at work

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Special themed issue on return to work

Work accommodation offers are on the rise, but not always accepted

Workplaces in Ontario are headed in the right direction when it comes to offering injured employees a work accommodation, but there's still more work to be done.

A work accommodation offer and its acceptance by an injured worker significantly predict a shorter work absence. These were findings from an Institute for Work & Health study published in the *Journal of Occupational and Environmental Medicine* in 2007.

"Our study found that 69 per cent of workers who were off work due to a musculoskeletal injury were offered a work accommodation six months post-injury," says Scientist Dr. Renée-Louise Franche, who led the study. By contrast, in another Institute study conducted more than 10 years ago, the rate of work accommodations was 38 per cent one year after injury.

Although this increase is encouraging, only 84 per cent of the workers in the current study accepted the offer. "This is one of the first studies to look at the acceptance of the offer rather than just the rate of offer itself," notes Franche. "The most important reason reported for refusing the offer was not being physically ready or able to go back to work. We need to determine why this is and find solutions."

The study looked at 632 workers who had a Workplace Safety and Insurance Board (WSIB) lost-time claim. They had been absent from their jobs for more than five days. Workers' information was drawn from two separate sources: interviews and the WSIB administrative database, which captured information such as claim status and the time receiving wage replacement benefits. Participants were interviewed by telephone at one month and six months after their injury. They provided information including their return-to-work (RTW) experiences and duration of work absence.

Researchers compare six RTW strategies

Researchers compared the effectiveness of six early return-to-work/disability prevention strategies in this group of workers. These strategies were identified in a previous review (*see below*).

The goal was to see how each strategy affected the workers' time off and receipt of benefits. Researchers found two approaches were critical for effective early RTW. One strategy, described above, was around work accommodation.

They also found that when a health-care provider advised the workplace on how to prevent re-injury in the worker, there was a shorter work absence. "The key finding here is that it is the content of the interaction that is important," says Franche.

By using the same methods and population of workers to evaluate the effectiveness of each these strategies, the study identified the most critical strategies in an early (one month post injury) workplace-based return-to-work intervention program. ✪

An IWH systematic review completed in 2004 identified several strategies that were associated with a shorter duration of work absence. This new study in Ontario identified two strategies that are critical for effective early RTW (in bold):

- early contact with the worker by the workplace
- **work accommodation offer and acceptance**
- contact between the health-care provider and the workplace about workplace demands
- **advice from the health-care provider to the workplace on preventing re-injury**
- ergonomic worksite visits
- presence of a return-to-work coordinator

In this issue

INSTITUTE FOR WORK & HEALTH
INSTITUT DE RECHERCHE SUR LE TRAVAIL ET LA SANTÉ

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What researchers mean by …

grey literature

If you were a busy practitioner seeking information on managing back pain, where would you turn: a blog by a person describing her experiences, a fact sheet from a reputable hospital, a research study in a scientific journal or a tabloid newspaper article?

We all apply a level of trust to information based on the source and the quality we associate with it. Plus, time demands and our access to information or our ability to understand it can also influence what we choose.

Scientists generally place the most trust in information published in journals that use the peer-review process. "Peer review" means that each study submitted to a journal is sent by its editors to two or three other experts in that field. These experts, or peers, provide an anonymous critique with a view to improve the write-up of the study. If they don't think the study meets certain scientific standards, they might advise against publishing it at all. Peer review helps to maintain scientific standards.

Practitioners in workplaces may not have access to peer-reviewed journals, or the time or expertise to wade through scientific text. They're more likely to turn to other sources of information that they trust. Examples could be trade publications, government reports, survey results from a polling company or technical reports.

These documents are all considered "grey literature." The term grey literature comes from the uncertainty of the status of this information. Although there are several formal definitions, grey literature is essentially any document that hasn't gone through peer review for a publication. It can also include conference proceedings or doctoral theses.

Challenges with reviewing grey literature

When IWH reviewers conduct systematic reviews on a topic, they search for studies on that topic in peer-reviewed journals. We've found that practitioners who are consulted during reviews sometimes ask us to include the grey literature as well, to make sure that the search is as comprehensive as possible.

