cultural change		✓	✓
10. System change		✓	✓

Key:

Evidence Column:

- ✓ high quality and clearly points to an effective intervention
- ? evidence is either of mixed quality or couldn't agree on whether the intervention worked or not
- ✗ evidence is of a high quality but not clearly able to demonstrate an effect of the intervention

Employee and Stakeholder columns:

- ✓ clearly indicate support for the intervention
- ≡ indicates most favoured approach
- ✗ did not indicate support for an intervention
- ? had no opinion of an intervention because they had no/limited experience with it or focused on other interventions

2.3 Responses to the intervention types

Employee responses to the following intervention can be categorised into key themes of:

- information and process – what is available to me and who do I speak with to get it?”
- empathy and understanding – from employers, support providers, and the general public
- degradation of mental health and wellbeing – this is an underpinning theme to those noted above, employees say this is under prioritised by support providers.

We refer to these when discussing the employee feedback on the different interventions. More details are provided in Appendix 5.

1. Work accommodation

Evidence



Employees



Stakeholders



What is the problem being addressed?

Workplace accommodation is about making changes to the workplace or the way that work is done to allow all people the opportunity to work according to their capacity.

What is the approach?

Workplace accommodation includes changes in work schedules and work organization, development of the work environment, use of assistive technologies, assistance of other persons, and changes in commuting to and from work. Workplace accommodations can focus on a single person or a whole organisation.

What does the evidence say?

Five reviews on work accommodation were identified in the search strategy. One review revealed that workplace accommodations are rare. When workplace accommodations are used, the most common type is flexible scheduling/reduced hours. The direct costs associated with workplace accommodations are often low.

One review found moderate evidence that workplace accommodations promote employment participation, but low evidence that workplace accommodations administered by case managers increases return to work. This is not to say that workplace accommodation administered by case managers is less effective, but that the studies evaluating workplace accommodations administered by case managers are of low quality. We should be cautious in interpreting low quality evidence.

There was strong evidence for multi-domain interventions (a combination of health-focused interventions, service coordination interventions, and work modification interventions) that include workplace modifications in reducing time away from work. There was also strong evidence that multi-faceted interventions are ineffective without workplace accommodations.

What do stakeholders say?

This direct quote provides a good summary of stakeholder perspectives on work accommodation and demonstrates how strongly they support the role of the employer in facilitating work capacity:

‘Employers play such a pivotal role in people trying to stay at work. Government needs to educate them more in keeping their employees healthy.’

Specific feedback from stakeholders covers a number of themes:

- The need for management to be supportive – this was consistently raised in relation to return to work. The definition of ‘management’ goes beyond the senior manager and takes in the notion that the employees’ supervisor and colleagues – the people they used to work with every day – have the biggest role to play. ‘Support’ includes pro-active ‘reaching out’ by the workplace to the employee and that if the employee is the one tasked with reaching out every time (often for little result), there is a consequential negative impact on their confidence. The employer needs to be the ‘first mover’.
- Stigma and discrimination – seen by stakeholders as a major barrier to work accommodation. This can be either conscious or unconscious (comments such as ‘they should have returned to work by now’) and relate both to obtaining work (‘why hasn’t this person worked for two years’; or acquired disability and the associated societal perceptual barriers), as well as for those staying at or returning to work especially for those with a mental health condition. Stakeholders regard as highly important the need to create awareness and understanding that people can have a disability, go through an injury or illness and still have capacity to work.
- Job match – stakeholders suggest that there are tools already available that should be used to ‘job match’ for example, personality tests can be used much better for job matching.
- Recruitment methods – those born with or having acquired a disability do not have the same opportunities to work out their career development or work experience as their non-disabled peers. Even the way employers talk about and recruit makes it hard for people with a disability for example, : it may not be clear from the job description whether they can do the job; online applications may be an impediment if they can’t use a mouse or have visual impairments. Those with a disability are not the only ones impacted by recruitment tactics – recruitment tools such as ‘mass interviews’ can be daunting for someone who is lacking confidence, has a socially impacting health condition (e.g. someone with Asperger’s may be a genius IT technician but is unable to communicate/sell themselves) or has been out of the workplace for some time; they can be deterred from even applying for the job in the first place.
- Lack of employee understanding of what to expect from their employer.
- Driven by risk – Employers are risk adverse in accepting employees who are not 100% well.
- There is also a need to empower employers – even an employer willing to employ someone who requires a modified work environment can be disempowered through their simple lack of knowledge of how to go about it or what will be required of them.

What do employees say?

This intervention addresses the theme of *empathy and understanding*.

The workplace accommodations that employees had most experience with were flexible scheduling of work hours and switching to light duties. Employees noted that these were temporary solutions and their suitability varies with individuals’ conditions. Others noted that a change in duties can be traumatic because it means switching from work that you have built a career on to something different. There are clear differences in the reactions of people who have not been out of the workforce for very long versus some who had been out of work for a significant time – the longer someone is out of work, the more willing they are to do anything. For instance, some said they wouldn’t be happy with light duties for the long term, whereas others who had been injured for longer said that they would happily do anything within their skillset.

Graded return to work was seen as an important form of work accommodation. One employee commented that some workplace accommodations are straightforward and easy to secure, whereas others are more challenging when the individual's health condition or disability is less visible.

Finally, employees mentioned that jobs exist but there are few employers who are willing to accommodate those with health conditions or disabilities.

Employees reflected the stakeholder idea that their employer reaching out to them, even if that is just the occasional check in to see how they are, has a demonstrable impact on their emotional wellbeing and confidence in their future. This was demonstrated quite clearly in the Citizen Panel by one employee whose employer had maintained regular contact with them, and their emotional wellbeing compared to other panel participants.

What has helped/could help?

- Flexibility and understanding on the part of the employer. A forum for employers who are open to accommodating those with disability to advertise job positions.
- Standards established for Employers.
- Disability Confident Recruiter. An organisation should have to go through a process that makes all their systems accessible and inclusive.
- The need to remove employer and cultural stigma and barriers – whether conscious or unconscious – and create awareness of the benefits of 'good work'.
- Educating employers on good job design – how to design the job to have the appropriate breadth and depth. That means clarity, authority, delegation of duty and decision-making autonomy, variation of task – good work.
- 'On the job' training for intellectually or physically disabled – rather than tertiary education.
- Policies that explain what happens and commit to doing whatever is reasonable if an employee cannot work/has to change their working circumstances and guidance that helps employees understand how to respond if they are experiencing difficulties.
- Job coaches.

2. Support

Evidence



Employees



Stakeholders



What is the problem being addressed?

It can be difficult to manage your health condition or disability if it impairs you physically and/or mentally. That means it can be especially difficult to find or get back to work. Support is about making job-seeking and return to work easier for those with a health condition or disability.

What is the approach?

Support takes many different forms, sometimes it's about speeding up the process of getting someone into new work, other times it's about helping people stay in existing work. The latter form is sometimes referred to as a 'place-train' model and Individual Placement and Support (IPS) is the most structured and well-defined form of this approach. It is based on the philosophy that anyone is capable of gaining and maintaining competitive employment, provided the right job with appropriate support can be identified. Other forms of supported employment can include coaching and education. Supported employment may also be augmented for example with additional rehabilitation or skills training.

What does the evidence say?

Evidence from nine reviews was largely in favour of support approaches for improving empowerment, work participation, and return to work. Individual placement and support programs are an effective intervention across a variety of contexts and economic conditions and are perhaps twice as effective as traditional rehabilitation programs such as ‘train-place’ models for getting people into work. The evidence ranged from tentative to strong for augmented supported employment. There was moderate to strong evidence that coaching and education support improves return to work and sickness absence outcomes. Not all reviews arrived at the same conclusion – some found insufficient evidence for effective support strategies in obtaining and maintaining employment.

What do stakeholders say?

Stakeholders in roles of helping people find suitable employment believe ‘motivation’ and ‘confidence’ is a critical factor of being able to find work. The ideas that stakeholders put forward consistently went to these two themes:

- Training, retraining, reskilling to gain, retain or re-enter work.
- Motivational interaction training to improve confidence.
- Tools on how to get a job – resume writing etc.

What do employees say?

This intervention addresses the theme of degradation of mental health and wellbeing. Employees believe too many support programs focus on physical support and skills training – there are few programs aimed at supporting mental health during rehabilitation and/or the job search. Access to relevant support programs is also sometimes difficult, with one employee saying

“You need to make yourself look twice as bad in order to get half the help you need”

This sentiment was also echoed by stakeholders.

What has helped/could help?

- Training, retraining, reskilling to gain, retain or re-enter work.
- Motivational interaction training.
- Tools on how to get a job – resume writing, interview practice.

3. Mentorship

Evidence



Employees



Stakeholders



What is the problem being addressed?

Navigating disability support systems can be a frustrating and lonely experience. Mentorship addresses both problems of handling complexity and of doing it alone.

What is the approach?

Mentorship relationships involve the provision of ongoing guidance, instruction, and encouragement from a mentor with experience to promote competence and employment participation on the part of the individual.

What does the evidence say?

Two reviews suggest that the evidence regarding mentorship is mixed depending on the outcome measure. Mentorship may be effective for improving employment or work-related outcomes, though the quality of the evidence is low. However, evidence regarding the effectiveness of mentorship in improving empowerment is inconsistent and also of low quality.

Some evidence suggested that mentorship could increase depression in individuals. Considering that a mentor may be a person with a similar disability as the individual, developing a relationship with this mentor may highlight the individual's own health-related problems. Another concern is that mentors may offer advice outside their domain of expertise. Mentors, therefore, may be workplace mentors who can help the individual in their employment transitions, life mentors who can support the individual socially, or health mentors who may share similar health experiences as the individual.

What do stakeholders say?

Stakeholders highlight that a 'loss of confidence' starts immediately and grows the longer someone is away from work.

Whilst in no way suggesting they should become a nominated mentor, stakeholders see the claims manager as being able to take a stronger role in encouraging their customers to wellbeing and work. Stakeholders are concerned this is currently limited by the process driven nature of schemes that typically disempower claims managers from being able to make judgements and ability to form valuable relationships with clients to help motivate them.

What do employees say?

Mentorship approaches speak to the themes of information and process, and degradation of mental health and wellbeing. Mentors or support groups were often the only way that employees felt they could discover what services they were eligible for. Mentorships were often informal relationships or voluntary in nature – employees voiced concern about the over-reliance on volunteer networks. Mentors also provided social and emotional support as mentors often shared similar experiences or situations to the employee.

What has helped/could help?

- Make Claims Managers into 'relationship managers' and create a bespoke training program.
- Use advocacy organisations that are in touch with the needs of their specific group e.g. spinal cord association as a central forum.
- Use Behavioural Economics theory to restructure language that is positive, constructive and future focused. Introduce the notion of re-engaging with life (not just work).
- Develop a web platform that contains relevant services and motivational tools.

4. Goal setting

Evidence



Employees



Stakeholders



What is the problem being addressed?

Goal setting approaches are about staging rehabilitation or job-seeking in order to preserve and enhance motivation.

What is the approach?

The practice of setting goals is thought to influence individuals' feelings of empowerment. By thoughtfully setting measurable goals, individuals can track progress in their rehabilitation or return to work. Successfully meeting these goals is thought to increase a person's belief in their ability to achieve further employment-related goals (self-efficacy).

What does the evidence say?

Two reviews looked at the effect of goal-setting. Goal-setting approaches may nurture empowerment, although the quality of evidence was mixed but evidence for improving work participation and occupational performance was mixed. It might be that goal-setting may be useful for rehabilitation but not necessarily helpful with employment.

What do stakeholders say?

Stakeholders believe outcomes are better when dealing with someone who understands the choices they have and what support can be put in place to achieve those.

They also support the idea of getting the employee to commit to things they will do 'one step at a time' – depending on the circumstances of the person, a goal and achievement may be as simple as a walk to the end of the road, making a meal or talking to someone in a shop.

What do employees say?

Goal-setting approaches address the theme of degradation of mental health and wellbeing. Employees see goal-setting as an important tool in achieving their employment goals. Goal-setting helps with the mental health aspect of recovery according to employees. Achieving goals helps alleviate feelings of helplessness by demonstrating what the individual is still capable of doing.

What has helped/could help?

- While employees value goal-setting, they believe that other things need to be done first before goal-setting strategies can be effective. For example, some think that an overhaul of case management activities would be necessary before goal-setting strategies could be effective. Employees want support providers and case managers to be more involved in their case and see shared goal-setting as a potentially effective means of doing so.
- Improving health literacy indirectly impacts goal-setting. Health literacy includes tailored information that helps people understand what will happen throughout their recovery journey, how to get the support they need and helps them identify what is possible.
- The use of future-focused language is an aid to goal-setting.

5. Person-centred planning

Evidence



Employees



Stakeholders



What is the problem being addressed?

Employees often find that the services and support provided to them are not suited to their needs. Person-centred planning addresses the problem of individuals unique needs falling through the cracks for example, as people they move between different benefit and income support systems.

What is the approach?

There is an ongoing transformation of disability service delivery, progressing from a system-centered approach to a person-centered approach. Under a person-centered approach, support and services are tailored around the individual and their unique needs rather than enforcing a one-size fits all approach. Person-centred planning is an approach aimed at achieving individualised support for people with disability and treating them with dignity, compassion, and respect.

What does the evidence say?

One review focuses on person-centred planning. There are small-scale successes of person-centred planning approaches improving empowerment (i.e. community and life participation). The evidence of these successes, however, is of low quality so cautious interpretation is advised. The evidence for person-centred planning improving employment outcomes is inconclusive.

What do stakeholders say?

'Schemes work in streams. But that doesn't work for the client.'

Stakeholders very much support the idea of a person-centered approach with some already achieving results in their own system with this approach. Stakeholder feedback was that 'the system' makes the person the problem and the way it is run assumes the system knows more about the employee than the individual knows about themselves – 'we do things TO people'.

Stakeholders are conscious of how much being part of 'the system' detrimentally exacerbates the person's situation and how dealing with the system can actually lead to secondary psychological conditions. The types of barriers people face include situations such as:

- wanting to return to work but not being allowed to – 'they won't let me'
- not knowing who is responsible for what, what resources are available, or where to go at what point in time in the process
- long, drawn out, confusing systems – 'even if you know what you're doing its hard and demotivating'
- the need to repeat their story multiple times and re-prove their case when moving between jurisdictions or if they get some work but end up needing to go on a pension again.

The universal opinion of stakeholders is that the employee needs to be put at the centre of the claim and that it is important they are heard and understood.

'Get them to identify what they need and co-design their journey. If they co-own the way forward, they will be better engaged, more likely to make a success of the plan and less likely to fall back into the compensation system once they're working.'

What do employees say?

Person-centered planning addresses the themes of *information and process* and *empathy and understanding*. Employees would welcome an increase in person-centered planning approaches. They say while the current approach of one-size-fits-all may provide a bare minimum level of support, employees often need more nuanced understanding from support providers. The effect of a one-sized-fits-all approach leaves employees feeling ignored, with one employee saying: "... but it's not person-focused, they're indifferent and that is what breaks people". Employees also explain that the reliance on a one-size-fits-all system has led to a feeling among employees that support providers assume all clients are cheating the system.

What has helped/could help?

- Employees said that a person-centered approach probably requires a key contact or case manager, and the success of the approach relies heavily on the quality of this key contact. Another possible barrier to effective person-centered approaches relies on the individual's personal motivation. Some of the employees we spoke to said they would rather be told what to do by experts. Others said that they did not want to sit in the driver's seat because they been in the driver's seat for years and got nowhere.
- Better pathways between system – that includes common forms, common processes, common language, common standards (e.g. for claims managers).
- Simple accessible tools people can use and understand.
- Stakeholders suggest a recognised leader to achieve common agreement across the various jurisdictions.
- A triage system either in the same manner as a 'triage nurse' that helps guide people to the right services, or an even bigger suggestion of a universal triage system bringing all the experts together – one stop shop source of medical and job experts including wellbeing, doctors, psychologists, common law and a relationship manager links directly to these.
- Provider partnerships. Create partnership with health providers all contributing to the individual employee plan.

6. Problem-solving

Evidence
?

Employees
?

Stakeholders
?

What is the problem being addressed?

Disability, injury, and illness can cause chronic stress, which can be managed by helping individuals to change how they approach their difficulties, and gain skills to cope effectively with stress. Problem-solving approaches are about giving individuals a toolkit for managing condition-related stress.

What is the approach?

During the last decade, there has been an increase in the number of studies that have examined the effectiveness of interventions that incorporate teaching problem-solving skills to workers who are receiving disability benefits. These skills are aimed at enabling them to solve work-related problems. Evidence suggests that these skills help to develop a sense of control regarding stressors. In turn, this can moderate the effects of work stressors that could contribute to disability and ill health.

What does the evidence say?

Three reviews were identified on problem-solving. The reviews suggested that these interventions show most promise for *partial* return to work, but not so for return to *full* duties. Problem-solving interventions alone may not be enough to reduce sick leave but a combined problem-solving and a therapy intervention such as, cognitive behaviour therapy did have significant effect on total sick leave days. Other evidence was mixed.

What do stakeholders say?

There was no direct reference from stakeholders but improving health literacy was a major outcome from the stakeholder interviews and this goes some way to the notion of problem solving.

What do employees say?

Problem-solving approaches address the theme of *degradation of mental health and wellbeing*. Employees had little to say regarding problem-solving approaches.

7. Strength-based interventions

Evidence



Employees



Stakeholders



What is the problem being addressed?

A sudden change in health can increase feelings of helplessness and vulnerability. Strength-based interventions are about increasing empowerment by focusing on the individual's strengths.

What is the approach?

Qualities such as self-efficacy, social problem-solving, sense of purpose, empathy, humour, resilience, and hope are all targeted by strength-based approaches. Strengths can be considered at the personal level (self-efficacy) or at the interpersonal level (positive caring relationships), and the approach emphasizes that every person can build a meaningful and satisfying life with a focus on their strengths.