One concern of reviewers is the scientific quality of the studies. If an article doesn't go through peer review, it's possible for the author to make claims or interpretations that aren't supported.

Until recently, it has been more difficult to systematically search the grey literature than peer-reviewed studies. These documents often aren't indexed (or catalogued) in the major databases that are typically and systematically searched in reviews. It usually requires extra effort to find and get copies of these documents.

The format of a grey literature document can be quite diverse, unlike scientific papers that follow the structure of presenting background information, study methods, results and a discussion. So it's more difficult for reviewers to systematically extract information from grey literature as they do for peer-reviewed papers.

The benefits of reviewing grey literature

Grey literature documents can provide a richer source of detail than a scientific study. Because they aren't tied to a conventional structure, they can be longer and provide more detail. Research results can be written in a style that is more accessible and useful to a practitioner than a scientific paper.

Grey literature can also be published more quickly since it does not have to go through the potentially lengthy peer-review process. And in cases where there isn't much information on a topic in peer-reviewed research, grey literature may provide a valuable source of information.

Finally, grey literature is becoming easier to find. Increasingly, it is available on the Internet, and search engines and databases are providing ways of locating it.

Comparing results

In a recent review on participatory ergonomics, IWH researchers included grey literature documents in their review in response to requests from external practitioners. The end result? The findings from grey literature documents were similar to the peer-reviewed.

Grey literature can provide a systematic review with an additional source of rich information, depending on the topic and the nature of the research. The challenges and benefits need to be weighed against each other when deciding on whether to include it in a systematic review. ✪

A return to work may not mean a full recovery

When workers return to work after an injury, it may not mean that they have fully recovered, a new Institute for Work & Health study suggests.

Researchers interviewed 632 workers with lost-time claims for work-related musculoskeletal injuries of the back or upper body. These workers provided information about their physical and mental health, workplaces, health-care providers and insurers at one month and six months after their injury.

Three categories of workers were identified at one month: workers who had a sustained first return to work, workers who returned to work but injury symptoms had recurred, and workers who did not return to work over the course of the follow-up. (A sustained return to work means workers remained at work after their return.)

"At six months after injury, 38 per cent of workers who had attempted a return to work reported at least one recurrent work absence," says Dr. Ute Bültmann, a researcher from the Netherlands who took part in this study during a work placement at the Institute. "This finding is consistent with previous research that suggests that a first return to work does not translate into a complete recovery from a musculoskeletal disorder." The results of this study were published in the journal, *Quality of Life Research* last year.

Workers who had a sustained first return to work reported better health and fewer work limitations than other workers. However, even 27 per cent of workers with a sustained return to work at the one-month interview had experienced a work absence by the six-month interview, notes Bültmann.

Depressive symptoms in workers

Additionally, researchers found high levels of depressive symptoms in all injured workers, and especially in those with a recurrence of work absence and those who did not return to work.

"This finding is in line with earlier studies that show that depressive symptoms are common in MSK-injured workers. This highlights the need to address and examine the mental health of workers who suffer a workplace injury," notes Bültmann.

An epidemiologist and associate professor at the University Medical Center Groningen, University of Groningen in the Netherlands, Bültmann was involved in this study while she was a researcher in the Canadian Institutes of Health Research (CIHR) Work Disability Prevention Strategic Training Program. Funded by the CIHR, it is the first training initiative of its kind to focus on a transdisciplinary approach for the prevention of work disability. Several Institute scientists serve as mentors and advisors in this program.

Bültmann was recently appointed an IWH Adjunct Scientist. She plans to visit in the fall of 2008 to collaborate on additional projects. ✪

To find out more about the CIHR Work Disability Prevention Strategic Training Program, visit: www.usherbrooke.ca/wdp/eng/index.html

In Brief ...

Workers with musculoskeletal injuries may not have fully recovered when they return to work.

More evidence in favour of return to work and disability management

A new review has confirmed that disability management and return-to-work programs are effective, replicating findings from two other systematic reviews from the Institute for Work & Health (IWH).