What does the evidence say?

We found one review that considered strength-based interventions. The results suggest that a strength-based approach may improve empowerment (e.g. self-esteem, self-efficacy, sense of hope) but the evidence quality is questionable. There are not enough studies with strong methodology to conclude that strength-based approaches work.

Additionally, there is difficulty isolating the effect of strength-based approaches as they were often a single element within complex, multifaceted interventions. In the case of severe psychological symptomology for example, suicidal ideation, clinicians are cautioned against using only a strength-based approach completely isolated from medical treatment approaches.

What do stakeholders say?

The longer a person is in 'the system', the greater the loss of confidence and the harder it is to rebuild. One of the stakeholders provides motivational training for their clients and others, whilst not using a formal 'motivational' system, train their customer interface teams in positive reinforcement skills.

What do employees say?

Strength-based approaches address the *degradation of mental health and wellbeing*. Employees had little to say regarding strength-based approaches.

8. Education

Evidence



Employees



Stakeholders



What is the problem being addressed?

Understanding a condition is an essential first step in recovery. Education is about helping individuals to understand their condition and navigate issues that restrict their ability to work.

What is the approach?

Education interventions seek to inform individuals about the side effects of their conditions, as well as techniques for coping and managing stress. Most interventions use some form of counselling to address participants' disease-related anxieties and provide information on the causes and course of their condition to dispel misconceptions. These are sometimes referred to as 'psycho-education' approaches.

What does the evidence say?

Two reviews evaluated education approaches. Education might be useful for relieving condition-related anxiety though the quality of evidence is low. Evidence is unable to show that education has a beneficial effect on return to work rates and outcomes.

What do stakeholders say?

Outcomes are better if you are dealing with someone who understands their choices, what support can be put in place, and be engaged in that support.

This also means improving health literacy – understanding that they should be able to get back to work, work is good for health and is a form of therapeutic intervention, that waiting for recovery can delay recovery, and knowing they need to get help.

Education is also helping people understand what type of work might be an entry for them – not necessarily a long-term solution but to re-enter (lower status, lower pay is a psychological blow that needs framing) and tailored information to demonstrate what happens/how to help in different circumstances.

What do employees say?

Education approaches address the theme of *empathy and understanding*. Employees felt that education would be a broadly useful tool – not for themselves but, rather, for the people around them. Employees are already educating themselves as much as possible, mostly out of necessity, so further education may not be the most effective tool for them. Where education might be more effective is in educating others that these employees have to interact with. Employees described a need for education aimed at high-level cultural change, as well as education aimed at low-level individual change.

Education for support providers, case managers, employers, GPs, families, and the general public would help empower employees to achieve their employment goals. According to the employees:

- support providers and case managers need expertise when working with populations with health conditions, instead of applying a one-size fits all approach that works for the general population
- educating employers about the mental health and wellbeing component of rehabilitation and return to work would help create flexible and understanding workplaces
- there is wide variability in GPs' understanding of the work disability support system – GP education would help keep the standard more consistent
- families need to be included in the education process as they often feel helpless. Changes in mental health may not always be obvious, so teaching families about mental health could help them feel equipped for supporting their family member.
- finally, employees felt that their recovery and return to work would be greatly helped by educating the general public to be more aware and conscious of those with disability or conditions that make it difficult for them to work. Some employees highlighted how their conditions had no visible symptoms, so would have difficulty receiving support from members of the public. Others reported hostility and micro-aggressions directed towards them because of their injury/condition.

What has helped/could help?

- Cultural change around stigma, discrimination and the benefits of good work.
- Health literacy programs.
- Education around the value of job design and how to apply.

9 &10 Culture and System change

Employees



Stakeholders



Under the Rapid Literature Review search terms, no evidence was identified under the category of 'culture change', but recognition of the need for culture change came out strongly in the expert stakeholder and employee interviews.

Furthermore, with its academic principle of assessing specific interventions, the ability or purpose of the Rapid Literature Review is not to understand the interplay across different components of the benefit and income support system. Whereas for employees and expert stakeholders how the system works is key to empowerment.

Much of the employee and stakeholder commentary that has been relayed in the previous pages all point to the importance of culture and system change – such as poor understanding by employers of the value of employees with a physical or psychological condition and the importance of changing norms around not only their perceptions, but also the perceptions of the many players involved in the processes of the benefit and income support system including doctors and claims managers); or the call from employees for interventions that facilitate easier use of and greater empathy from 'the system'.

Further examples of the need for culture and system change can be seen in the following pages where more detailed intervention suggestions by employees are captured.

3.0 Other Empowerment Interventions

The empowerment interventions described in this section were identified through the Citizen Panel and individual interviews with employees and expert stakeholders.

Compassion and understanding training for case managers

What is the problem being addressed?

Case managers may not have the understanding or flexibility in order to most adequately support individuals with health conditions in returning to work.

What do employees say?

Compassion and understanding training for case managers relates to the theme of *empathy and understanding*. An issue that arose from several conversations with employees was that case managers often lack compassion or even a basic understanding of the employee's condition. Little understanding from the case manager has a flow-on effect to the sorts of services that the employee is given access to.

What has helped/could help?

- Greater provisions for support providers to go “off-script” – an idea that was actively promoted by stakeholders.
- Stakeholders also raised the idea of motivational interactive training for claims and case managers

Advocacy groups

What is the problem being addressed?

Individuals can feel miniscule against the system when they are trying to secure the best support for themselves.

What do employees say?

Advocacy groups address the theme of information and process. Employees often said the largest drain on their motivation was constant self-advocacy. Needing to be “on top of every single cog in the system” was described as draining and demotivating. Some employees said they were fortunate to have an advocate helping them to navigate the complexity and “couldn't imagine surviving the ordeal without one”. Employees then suggested that more formalized advocacy groups would be of benefit to their return to work, though others cautioned on the overreliance of volunteers.

Advocacy groups differ from mentorship programs in that they are more focused on navigating the systems with specific guidance and understanding, whereas mentors appear most helpful in more general contexts (for example in navigating the world with a new-found health condition).

While there is considerable overlap between advocacy groups and mentorship programs, we have kept them separate to reflect the source— here as an item that employees produced as a resource they have relied on, and mentorship programs as an intervention discovered in the rapid review.

What has helped/could help?

A website to connect individuals to willing volunteers.

Employer forums

What is the problem being addressed?

Job-seekers with health conditions express frustration in searching for employers who are willing to accommodate their condition. Employees are also frustrated that job service providers lack the ability to match them up with willing employers.

What do employees say?

Employer forums address the themes of *information and process and empathy and understanding*. Employees looking for new work find it difficult to connect with employers that are flexible and willing to accommodate workers with disability or impairment. An employer forum that: educates employers about workplace accommodation; connects employers with those willing to work; and makes it easier for job service providers to build a network of potential employers would help address a number of issues employees face with workplace participation.

What has helped/could help?

Build awareness and understanding of good work.

Stakeholders say

There's a need to create a universal awareness, understanding and a belief amongst employers, employees, health professionals – all Australians – that 'good work' is good for you and that getting back to work before you're 100% well is a proven aid to recovery (with appropriate medical clearance).

'We (the industry) all talk about the benefits of good work, but we're in a bubble – we need to get the message beyond the people in the industry. As a nation we need to accept the importance of work.'

Transition seminars and managers

What is the problem being addressed?

Employees describe the support they receive as fractured and they want it simplified to something like a flow chart. Transition management represents a unification of support services with a focus on navigating the transition into work.

What do employees say?

Transition seminars and managers address the theme of *information and process*. A key outcome from discussions with employees is the desire for more centralised process regarding support provision and return to work. One specific example from discussions included the notions of transition seminars and managers. This idea borrows from the defense force, where defense personnel are debriefed from their duties and prepared for life as a civilian. A similar exercise could exist for a person transitioning from one stage of employment participation (e.g. unemployed) to another (e.g. part-time employment). A 'transition manager' represents an evolution of the current 'case manager' role but with a focus on the wellbeing of the employee as they navigate their rehabilitation and return to work.

What has helped/could help?

Willingness from support providers to investigate alternative support methods.

Group activity access

What is the problem being addressed?

Employees with health conditions sometimes feel like there's nothing they can do and have low self-efficacy. They also feel isolated when they are unable to work. Group activity provision addresses these problems of low self-efficacy and isolation.

What do employees say?

Activity provision was a key focus for a number of employees whose wellbeing suffered by coming off work and suddenly having nothing to do. From a wellbeing perspective, employees discussed the notion of support providers offering wellbeing activities such as gym memberships, art classes. Importantly, these would either be activities to be completed as a group (group rehabilitation at a gym) or were inherently group-oriented (art classes).

What has helped/could help?

Confidence and knowledge would help individuals approach new groups and activities. Sometimes they don't know where to find such things and it would be helpful if a case manager or web-based platform could point them in the right direction.

Group-based case management

What is the problem being addressed?

Navigating the disability support system can be difficult and lonely as an individual. Group-based case management allows individuals to share knowledge (making navigation easier) and experiences with others.

What do employees say?

According to the employees we spoke with, one of the most difficult aspects of being unable to work is social isolation. The negative effect of isolation on their mental health and wellbeing was clearly very important to employees. Another side effect of social isolation was that employees were unable to find relevant information without the help of another person who had the same experience. Employees suggested that group-based case management, where support providers could manage the cases of several employees with similar conditions simultaneously, could solve both these problems. By meeting together in the same space (physical or digital), employees could share experiences, share learnings, and interact with others for social support.

What has helped/could help?

A willingness on the part of the support provider to consider alternative support strategies.

Customer feedback as a KPI

What is the problem being addressed?

Support providers are perceived as lacking transparency. Empowering individuals by making customer feedback part of the support provider's Key Performance Indicator (KPI) could address this issue of transparency.

What do employees say?

A large issue for employees was a perceived lack of accountability and transparency on the part of the support providers. Employees we spoke to felt that a solution could be to include customer feedback in the performance evaluation of support providers.

What has helped/would help?

A platform for collating customer feedback.

Table 3: Summary of possible interventions

Category	Problem	Desired outcome	Possible intervention	How does the intervention empower individuals?
Culture change				
Culture change	Societal attitudes and beliefs prevent individuals with health conditions from full participation (life, work).	Change in societal attitudes and beliefs regarding 'good work'; permission to GPs for suggesting gradual return to work; permission for families to be comfortable with employee returning to work.	An awareness campaign to change beliefs and attitudes.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
System change (support providers)				
Person-centred planning	Support providers lack transparency (e.g. employees are only made aware of a portion of services available to them)	Support providers provide list of full suite of support options.	Educate decision-makers from support providers on importance of transparency and tools to enable this.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
	Employees often find that the services and support provided to them are not suited to their needs - feel like they fall through the cracks.	Support providers restructure their support delivery around person-centred planning	Engage support providers in the development and application of a common set of principles (eg: co-designing recovery program with the employee, enabling and training claims managers on how to go 'off-script') that include short term 'simple to uptake' and 'long term' program changes in delivery.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)

Category	Problem	Desired outcome	Possible intervention	How does the intervention empower individuals?
System streamlining	Support is fractured, complex and confusing.	Improve ease of use, better consistency and better connection between systems.	1. Engage with providers in developing common language and common forms to maintain consistency of experience between systems and medical services.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
			2. Provide a cross sector online triage service personed by real people who can help navigate through different systems and to different services.	Empowering things that individuals can action themselves but relies on action from someone else (dependent self-empowerment)
	Employees have to repeat their stories and medical requirements multiple times throughout their journey, especially when transitioning through different points of the system.	Improve ease of use, better consistency and better connection between systems.	<p>1. Investigate tools and operating structures that can de-duplicate processes and enable sharing of information across systems and providers.</p> <p>2. Identify a transition management process that facilitates the ease of movement from one system to the next.</p>	<p>Empowering things that individuals cannot action themselves (dependent empowerment provided by others)</p> <p>Empowering things that individuals cannot action themselves (dependent empowerment provided by others)</p>
Education	Changes in health conditions cause stress and anxiety	Improved health literacy for employees and their employers and families	Psycho-education approach to increase health literacy	Empowering things that individuals can action themselves but relies on action from someone else (dependent self-empowerment)

Category	Problem	Desired outcome	Possible intervention	How does the intervention empower individuals?
Goal-setting	Disability, injury, and illness can take their toll on motivation.	Goal-setting interventions offered by support providers.	<p>1. Goal-directed occupational therapy program.</p> <p>2. Use behavioural economics strategies to train claims managers to introduce goal-setting objectives into their interactions with their client.</p> <p>3. Reframe language to positive motivation.</p>	<p>Empowering things that individuals can action themselves but relies on action from someone else (dependent self-empowerment)</p> <p>Empowering things that individuals cannot action themselves (dependent empowerment provided by others)</p> <p>Empowering things that individuals cannot action themselves (dependent empowerment provided by others)</p>
Problem-solving	Disability, injury, and illness can cause chronic stress	Problem-solving included in support offered by support providers.	Problem-solving skills training delivered by occupational therapist	Empowering things that individuals can action themselves but relies on action from someone else (dependent self-empowerment)
Mentorship	Navigating the benefit and income support system can be a frustrating and lonely affair.	Maintain the confidence and momentum of the employee to stay positive.	Provide motivational training for claims managers.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
Strength-based interventions	A sudden change in health can increase feelings of helplessness and vulnerability.	Strength-based interventions included in support offered by support providers.	Incorporating a rehabilitation and return to work strategy that plays to the individual's strengths.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)

Category	Problem	Desired outcome	Possible intervention	How does the intervention empower individuals?
Work accommodation (employers)				
Education	Job descriptions do not convey whether the job can be done by someone with a health condition.	Advertisements for job positions include a statement of minimum required ability.	Educate decision-makers from employers on the importance of inclusive language, and how employees do not need to be 100% healthy to be productive	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
Support	Employees constantly reach out, often for little result	Employers reach out to employees as part of claim/case management.	Design intervention to train employers to reach out first and often to employees during their rehabilitation.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
Work accommodation	Group interviews can be daunting.	Hiring practices changed to be more inclusive.	Develop guidelines and education programs for employers and recruitment agencies.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
Education	Difficult to find employers who are willing to recruit people with health conditions.	Increase willingness of employers to hire those with health conditions.	Create a forum for: (1) providing employers with education materials regarding good work; (2) developing job service providers employer networks; and (3) putting potential employees in touch with willing employers.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
			Identify a system that provides training and standards for employers/recruitment agencies to become a Disability Confident Recruiter/Employer.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
			Intervention to encourage employers to provide 'on the job' training for intellectually or disabled job seekers rather than requiring a tertiary qualification.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)

Category	Problem	Desired outcome	Possible intervention	How does the intervention empower individuals?
Employee empowerment				
Mentorship	Individuals can feel miniscule against the system when they are trying to secure the best support for themselves.	Employees feel socially supported	Online resource collating online- or community-based mentorship programs and support groups. Design an intervention to maximise the number of employees who access the materials.	Empowering things that individuals can action themselves but relies on action from someone else (dependent self-empowerment)
	Unsuitable mentors can have an adverse effect. This exacerbates incidences of depression and hopelessness.	Link employees to positive influencers.	Use advocacy organisations that are in touch with the needs of the employees specific group as a central forum (eg: spinal cord association).	Empowering things that individuals can action themselves but relies on action from someone else (dependent self-empowerment)
System	Navigating the disability support system can be difficult and lonely as an individual.	Employees feel socially supported.	Group-based case/claim management.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
			One stop shop portal' that connects to services, mentor groups, 'good work' credentialed employers, job search services, job application guidance, motivational training etc.	Empowering things that individuals can action themselves but relies on action from someone else (dependent self-empowerment)
Education	Employees unaware of what to expect of employer	Employees more clearly understand what to expect of their employer.	Collate online information regarding employer obligations. Design an intervention to maximise the number of employees who access the materials. Employer guidelines.	Empowering things that individuals can action themselves but relies on action from someone else (dependent self-empowerment)

Category	Problem	Desired outcome	Possible intervention	How does the intervention empower individuals?
Job seeking	It can be difficult to manage your condition when it impairs you physically and/or mentally. That means it can be especially difficult to find or get back to work.	Employees feel supported	Individual placement and support (IPS) approach from job search provider.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
	Difficult to find employers who are willing to recruit people with health conditions. Group interviews can be daunting.	Employees are given the confidence to keep looking for work.	Access to a job coaching system manned with coaches trained for the special needs of people with a physical or psychological health condition.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)
	Loss of skills, either due to onset health condition or long-term unemployment.	Have the skills to find suitable employment.	Interventions that give access to training/retraining.	Empowering things that individuals cannot action themselves (dependent empowerment provided by others)

4.0 Conclusion

The purpose of this study is to identify what can help employees to help themselves – to use work as part of their recovery. However, a distinction must be drawn between the different types of empowerment interventions:

1. Independent self-empowerment – empowering things that individuals can action themselves right now without help from anyone else.

Neither the academic evidence, expert stakeholder interviews nor employee interviews identified independent self-empowerment interventions.

2. Dependent self-empowerment – empowering things that individuals can action themselves but relies on action from someone else, for example, ‘mentorship’ is the most favoured intervention by employees but facilities to access mentorship would have to be established to enable access.

3. Depended empowerment – empowering things individuals cannot action themselves.

Dependent self-empowerment

The following interventions and examples were identified that individuals can action themselves once a mechanism is established.

- **Mentorship:** community-based programs and support groups or advocacy group forums that individuals can access via online resources or use of advocacy organisations that are in touch with the needs of specific employee groups as a central forum.
- **Education:** a collation of online information regarding employer obligations and guidelines to help employees understand their entitlements was highly supported by employees, or a psycho-education approach to increase health literacy – though review evidence for this was inconclusive.
- **Goal setting:** a goal directed occupational therapy program.
- **System facilitation:** a portal that connects to services, mentor groups, ‘good work’ credentialled employers, job search services, job application guidance; or an online triage service provided by real people who can help navigate through different systems and to different services.