"These programs reduce or control the severity of injury in injured workers or reduce workers' compensation claims," says Dr. Shelley Brewer, who led the systematic review along with a team at IWH. Brewer is a Chemical Loss Control Specialist with ChemPlan Inc., who conducted the review while at the University of Texas School of Public Health in Houston.

The review looked at the effectiveness of injury/illness prevention and loss control programs (IPCs). IPCs include three Ps – work **practices** among employees, **policies** developed by employers and **programs** required by regulation.

In the category of RTW/disability management, reviewers found eight studies of sufficient scientific quality. All showed positive effects compared with a control or comparison group.

The studies looked at different types of approaches. Among these were a graded activity program, rehabilitation programs, disability case management programs and return-to-work policies.

"We recommend the development of multi-component disability management programs, using an approach that involves the health-care provider, company supervisors and employees, and workers' compensation carriers," says Brewer.

Previous IWH reviews on workplace-based RTW programs, and on the economic evaluation of disability management interventions also showed they were effective. All three reviews are available on the Institute's website: www.iwh.on.ca ✪

In Brief ...

Disability management and return-to-work programs reduce injury severity in injured workers and reduce workers' compensation costs.

New tool opens dialogue on return-to-work issues

In recent years, the Institute for Work & Health's Knowledge Transfer and Exchange department has made tool development a priority. "We have mature research results from our scientists on several occupational health and safety issues. We need to translate this evidence so people can use it in their work," says Kathy MacDonald, a Knowledge Transfer Associate at the Institute. "It is also important to include the people who will use the tool during its development."

The Seven Principles for Successful Return to Work

The principles are based on the evidence from a systematic review completed in 2004 by Drs. Renée-Louise Franche and Ellen MacEachen, and other researchers. The seven principles are based on the literature to date and may change as new research evidence becomes available.

1. The workplace has a strong commitment to health and safety, which is demonstrated by the behaviours of the workplace parties.

2. The employer makes an offer of modified work (also known as work accommodation) to injured/ill workers so they can return early and safely to work activities suitable to their abilities.

3. RTW planners ensure that the plan supports the returning worker without disadvantaging co-workers and supervisors.

4. Supervisors are trained in work disability prevention and included in RTW planning.

5. The employer makes an early and considerate contact with injured/ill workers.

6. Someone has the responsibility to coordinate RTW.

7. Employers and health-care providers communicate with each other about the workplace demands as needed, and with the worker's consent.

One such area is return to work. Institute Scientists Dr. Renée-Louise Franche and Dr. Ellen MacEachen conducted a systematic review to determine what works best in workplace-based return to work. The results of this review were the basis for the Seven Principles for Successful Return to Work (*see sidebar*). "We're now taking these seven principles and developing a tool that can help occupational therapists communicate with employers around improving return-to-work programs," notes MacDonald.

Occupational therapists endorse idea

In 2006, Institute researchers presented the seven principles to a group of occupational therapists (OTs). These OTs were considered informal opinion leaders by their peers. This group, who form one of the Institute's educationally-influential (EI) networks, discussed how the principles could be incorporated into their practice.

Following this discussion, the occupational therapists saw an opportunity to turn the seven principles into a tool that would benefit employers and OTs. Gabriele Wright, an occupational therapist who practices in the Guelph area, volunteered to sit on a working group to create the tool. "Employers need to accommodate injured workers – it's not only a legal requirement, to me, it's the right way to go," she says. "With this tool, we can take a potentially complex process of return to work and turn it into more digestible bites."

The working group was a "unique collaboration" with representatives from the Ontario Society of Occupational Therapists (OSOT), the Institute for Work & Health and occupational therapists in the field, says Lynn Shaw, a member of the group. "All of the partners were very active and the College of Occupational Therapists of Ontario (COTO) was supportive of this project," notes Shaw, an assistant professor in the school of occupational therapy at the University of Western Ontario.

Working Together created

Over the next year, the group met several times to develop *Working Together*, the draft tool. "This is an engagement tool that will help occupational therapists talk to employers about the questions they may have about the return-to-work process," explains MacDonald.