Dependent empowerment

What this investigation learnt from employees and from stakeholders is that the best efforts at self-help are defied by systems that are complex and unsupportive. In the words of a key stakeholder ‘they cannot fight a bad system’. What is clear is that there is no silver bullet. Employee empowerment is reliant on broader changes and a multi-dimensional approach.

- *Cultural change* – shifting beliefs and attitudes towards the value of good work and inclusion is important. Cultural provides the over-arching context and motivation that makes individual interventions effective. It is a high order ‘empowerment’ tool for all participant cohorts. It also goes hand in hand with the need for better cross-community health literacy.

There is growing evidence that demonstrates that without shifting cultural beliefs and social norms, in this case around the benefits of good work and employing people with health conditions or disability, the effectiveness of empowerment interventions can be compromised. This is evidenced in some of Australia’s largest behaviour change programs such as road safety, workplace safety and smoking, where education and legislation do not work in isolation of creating an emotional connection to the benefit of a particular behaviour.

Stakeholders repeatedly raise the importance of creating universal awareness, understanding and a belief amongst employers, employees, health professionals – all Australians – that ‘good work’ is good for you and that working is a proven aid to recovery and emotional wellbeing.

- *System change* – the evidence from employees’ experiences of the benefit and income support systems may be considered harsh by some, but presents a very real impediment to individual empowerment, even leading to worsening health and greater reliance on the system by contributing to secondary conditions such as depression. Parts of the system are out of step with current best practice approaches to customer-centric servicing and streamlined operating processes, and this is a challenge that needs to be addressed.
- *Work accommodation* – the need for employer’s to better understand and support the individual capabilities of employees with a physical or psychological condition or disability is supported by evidence, employees and stakeholders. Effective work accommodation is the coalface of the work experience and enabling individuals to obtain, stay at or return to work is reliant on employer engagement.

Additional information

Stakeholder research – the best time to intervene

Stakeholders were asked about the most advantageous time in the process to intervene.

Early intervention was universally considered a priority to provide hope and inspiration early on. This included the very first conversation on this basis this is the time when you get to know the customer, their story and what they're like, as well as being able to set expectations from the start (i.e. tell them what is going to happen, their role, the employers role, win trust, help them make decisions).

In the case of injury or illness that impacts an existing work situation, there was also the notion that the first contact should be before the person becomes involved in the work disability system.

'the system is focused on your health, you get a doctor, a physiotherapist, a specialist, but nobody focuses on your ability to work, and this leads to an immediate loss of confidence to work. The work conversation needs to start immediately – even if it is not a full chat because of the circumstances, it is someone saying 'I will come and talk to you about how to help you get back to work'.

Another idea was the need for early understanding and notification as soon as something happens to ensure the employer and documents are handled in the right way.

Overall consensus is that the strategy needs to be about prevention. Understanding by people before they even find themselves in the situation so they know what to do thereby lessening the 'adversarial' feeling of the situation and triggering the notion that 'if you find yourself in this situation speak up quickly'.

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Appendices

Appendix 1: Examples of intervention types

1. Work accommodation

Examples from literature of what work accommodation interventions incorporate:

- Individual case management and job search assistance
- Changes to the workplace or equipment
- Changes in work design and organisation
- Changes in working conditions or work environment
- Case management with worker and employer
- Early contact with worker by workplace
- RTW coordination
- Worksite ergonomic visit
- Healthcare provider contact with workplace

2. Support

Examples from literature of what support/individual placement and support (IPS) interventions incorporate:

- Individual placement and support principles: competitive employment as primary goal; eligibility based on patient choice; integration of vocational and clinical services; job search guided by individual preferences; personalised benefits counselling; rapid job search; systematic job development; time-unlimited support
- Augmented IPS: IPS with added specialised training components (e.g. augmented with cognitive training, work-related social skills, workplace skills)
- Traditional vocational rehabilitation models: focus on the interventions in the setting prior to initiating work activity
- Supported employment models: focus on the immediate competitive job search
- Work-focused treatment of health conditions (e.g. common mental disorders)

3. Mentorship

Examples from the literature of what mentorship interventions incorporate:

- School-based interventions with peer mentors (e.g. class-based competency-building program aimed at fostering self-determination in students)
- Community-based interventions with peer mentors (e.g. programs based outside schools or other institutions)
- Work-based interventions (e.g. coworker training via standardized one-on-one approach)
- Family employment awareness training (e.g. standardised knowledge-based training program for families)
- Online mentorship program (e.g. email methods for mentors to provide support and information sharing)

4. Goal setting

Examples from the literature of what goal-setting interventions incorporate:

- Goal-directed occupational therapy program
- Group-based goal setting approach
- Specific occupation-based goal setting

5. Person-centered planning

Person-centered planning (PCP) is not a standardized intervention but an umbrella term that is often used to describe approaches and techniques that share common characteristics. Five key features include:

- The person at the center
- Family members and friends are partners in planning
- The plan reflects what is important to the person, their capacities, and what support they require
- The plan results in actions that are about life, not just services and reflect what is possible and not simply what is available
- The plan results in ongoing listening, learning, and further action

6. Problem-solving

Problem-solving interventions are usually delivered as a training program. Some examples from the literature include:

- Problem-solving training combined with graded activity
- Problem-solving skills training delivered by occupational therapist
- Problem-solving component in guideline-based care provided by occupational physicians
- Problem-solving trainer training for occupational physicians
- Problem-solving component in collaborative care intervention involving worker, manager, and occupational therapist
- Individual- and group-based problem-solving training delivered by psychologists.

7. Strength-based interventions

Examples from the literature of what strength-based interventions incorporate:

- Strength-based case management
- Strengths-based brief solution focused counselling

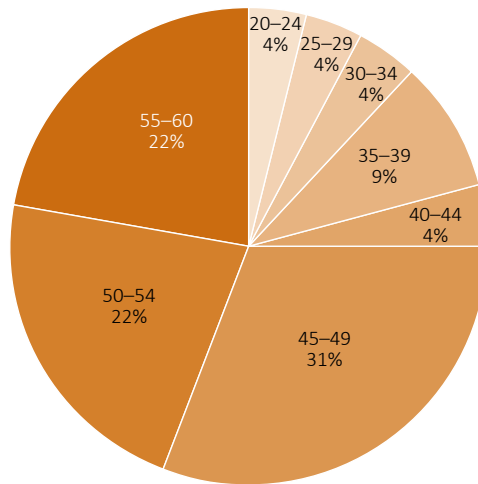
8. Education

Examples from the literature of what education interventions incorporate:

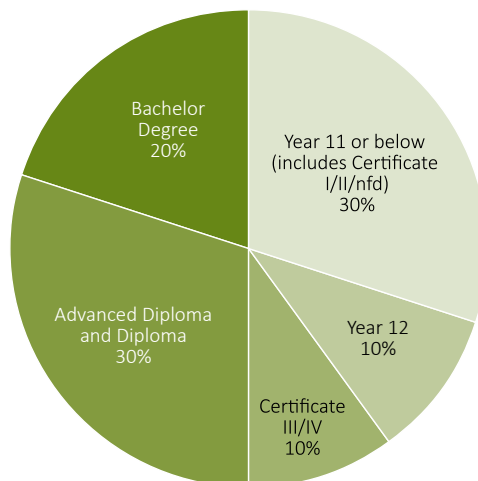
- Psycho-educational interventions (e.g. participants learn about physical side effects, stress and coping techniques)
- Patient counselling and health education
- Stress management and relaxation training

Appendix 2: Detailed breakdown of citizen panel attendees

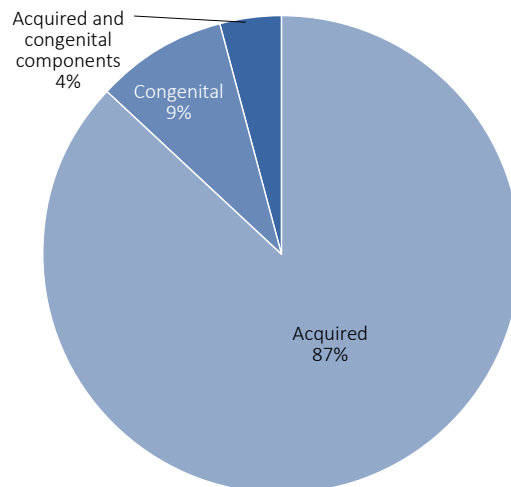
Participant age



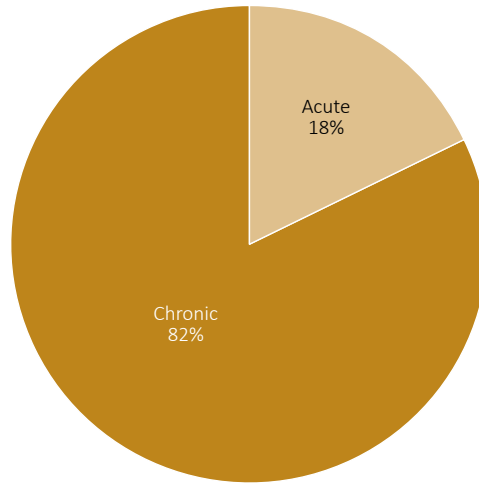
Participant education



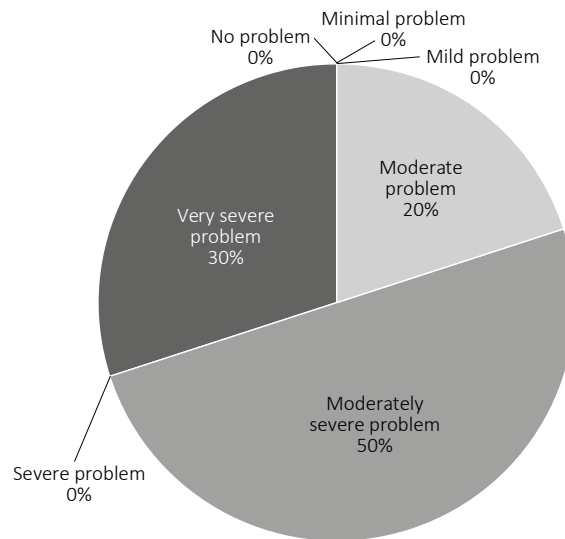
Congenital vs acquired



Chronic vs. acute



Severity



Appendix 3: Project methods

Rapid review methods – Search strategy

A comprehensive search of the following database was undertaken: PsycINFO via Ovid, Medline via Ovid, Cochrane Library and CINAHL. The Medline search strategy is reproduced below:

Table 4. Medline search strategy

Search string	
1	return to work [tw] OR return-to-work [tw] OR RTW [tw] OR re-employ* [tw] OR employment [tw] OR unemployment [tw] OR unemployed [tw] OR retirement [tw] OR employab* [tw] OR absenteeism [tw] OR vocational [tw] OR (commenc* adj3 work) [tw] OR (commenc* adj3 job) [tw] OR (stay* adj3 work) [tw] OR (stay* adj3 job) [tw] OR (work adj2 participat*) [tw] OR (modif* adj2 work) [tw] OR (work adj2 adjust*) [tw] OR (retain adj2 work) [tw] OR (retain adj2 job) [tw] OR (job adj2 retention) [tw] OR (work adj2 retention) [tw] OR (job adj3 re-ent*) [tw] OR (work adj3 re-ent*) [tw] OR (work adj3 reintegrat*) [tw] OR (job adj3 re-integrat*) [tw] OR (modif* adj2 dut*) [tw] OR (light adj2 dut*) [tw] OR (work adj2 ability) [tw] OR (work adj2 status) [tw] OR (recover* adj2 work) [tw] OR (obtain* adj3 work) [tw] OR (obtain* adj3 job) [tw] OR (work adj3 capacity) [tw] OR (occupational adj2 outcomes) [tw] OR (sick* adj1 leave) [tw] OR (sick* adj3 absence) [tw] OR (work adj3 accommodat*) [tw] OR (job adj3 accommodat*) [tw] OR “workplace” [Subject Heading] OR “return to work” [Subject Heading] OR “work” [Subject Heading] OR “employment” [Subject Heading] OR “sick leave” [Subject Heading] OR “job satisfaction” [Subject Heading] OR “occupational medicine” [Subject Heading] OR “rehabilitation, vocational” [Subject Heading] OR “occupational health” [Subject Heading] OR “unemployment” [Subject Heading] OR “absenteeism” [Subject Heading] OR “occupations” [Subject Heading] OR “occupational health services” [Subject Heading] OR “work capacity evaluation” [Subject Heading] OR “vocational guidance” [Subject Heading]
2	disability [tw] OR disease [tw] OR injury [tw] OR illness [tw] OR disorder [tw] OR cognitive impairment [tw] OR cognitive dysfunction [tw] OR musculoskeletal disease* [tw] OR cancer [tw] OR osteoporosis [tw] OR arthritis [tw] OR asthma [tw] OR chronic obstructive pulmonary disease [tw] OR COPD [tw] OR chronic pain [tw] OR cardiovascular disease [tw] OR diabetes [tw] OR chronic condition [tw] OR mental health [tw] OR chronic disorder [tw] OR psychological disorder [tw] OR “Disabled persons” [Subject Heading] OR “Intellectual Disability” [Subject Heading] OR “Mental Disorders” [Subject Heading] OR “Wounds and Injuries” [Subject Heading] OR “Chronic Disease” [Subject Heading] OR “Cognitive Dysfunction” [Subject Heading] OR “Musculoskeletal Diseases” [Subject Heading] OR “Neoplasms” [Subject Heading] OR “Osteoporosis” [Subject Heading] OR “Arthritis” [Subject Heading] OR “Respiratory Tract Diseases” [Subject Heading] OR “Pulmonary Disease, Chronic Obstructive” [Subject Heading] OR “Asthma” [Subject Heading] OR “Back Pain” [Subject Heading] OR “Chronic Pain” [Subject Heading] OR “Cardiovascular Diseases” [Subject Heading] OR “Diabetes Mellitus” [Subject Heading] OR “Depression” [Subject Heading] OR “Anxiety Disorders” [Subject Heading] OR “Stress Disorders, Post-Traumatic” [Subject Heading]
3	review* OR meta-synthesis* OR meta-analysis*
5	#1 AND #2 AND #3

Screening and selection

One reviewer screened the citations against the inclusion and exclusion criteria listed in Table 2. Data extracted from the included articles was used to inform a commentary on the outcomes of empowerment-focused interventions.

Table 5. Inclusion and exclusion criteria

	Include	Exclude
Study Type	<ul style="list-style-type: none"> Systematic or narrative reviews. Reviews of quantitative or qualitative studies will be included 	<ul style="list-style-type: none"> All primary study designs
Population	<ul style="list-style-type: none"> Individuals navigating disability systems; at various stages of work status (i.e. returning to work; remaining at work; commencing new work); with injuries (mental or physical), disabilities (cognitive or physical), or disease (e.g. cancer); in various systems (e.g. workers' compensation and disability support systems, superannuation and life insurance, employer-funded income support). 	<ul style="list-style-type: none"> Reviews describing impact on non-immediate/proximal outcomes Families of individuals
Study Design	<ul style="list-style-type: none"> Interventional (RCT preferred but all designs accepted) 	
Study Setting	<ul style="list-style-type: none"> International (with focus on Australia, Canada, New Zealand and the US) 	
Intervention	<ul style="list-style-type: none"> Use of empowerment i.e. active participation, navigation, self-management (insurance), health literacy, scheme navigation, work planning, problem solving, support mechanisms, self-management support, self-sufficiency, quality of life (e.g. community involvement, family stability), and active interventions. 	<ul style="list-style-type: none"> Interventions that don't have an evaluation component
Outcome	<ul style="list-style-type: none"> Sustained work status change Feelings of empowerment Individuals' attitudes, needs, and motivations 	<ul style="list-style-type: none"> Reduction in illness or poisoning (unless interventions evaluating other outcomes are also included within the review)
Publication status	<ul style="list-style-type: none"> English-language Peer-reviewed journal publications or reports Published 1998 - 2018 	

Appendix 4: Quality appraisal

Criterion (AMSTAR 2)	Bisung (2018)	Cheng (2018)	Cullen (2018)	D'Amico (2018)	De Boer (2015)	Dewa (2015)	Dewa (2018)	Doki (2015)	Donker-Cools (2016)
1. Did the research questions and inclusion criteria for the review include the components of PICO?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?	No	No	No	No	Yes	No	No	No	No
3. Did the review authors explain their selection of study designs for inclusion in the review?	No	No	Yes	No	No	No	No	No	No
4. Did the review authors use a comprehensive literature search strategy?	No	Partial yes	Partial yes	Partial yes	Yes	Partial yes	Partial yes	Partial yes	Partial yes
5. Did the review authors perform the study selection in duplicate?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Did the review authors perform data extraction in duplicate?	No	Yes	Yes	Yes	Yes	No	No	No	Yes
7. Did the review authors provide a list of excluded studies and justify the exclusion?	No	No	Partial yes	No	Yes	No	No	No	No
8. Did the review authors describe the included studies in adequate detail?	No	Partial yes	Partial yes	Partial yes	Partial yes	Yes	Partial yes	Partial yes	Partial yes
9. Did the review authors use a satisfactory technique for assessing the risk of bias in individual studies that were included in the review?	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No
10. Did the review authors report on the sources of funding for the studies included in the review?	No	No	No	No	Yes	No	No	No	No
11. If meta-analysis was performed, did the review authors use appropriate methods for statistical combination of results?	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	N/A
12. If meta-analysis was performed, did the review authors assess the potential impact of risk of bias in individual studies on the results of the meta-analyses or other evidence synthesis?	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	N/A