The working group structured the seven principles into four stages that were more intuitive to the way occupational therapists work. Then, they drafted questions employers might have around return to work and linked them to specific principles. Using OTs' scope of practice and skill sets, each principle was then linked with specific actions an occupational therapist could offer the workplace to implement the principle.

Working Together is in a booklet format. "It was designed so that an occupational therapist can pull out even one section and take it to the employer," says Shaw. "That way, it's more functional and it's flexible."

Wright added, "This tool will give teeth to my recommendations [to employers]. I've already referenced the seven principles' research to support my suggestions."

Next steps

The working group has sent the draft tool out for feedback to the researchers, the larger EI network, and to OSOT and COTO. In addition, the tool will be evaluated to determine how the occupational therapists use it.

"This project demonstrated that the occupational therapists are picking up well-grounded research and are moving forward with it," explains MacDonald. "The Institute for Work & Health can only go so far with the research evidence – then the findings need to be used in the field to improve occupational health and safety issues." ✪

For more information about this tool, please contact Jane Gibson, Director of Knowledge Transfer, at jgibson@iwh.on.ca.

IWH has a rich history in return-to-work research

When the Institute for Work & Health was established in 1990, the three senior scientists who were brought on board to lead research projects knew they had to launch an "ambitious, large study" to make the Institute's mark.

Over the next year, these scientists – Drs. John Frank, Claire Bombardier and Harry Shannon – along with other researchers, began to construct what was one of the largest and most complex occupational health research projects in Canada to date.

Study identified risk factors

The Ontario Universities Low-Back Pain Study examined which factors contributed to low-back pain reports in workers at an auto assembly plant. "This study was one of the most in-depth and sophisticated studies ever done on the biomechanical and psychosocial factors affecting back injuries," says Dr. John Frank, the Institute's first Scientific Director.

The study identified several risk factors that were associated with low-back pain reports from these workers. They included having a physically demanding job, perceptions of a poor workplace social environment, and inconsistency between a worker's job and education level.

Then, to look at the factors affecting the duration of disability after sprains and strains, Institute researchers initiated the even larger Early Claimant Cohort (ECC) study in 1994. This study also tested the effectiveness of an early, active, exercise and education program for injured workers. The program was sponsored by the workers' compensation board and was community-based, in physiotherapy and chiropractic clinics across Ontario. The researchers found that there were no health-related or return-to-work advantages with this treatment program, compared with usual care.

These two "flagship" studies became cornerstones of workplace-based studies, as well as return-to-work and work disability prevention knowledge at the Institute.

Dr. John Frank

Communication issues

Frank noted that after a few years of directing the scientific program at the Institute, the scientists were becoming aware of some communication challenges in the occupational health and safety system. "By the time we finished the ECC, it was clear to us that the relationship among the workplace, the injured worker and the care system was the critical factor, and that it was frequently dysfunctional," says Frank, now Scientific Director at the Institute of Population and Public Health, Canadian Institutes of Health Research.

This premise led to the development of one of the Institute's first disability management tools, the *Work-Ready Workshop*. To create this tool, different stakeholders such as health-care providers, workplace decision-makers, injured worker representatives, and policy-makers came to the same table to discuss return to work. The materials for the workshop were built on a series of case studies that showed situations in which return to work was delayed. Each case study came with an analysis of what happened, and provided recommendations to improve the final outcome, based on scientific evidence. "*Work-Ready* focused on changing what the stakeholders knew and understood to be important, and their attitudes around return-to-work practices," notes Frank.

Primary and secondary prevention

In 2003, Frank co-authored an IWH paper – *Preventing Injury, Illness and Disability at Work: What Works and How Do We Know?* (later published in the *Scandinavian Journal of Work and Environmental Health* in 2006) – that aimed at initiating a dialogue about prevention among Ontario occupational health and safety organizations. One of four themes in this paper addressed the merging of primary and secondary prevention approaches. The goal of primary prevention is to protect people from developing an illness or experiencing an injury. Secondary prevention aims to reduce disability and promote recovery after an injury or illness has occurred.

"Combining primary and secondary preventive interventions can yield a greater impact than the sum of the impacts from separately implemented interventions," the paper notes.