Criterion (AMSTAR 2)	Bisung (2018)	Cheng (2018)	Cullen (2018)	D'Amico (2018)	De Boer (2015)	Dewa (2015)	Dewa (2018)	Doki (2015)	Donker-Cools (2016)
13. Did the authors account for risk of bias in individual studies when interpreting/discussing the results of the review?	No	No	Yes	No	Yes	No	Yes	Yes	Yes
14. Did the review authors provide a satisfactory explanation for and discussion of heterogeneity observed in the results of the review?	No	Yes	Yes	No	Yes	Yes	No	No	Yes
15. If they performed quantitative synthesis, did the review authors carry out an adequate investigation of publication bias (small study bias and discuss its likely impact on the results of the review)?	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	N/A
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
TOTAL yes / applicable items	1/13	7/13	11/13	7/13	15/16	7/13	7/13	10/16	8/13

Criterion (AMSTAR 2)	Fong (2018)	Gaudreault (2014)	Hegewald (2019)	Laires (2017)	Levack (2015)	Lindsay (2016)	McDowell (2014)	Modini (2018)
1. Did the research questions and inclusion criteria for the review include the components of PICO?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?	Yes	Yes	Yes	No	Yes	No	No	Yes
3. Did the review authors explain their selection of study designs for inclusion in the review?	No	No	Yes	No	Yes	No	No	No
4. Did the review authors use a comprehensive literature search strategy?	Partial yes	Partial yes	Yes	Partial yes	Yes	Partial yes	Partial yes	Partial yes
5. Did the review authors perform the study selection in duplicate?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
6. Did the review authors perform data extraction in duplicate?	No	Yes	Yes	No	Yes	Yes	No	No
7. Did the review authors provide a list of excluded studies and justify the exclusion?	Yes	No	Yes	No	Yes	No	No	No
8. Did the review authors describe the included studies in adequate detail?	Partial yes	No	Yes	Partial yes	Yes	Yes	Partial yes	No
9. Did the review authors use a satisfactory technique for assessing the risk of bias in individual studies that were included in the review?	Yes	Yes	Yes	No	Yes	Partial yes	No	Partial yes
10. Did the review authors report on the sources of funding for the studies included in the review?	No	No	Yes	No	Yes	No	No	No
11. If meta-analysis was performed, did the review authors use appropriate methods for statistical combination of results?	Yes	N/A	Yes	N/A	Yes	N/A	N/A	Yes
12. If meta-analysis was performed, did the review authors assess the potential impact of risk of bias in individual studies on the results of the meta-analyses or other evidence synthesis?	No	N/A	Yes	N/A	Yes	N/A	N/A	No
13. Did the authors account for risk of bias in individual studies when interpreting/discussing the results of the review?	Yes	Yes	Yes	No	Yes	No	No	No
14. Did the review authors provide a satisfactory explanation for and discussion of heterogeneity observed in the results of the review?	Yes	No	Yes	No	Yes	No	No	Yes

Criterion (AMSTAR 2)	Fong (2018)	Gaudreault (2014)	Hegewald (2019)	Laires (2017)	Levack (2015)	Lindsay (2016)	McDowell (2014)	Modini (2018)
15. If they performed quantitative synthesis, did the review authors carry out an adequate investigation of publication bias (small study bias and discuss its likely impact on the results of the review)?	No	N/A	Yes	N/A	Yes	N/A	N/A	Yes
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	Yes	Yes	Yes	No	Yes	Yes	No	Yes
TOTAL yes / applicable items	11/16	8/13	16/16	3/13	16/16	7/13	4/13	9/16

Criterion (AMSTAR 2)	Munoz-Murillo (2018)	Nevala (2015)	Nieuwenhuijsen (2014)	Nigatu (2016)	Ratt (2016)	Sabariego (2018)	Suijkerbuijk (2017)	Trenaman (2014)
1. Did the research questions and inclusion criteria for the review include the components of PICO?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?	Yes	Yes	Yes	No	Yes	No	No	Yes
3. Did the review authors explain their selection of study designs for inclusion in the review?	No	No	Yes	No	Yes	No	No	No
4. Did the review authors use a comprehensive literature search strategy?	Partial yes	Partial yes	Yes	Partial yes	Yes	Partial yes	Partial yes	Partial yes
5. Did the review authors perform the study selection in duplicate?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
6. Did the review authors perform data extraction in duplicate?	No	Yes	Yes	No	Yes	Yes	No	No
7. Did the review authors provide a list of excluded studies and justify the exclusion?	Yes	No	Yes	No	Yes	No	No	No
8. Did the review authors describe the included studies in adequate detail?	Partial yes	No	Yes	Partial yes	Yes	Yes	Partial yes	No
9. Did the review authors use a satisfactory technique for assessing the risk of bias in individual studies that were included in the review?	Yes	Yes	Yes	No	Yes	Partial yes	No	Partial yes
10. Did the review authors report on the sources of funding for the studies included in the review?	No	No	Yes	No	Yes	No	No	No
11. If meta-analysis was performed, did the review authors use appropriate methods for statistical combination of results?	Yes	N/A	Yes	N/A	Yes	N/A	N/A	Yes
12. If meta-analysis was performed, did the review authors assess the potential impact of risk of bias in individual studies on the results of the meta-analyses or other evidence synthesis?	No	N/A	Yes	N/A	Yes	N/A	N/A	No
13. Did the authors account for risk of bias in individual studies when interpreting/discussing the results of the review?	Yes	Yes	Yes	No	Yes	No	No	No
14. Did the review authors provide a satisfactory explanation for and discussion of heterogeneity observed in the results of the review?	Yes	No	Yes	No	Yes	No	No	Yes

Criterion (AMSTAR 2)	Munoz-Murillo (2018)	Nevala (2015)	Nieuwenhuijsen (2014)	Nigatu (2016)	Ratt (2016)	Sabariego (2018)	Suijkerbuijk (2017)	Trenaman (2014)
15. If they performed quantitative synthesis, did the review authors carry out an adequate investigation of publication bias (small study bias and discuss its likely impact on the results of the review)?	No	N/A	Yes	N/A	Yes	N/A	N/A	Yes
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	Yes	Yes	Yes	No	Yes	Yes	No	Yes
TOTAL yes / applicable items	11/16	8/13	16/16	3/13	16/16	7/13	4/13	9/16

Criterion (AMSTAR 2)	Tse (2016)	Wheeler (2016)	Vooijs (2015)
1. Did the research questions and inclusion criteria for the review include the components of PICO?	Yes	Yes	Yes
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?	Yes	Yes	Yes
3. Did the review authors explain their selection of study designs for inclusion in the review?	No	No	Yes
4. Did the review authors use a comprehensive literature search strategy?	Partial yes	Partial yes	Yes
5. Did the review authors perform the study selection in duplicate?	Yes	Yes	Yes
6. Did the review authors perform data extraction in duplicate?	No	Yes	Yes
7. Did the review authors provide a list of excluded studies and justify the exclusion?	Yes	No	Yes
8. Did the review authors describe the included studies in adequate detail?	Partial yes	No	Yes
9. Did the review authors use a satisfactory technique for assessing the risk of bias in individual studies that were included in the review?	Yes	Yes	Yes
10. Did the review authors report on the sources of funding for the studies included in the review?	No	No	Yes
11. If meta-analysis was performed, did the review authors use appropriate methods for statistical combination of results?	Yes	N/A	Yes
12. If meta-analysis was performed, did the review authors assess the potential impact of risk of bias in individual studies on the results of the meta-analyses or other evidence synthesis?	No	N/A	Yes
13. Did the authors account for risk of bias in individual studies when interpreting/discussing the results of the review?	Yes	Yes	Yes
14. Did the review authors provide a satisfactory explanation for and discussion of heterogeneity observed in the results of the review?	Yes	No	Yes
15. If they performed quantitative synthesis, did the review authors carry out an adequate investigation of publication bias (small study bias and discuss its likely impact on the results of the review)?	No	N/A	Yes
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	Yes	Yes	Yes
TOTAL yes / applicable items	11/16	8/13	16/16

Appendix 5: Detailed thematic analysis

Information and process

What do employees say?

- The complexity of the ‘system’ is overwhelming – (ie: Workers’ Compensation, Motor Accident, Disability Support Pension, superannuation, life insurance, Disability Employment Services).
- Lack of accountability – being on calls for hours then getting shifted along the line; delays in payments because the necessary information isn’t complete, but the employee isn’t advised there is a problem therefore can’t redress it.
- Support providers aren’t transparent in what they can offer.
- Websites are too overwhelming, there are too many options.
- When able to find relevant information, it is often difficult to understand.
- Once you’re in a process, you need to spend a lot of time and effort following it up to make sure you don’t fall through the cracks.
- Uncertainty – payments get adjusted without any apparent reason or notice.
- The siloed nature of the system – each ‘supplier’ only considering their role.
- Repetitiveness – the number of times information has to be supplied/resupplied; the number of different medical examinations required (“I applied to go on a Disability pension but didn’t have enough points. So I had to go back to the psychologist again and that cost me \$300”).
- Lack of communication between parties (e.g. GP said to get a massage, but support provider wouldn’t cover it).

What has helped/would help?

- Networks of others with similar situations: can suggest options that aren’t always made visible by providers
- Central contact points: either an individual or an organisation
- Some kind of person to administer triage and help the individual figure out what is available to them
- Someone to make sure you are coping
- Having a physical office where you can speak to someone

Empathy and understanding

What do employees say?

- Lack of understanding from support providers (one size fits all approach, little room for flexibility in the system), employers (likely to assume you can’t do anything), and general public (“I’m young so I don’t look sick, but I am.”)
- Feeling that you need the support providers more than they need you — leads to feelings of being manipulated by support providers
- Nobody asks you what you can do

What has helped/would help?

- Flexible employers
- Advocates

Mental health and wellbeing

What do employees say?

- Being off work makes it harder to get work, which leads to loneliness, loss of self-confidence, loss of perceived control
- Work provides a network of social interaction
- Loss of social networks leads to degradation of mental health
 - No provision from support providers to give you something else to do (e.g. a gym membership might have obvious physical benefits but could also buffer mental health by giving routine and an opportunity to develop new social networks)
- The very real 'effort' of dealing with the system is mentally draining and demoralising.

What has helped/would help?

- Wellbeing activities (e.g. art classes, yoga) to help build routine and offer social contact
- Counselling as part of rehabilitation

'Good' work

What do employees say?

- Achieving work goals can have a positive effect on stabilising
- Doing some work can help in other wellbeing aspects e.g. mental health and motivation
- Returning to work means being productive, and having focus and direction
- Working alleviates financial stress

What has helped/would help?

- Volunteering was useful because there was less pressure to perform

Expertise

What do employees say?

- A number of support providers have no specialised experience working with disabled population
- Conventional job service providers pick up cases with disability to earn more money but do not have the requisite expertise
- Some support providers work in specialty areas but don't employ people with a background in area
- Case managers need to know the ins and outs of the disability group
- If there isn't expertise then there is tension because there isn't a shared understanding of what's expected

What has helped/would help?

- Case managers with deep experience or background in area of disability
- Speciality support providers (e.g. OSTARA)

Transparency

- Transparency around charter of service provider
- Transparency around rights of customers
- Transparency around services customers are entitled to
- Some support providers have a variety of different acts and charters to navigate

What has helped/would help?

- Support groups and sharing experiences allows individuals to get a better grasp on what's available to them

Attitudes to work

Every one of the employees who participated in this research wanted to work and had been looking for work. Their desire to work was not a barrier to work participation. This is not an aspect of the recruitment criteria but a natural phenomenon.

"Self-confidence dwindles the longer you aren't in work" and...

"Stability and routine are important for mental health".

Being employed is important for them in a number of ways:

- providing purpose
- being a productive member of society
- self sufficiency
- not being a burden on family and friends
- learning, opportunity, growth
- as well as more functional aspects such as money and travel.

Perceptions of getting employment

- If you're older you get nowhere. The market is saturated with young people who will do it on the cheap.
- You put in for 600 jobs and once they know why you left your last job they don't want to know. They don't want you to have time off to get help.
- People who work from home become 'invisible'.
- You have to lie to get work – they don't employ you if you tell the truth.
- Support from colleagues in the workplace/workplace culture. If you're returning to work people need to be welcoming, have a cuppa with you, provide an induction course, be patient. Give you training so you feel good and confident. It starts at the top – and with policies and practices in place for no bullying/discrimination.
- Risk of financial penalties of going back to work.

Personal challenges

- The fear of not finding a job – any job – and being able to stay in it.
- Not being able to cope with the job.
- Loss of confidence. The battle with the injury, the legals, doctors' appointments, paperwork.

Other

- Disability support system is very punitive — adds extra stress and pressure
- Job service providers are competing for government money — contrast against Centrelink who had no problem with documentation
- Would enrol in programs that get them more government money instead of the program that was best suited
- Job service providers (JSPs) are competing for their existence, so will often expand their scope to include those with health conditions. This occurs despite the JSP having no expertise working with people like that
- Over-reliance on volunteers
- “You need to make yourself look twice as bad in order to get half the help you need”
- Assessments by independent medical examiners (IMEs) are often a negative experience
- Independent appeals body doesn’t even have disability access — was five minutes late because elevator was broken, was told they missed an appointment
- Lost all payments because of error on part of doctor
- Every single appointment is 3pm in the city and you can’t bring children with you to the appointment
- “Left injured, suffering, and untreated, with no belief in yourself”.

Appendix 6: Review quality

Intervention	Review	Outcome	Quality	Result
Goal setting	Levack et al., 2015	Empowerment	16/16	Low quality of evidence that goal setting increases wellbeing and perceived self-efficacy
Goal setting	Wheeler et al., 2016	Empowerment	7/13	Moderate evidence that goal-directed rehab improves goal attainment
Strength-based interventions	Tse et al., 2016	Empowerment	6/13	Weak evidence that strength-based interventions improve self-esteem, self-efficacy, social support, spiritual well-being and psychiatric symptoms
Goal setting	Levack et al., 2015	Work outcomes	16/16	Unclear what the effect of goal-setting has on work participation – not enough data/reporting
Goal setting	Wheeler et al., 2016	Work outcomes	7/13	Moderate evidence that goal-directed rehab improves occupational performance
Education	De Boer et al., 2015	Work outcomes	15/16	Low quality evidence of no effect of psycho-educational interventions on RTW rates or quality of life (compared to care as usual)
Education	Hegewald et al., 2019	Work outcomes	16/16	Low- to very low-certainty evidence. Unclear whether counselling plus health education programs improve RTW
Mentorship	Lindsay et al., 2016	Work outcomes	7/13	Partial evidence that mentorship interventions improve school- or work-related outcomes
Mentorship	Wheeler et al., 2016	Work outcomes	7/13	Insufficient evidence that peer-mentoring improves quality of life
Person-centred planning	Ratti et al., 2016	Work outcomes	9/13	Low quality evidence that person-centred planning may have a positive, yet moderate, impact on community- and life-participation. Impact on employment outcomes is inconclusive.
Problem-solving	Dewa et al., 2015	Work outcomes	7/13	Inconsistent findings regarding effect of work-focused problem-solving on RTW
Problem-solving	Nigatu et al., 2016	Work outcomes	9/16	Problem-solving strategies (amongst other interventions) did not lead to improved RTW rates

Intervention	Review	Outcome	Quality	Result
Problem-solving	Doki et al., 2015	Work outcomes	10/16	No effect of problem-solving treatment alone on sick leave reduction but a combined problem-solving and CBT intervention did have significant effect on total sick leave days
Support	Cheng et al., 2018	Work outcomes	7/13	Insufficient evidence for effective support strategies in obtaining and maintaining employment. No assessment of evidence quality
Support	Dewa et al., 2018	Work outcomes	7/13	Low quality (high risk) evidence that individual placement and support (IPS) programs with augmentations (compared to IPS alone) may be more effective in employment outcomes
Support	Modini et al., 2016	Work outcomes	9/16	Fair- to good-quality evidence that individual placement and support programs are an effective intervention for competitive employment. Twice as effective as traditional rehabilitation programs.
Support	Muñoz-Murillo et al., 2018	Work outcomes	7/13	Good quality evidence that job access strategies seem to improve employment outcomes. The effectiveness of return to work strategies remains unclear
Support	Trenaman et al., 2014	Work outcomes	6/13	Some evidence that supported employment can improve employment outcomes but unable to assess quality due to heterogeneity of methods and factors.
Support	D'Amico et al., 2018	Work outcomes	7/13	Strong evidence for role of occupational therapy-based social participation interventions for improving social participation and occupational engagement. Interventions more effective when pair with client-centered goal focus
Support	Donker-Cools et al., 2015	Work outcomes	8/13	Strong evidence that worked-directed interventions in combination with education/coaching improves RTW
Support	Nieuwehuijsen et al., 2014	Work outcomes	12/16	Moderate evidence that coaching support plus regular care reduced sickness absence to moderate extent.

Intervention	Review	Outcome	Quality	Result
Support	Suijkerbuijk et al., 2017	Work outcomes	15/16	Moderate to low quality evidence that supported employment and augmented supported employment are more effective than the other interventions in obtaining and maintaining competitive employment
Work accommodation	Vooijs et al., 2017	Work outcomes	10/13	Medium quality evidence that three of four reviews on work accommodation reported beneficial effects on work participation
Work accommodation	McDowell et a., 2014	Work outcomes	4/13	Mixed quality evidence. Workplace accommodations are rare, but most common type is flexible scheduling/reduced hours. Direct costs associated with workplace accommodations are often low.
Work accommodation	Nevala et al., 2014	Work outcomes	7/13	Moderate evidence that types of workplace accommodation promote employment. Low evidence that workplace accommodation administered by cases managers increases RTW. Lists a number of drivers and barriers
Work accommodation	Cullen et al., 2018	Work outcomes	11/13	Strong evidence that combinations of at least two of health-focused interventions, service coordination interventions, and work modification interventions reduces time away from work. Strong evidence that CBT ineffective without workplace modification or service coordination.
Work accommodation	Sabariego et al., 2018	Work outcomes	8/13	Reliable quality evidence suggesting that positive changes employment status, return to work and sick leave outcomes were achieved with workplace accommodation interventions that involve graded sickness-absence certificates and part-time sick leave