In fact, Ontario's Health and Safety Associations (HSAs) are examining how they can embrace secondary prevention initiatives in their work (*see article on page 7*).

Tool development

More recently, Institute researchers – led by Dr. Renée-Louise Franche – conducted "the most sophisticated and comprehensive literature review on workplace-based return-to-work programs to date," says Frank. The results from this review were the basis for several products including the *Seven Principles for Successful Return to Work* and a draft tool for occupational therapists (*see article on page 4*).

"The research question was structured so broadly and yet appropriately, that it required a transdisciplinary centre to conduct it. You can hardly find a centre like the Institute in the United States or in Europe that can do this type of research," Frank says. ✪

As of July 1, 2008, Dr. John Frank will become Director of the Scottish Collaboration for Public Health Policy and Research based in Edinburgh, Scotland.

infocus

"Toxic dose" of too many problems can lead to long-term claims

Why do some lost-time claims last longer than anyone expected?

In recent years, about 20 per cent of lost-time compensation claims in Ontario are responsible for approximately 80 per cent of benefit expenditures.

Behind these numbers are the actual stories of injured workers. To understand their experiences, Dr. Ellen MacEachen, Dr. Agnieszka Kosny, Sue Ferrier and Lori Chambers from the Institute for Work & Health interviewed 69 injured workers, peer supporters and service providers from across Ontario. Their goal was to identify the factors that led to long-term or prolonged claims.

"Many workers we interviewed seemed to be typical workers, but they got what we called a 'toxic dose' of more than one problem," says MacEachen, the scientist who headed this study.

If, in addition to an injury, workers had an unsupportive workplace, financial problems and other issues that prolonged their claim, this "toxic dose" could lead to a spiral of negative events that complicated their claim. In many cases, it also had a devastating personal impact.

"If workers only had one problem they might have been able to proceed as expected," says MacEachen, "But it's the confluence of problems that tips things against their favour."

Although the researchers found some common themes that could prolong claims, each worker's situation was unique. If you were older and already had health problems, if you relied on walk-in clinics instead of a family doctor – these were just a few of the factors that could affect your return to work.

However, all workers needed goodwill from their employers. For instance, an employer might arrange modified work, but this would only succeed if the immediate supervisor was on board and the work was appropriate – not a meaningless "make-work" project that created resentment among colleagues, or work that was too difficult.

"If workers can't do the work, they might be reinjured or be in pain," says MacEachen. Indeed, many said they "over-complied." They knew they shouldn't be returning to work or that their modified tasks were too difficult. But they feared losing their jobs so they worked anyway, increasing their doses of pain medication to cope.

"I've seen a lot of guys like that," says Hal*, an injured worker from the study. "…[they] went back to work, doing whatever they were doing, just, popping pills like a son of a gun to keep going, and all they're doing is killing themselves."

On the other hand, some workers genuinely feared going back to work and may have resisted it, which could be viewed as uncooperative by employers or the compensation system.

Another underlying problem was miscommunication, which MacEachen likened to a game of "broken telephone,"

Mental health issues and medication use in injured workers

For some injured workers, their experiences dealing with a lost-time claim have led to mental health problems or issues with medication use.

As part of their study into long-term and prolonged claims, Scientist Dr. Ellen MacEachen and Research Assistant Lori Chambers looked more closely at these two areas. In addition to conducting a focused "mental health" analysis of interviews with 69 injured workers, peer helpers and service providers, the research team reviewed the studies on mental health problems such as anxiety or depression.

MacEachen noted that most mental health research takes a psychological approach – which means it focuses on diagnosing and treating an individual.

However, she notes, "There is very little understanding of systematic pathways to mental health problems in the context of work injury." There may be a number of external stresses or situations that can be identified. Reducing these stresses may minimize the emotional strain in some workers as they proceed through the return-to-work process.

"Mental health issues are associated with denied and delayed claims," says MacEachen. "And when a worker fails in return to work or

in the problems that occurred when workers, doctors, employers and adjudicators didn't have an effective or coordinated way of communicating.

Says Tracy*, an occupational physician, "…occasionally workers come to us literally with the letter the [compensation] board has sent them and they don't have a clue what it means. The language is totally inscrutable to them."

Sometimes the way a claim unfolded led to problems, and the lack of income or benefits hit some workers hard. "These unresolved claims can derail everything," says MacEachen.

Many workers had musculoskeletal disorders, which are injuries to muscles, tendons or other soft tissues that are difficult to diagnose. If additional medical reports were needed to verify the claim, this created delays. Or if a worker didn't report an injury immediately, thinking it would improve, this made it hard to establish the date and the work-relatedness of the injury. Some felt that their situations were not understood because there was no face-to-face contact with adjudicators.

"A person is more complex than what's written on paper," says Anne*, an injured worker peer helper.

It was also a challenge for workers to fill out the forms for a compensation claim, and missed deadlines would delay claims. Or they might be denied and have to appeal the claim to provide more evidence.

"Delays, denials and miscommunication can worsen an individual's situation, leading to poverty and poor health," says MacEachen. With no benefits coming in, some workers would drain their own resources or borrow money repeatedly from family and friends. Add the stress of an unsupportive employer, the pain of the injury, the diminishing goodwill from family or friends, and sometimes workers would develop mental health problems such as anxiety. (*see below*)

To help prevent such situations, MacEachen, Kosny and Chambers are developing a new tool to identify "red flags" and "green lights." Red flags are those toxic situations or roadblocks that could complicate their claim. If a red flag is identified, the idea is that the service provider needs to look into the individual context more to prevent these other issues from overwhelming the situation. Green lights identify helpful practices in the return-to-work process.

MacEachen has also presented her findings to staff at the Workplace Safety and Insurance Board's Return to Work/Labour Market Reentry branch. ✪

* *pseudonyms*

Some results from this research were published in Policy and Practice in Health and Safety, 2007.

in retraining, you can begin to see mental health problems."

She also says that the experience of dealing with the bureaucracy involved in a compensation claim can create stress and a sense of loss of control in a worker.

In their interviews, all of the workers said they had taken medication following their work injury. Twenty had used morphine-like drugs, opioids, to manage pain, and eight had used anti-depressants.

The effects of the medication can also make a return to work more difficult by impairing their communication and ability to focus, says MacEachen. With opioids, workers should not be driving, operating heavy machinery, or engaged in intense learning programs, but these limitations are sometimes not recognized.

What can help? MacEachen suggests that having someone "on their side," with face-to-face contact, could help workers cope.

There also needs to be a shift away from the thinking that mental health issues should be recognized and treated after they develop, says MacEachen. Instead, there needs to be a way to flag potential problems before they fully emerge. If not, a worker's situation can turn from one health problem, a physical one, to mental health problems that can last a long time.

HSAs to develop an education role in return to work

Ontario's Health and Safety Associations (HSAs) may soon take a more active role in educating their clients in work disability prevention and return to work, which is also known as secondary prevention. Traditionally, HSAs have provided information and services around preventing workplace injury and illness – also known as primary prevention – to their clients.

The Institute for Work & Health will provide knowledge transfer expertise around evidence-based return-to-work information, while the HSAs will act as conduits for this information to workplaces.

"This new project aims to engage the prevention system – including the HSAs, Ministry of Labour and the Workplace Safety and Insurance Board – as a whole so that we offer one consistent approach to disability prevention and return to work," says Nicole Lindo, Project Manager, Disability Prevention/Return to Work at the Municipal Health and Safety Association.

"Its purpose is to enhance the associations' understanding of disability prevention and return to work so that it's reflected in their programs, products and services," notes Lindo. By being well-informed, the HSAs can more effectively present the benefits of developing a return-to-work program with their clients. They can also link them to appropriate WSIB resources.

So far, roles and responsibilities for the HSAs have been developed and approved. The next step is to develop a pilot project that will target specific employers. "We want to identify where the greatest need is and develop specific content to fit these needs," says Lindo. ✪

For more information, contact Nicole Lindo at nlindo@mhsao.com.

Cochrane Back Review Group update

The Cochrane Back Review Group recently released three systematic reviews on low-back pain interventions, which are summarized below. Further details are available from the group's list of completed reviews: www.cochrane.iwh.on.ca/rev_comp.htm

Antidepressants not beneficial for low-back pain?

In a review of 10 trials, a team of Cochrane researchers found no clear evidence that antidepressants are more effective than placebo in managing chronic low-back pain. The finding is significant because doctors commonly prescribe antidepressants to patients with low-back pain to provide pain relief, help with sleep and reduce depression.

Researchers cautioned that larger and more sophisticated studies are required to confirm the conclusions of this review. Also, the findings do not suggest that patients with significant depression or with other specific types of chronic pain should avoid antidepressants.

NSAIDs can be effective when no sciatica present

Are aspirin, ibuprofen and other non-steroidal anti-inflammatory drugs (NSAIDs) effective in treating low-back pain? The evidence from 65 trials showed that they are slightly effective for short-term relief in patients with low-back pain without sciatica (pain and tingling radiating down the leg).

While the review found NSAIDs were more effective than a placebo or sham treatment, they did not appear to be more effective than other prescribed drugs such as paracetamol (acetaminophen), narcotics or muscle relaxants.

Education benefits patients with acute low-back pain

A single individual education session lasting two and a half hours can benefit people with acute (short-term) low-back pain.

Cochrane researchers, who reviewed 24 studies, concluded that patients with acute low-back pain who received intensive individual education sessions, in addition to their usual care, had better return to work and functioning than those who did not. Such educational sessions appeared as effective as other approaches such as chiropractic manipulation, physiotherapy or worksite visits for improving pain and function.

Providing written information alone was not as effective. Nor were information sessions lasting less than two hours. People with chronic, long-term low-back pain were less likely to benefit from education sessions than from non-educational therapies such as physiotherapy, yoga or exercises. ✪

Collaborative moving forward

The Workplace Disability Management Benchmarking (WDMB) Collaborative brings together Institute researchers, employers and disability management professionals to help establish benchmarks and identify the gaps in disability management practices. Employers can use these benchmarks to track and compare their performance and identify best practices with other employers in their sector.

The Collaborative is wrapping up the final phase of its pilot program, which is testing disability case management satisfaction metrics. A WDMB Forum, held in May 2007, provided current and future Collaborative members the opportunity to provide feedback about key issues identified during the pilot, and to comment on the WDMB's value. Individual company benchmarking reports for pilot project participants are almost complete.

The WDMB established an advisory board that met for the first time in November 2007 to begin planning for the 2009 data collection phase. There is strong continued support for the 2009 data collection in the financial sector, and plans to target expansion in the pharmaceutical and telecommunications sectors. ✪

For more information about the WDMB, contact Project Manager Roman Dolinschi at rdolinschi@iwh.on.ca

What's new on the web

Visit the Institute's website to access review findings and information on occupational health and safety, such as:

- the MSD Prevention Toolbox
- resources to help plan events for 2008 NAOSH Week (North American Occupational Safety and Health Week), which runs from May 4-10
- factors for success in participatory ergonomics, based on a systematic review
- recommendations from the injury prevention and control systematic review

Click on the links at **www.iwh.on.ca** under Recent Updates.

IWH News

Institute now accepting Syme Fellowship applications

The S. Leonard Syme Training Fellowships in Work & Health target young researchers at the master's or doctoral level intending to study work and health. The Institute offers two awards: a major award in the range of $15,000 to 20,000 and a minor award of $5,000 or less.

In the spirit of Dr. Syme's own contributions to research mentorship, candidates from any disciplinary background are eligible. Recipients of the award will typically be enrolled at an Ontario university that has a formal affiliation with the Institute (McMaster University, York University, University of Waterloo and the University of Toronto).

The deadline for applications is May 30, 2008. Application forms and additional information are available from the Institute's website at: www.iwh.on.ca/about/syme.php

Attend a workshop

Register now for the upcoming Systematic Review Workshop. Program details are on the IWH website at www.iwh.on.ca/sr/sr_workshops.php or contact us at srworkshops@iwh.on.ca